



Chapter 2

Health and Human Services

The health and human services function in California is the second largest area of expenditure in state government after education. Spending on these programs is estimated at \$64.8 billion in all funds and \$24.6 billion in state General Fund in Fiscal Year 2004–2005. This budget funds many essential services to Californians:

- Health services for 7.7 million people and income assistance to 2.4 million people.
- Emergency services and family counseling to 176,000 children whose home and family situation poses a danger to them and pays for the placement of 90,000 children in foster care.
- Job preparation and employment support services to 1.2 million CalWORKs' recipients and 79,000 physically disabled individuals.
- Purchases services and case management for 199,000 children and adults with developmental disabilities.
- Public health programs that provide Californians with information regarding disease, safe drinking water and environmental health issues.

Overall, the budget pays the salaries of 29,700 state employees to provide and oversee health and human services.

The California Performance Review's recommendations in this chapter improve the delivery of health and human services efficiency and effectiveness at both the state and county government levels.

First, there is a proposed reorganization of the state level health and human services functions into a single state Department of Health and Human Services. Second, there is a proposed realignment of the current state-county relationship in providing health and human services. These fundamental changes hold the potential for improved, less costly and more accountable services for California's needy and at-risk populations. Over the next five state fiscal years, this change is expected to generate significant savings for the General Fund and also in county funds. Because of the impact of the proposal on the counties, there is a companion proposal that offers a blueprint for realigning the current responsibilities for the delivery of health and human services that is currently shared by the state and the counties. Finally, there is a refocus of the basic operations in the delivery and oversight of health and human services. The changes proposed in this report in the following service areas are: children's services, public and mental health services, licensing and service oversight, and Medi-Cal Services.

This report includes a reorganized Health and Human Services function in state government. The new Department of Health and Human Services will reorganize into multiple program centers that operate the service delivery systems. The program centers are designed to maximize core competencies, avoid duplication of services and improve the state's purchase, delivery and oversight of health and human services. The proposed organization will revitalize the provision of health and human services by providing the department secretary with the tools to provide stronger direction and leadership including strategic budgetary direction, comprehensive policy analysis and development and management of data and technology.

Finally, the proposed organization will fix both responsibility and authority for all health and human services program with the Secretary for Health and Human Services. The reorganization will save General Fund money through shared administrative and support services, elimination of duplication of services and improvement in the efficiency of the organization.

Realignment

There are two recommendations in this report that propose fundamental change in the current division of responsibilities for the delivery of health and human services in California. One proposal calls for the transformation of the eligibility process for the Medi-Cal, CalWORKs and Food Stamp Programs. The proposal re-invents the forty-year old paper intensive system operated by county welfare departments. This system is very expensive and not customer friendly to the needy population of the state. The transformation will take advantage of current technologies to provide applicants with a consolidated system operated at the state level that will accept applications via the Internet, telephone and mail. The proposed system will provide for applications to be submitted 24-hours a day through the Internet. Individual applicants may also be assisted with the application by medical providers or community based organizations at significant savings from the current county operated system. A similar system is currently operational in two other large states and planned for two additional states in the next two years. The proposal will save significant funding in the health and human services system annually at the state, county and federal level when fully implemented.

The second proposal builds on the opportunity in savings and the shift of management oversight of the eligibility proposal and proposes a blueprint for sweeping change in the financing and delivery of health care and children's services in California. The current statutory arrangement divides responsibility for the financing of health services to the needy between the state and county governments. The division is based only upon whether the individual qualifies for the federal Medicaid program and funding. The vast majority of individuals qualify and are served by the state's Medi-Cal program. A smaller category of individuals defined as Medically Indigent Adults (MIA) by Welfare and Institutions Code Section 17000 remain the responsibility of the counties. The proposal revisits that division of



responsibility for health services between the state and counties in order to assure health care is provided on an equitable and cost-effective basis to California's entire needy population.

In addition, the proposal also calls for the state to make a fundamental change in the relationship between the state and counties in the delivery of child welfare services, foster care and other family support services. Currently, three levels of government, federal, state and county, provide rules and funding for the Child Welfare Services program. Rules are set at the state and federal level and services are delivered by the counties. Many reports have identified failures in the child welfare system. The relationship between the various levels of government, including categorical funding and requirements for detailed service documentation, distract from the real goals of the programs. The change would be for the counties to have clear responsibility for these programs, including a reliable funding source and authority for the day-to-day provision of services. The state role would shift to that of a partner to the counties in supportive innovation and best practices, as well as advocating with the federal government and state legislature to reduce or eliminate categorical restrictions and detailed reporting requirements. The ultimate state responsibility will be developing a system to measure real outcomes in child welfare services and foster care. Those outcomes need to measure the safety and well-being of California's children.

The proposal calls for the Governor to convene a group of representatives of the counties, the state Legislature and the administration to negotiate this transformation, develop an implementation schedule, and draft the legislation necessary to implement the change.

Children's services

This chapter includes seven proposals to improve children's services in California. Three focus on improvements in the delivery of child care, including one to simplify the subsidized child care system in California and another to revise payment policies in child care to insure quality child care. Two proposals focus on improvements in foster care including improving services through state leadership calling for the reporting of foster care outcomes by county, and requirement for changes in criminal background checks. One proposal offers an outreach program for the adoption of older children in foster care so that these children will start adulthood with the safety net of an adoptive family.

Public health and mental health services

Eight proposals focus on improvements in public health and mental health programs. One proposal calls for eliminating significant paperwork related to the allocation of funds to local public health departments. Another proposal is to change the current HIV reporting system in California to ensure that federal funds are not lost to the state in the future. Two proposals focus on streamlining the services in mental health and alcohol and drug services. One proposes a merger of the mental health and drug and alcohol programs at the state level and the other proposes the elimination of two city-based mental health programs, and transfer of the responsibilities to the local counties as occurs in the balance of the state.

Licensing and service oversight

Five proposals in this chapter offer improvements in the licensing and service oversight function in health and human services. One proposes the consolidation of all licensing of health facilities, health professionals and health care workers and community care facilities into one organizational unit in the Department of Health and Human Services. This offers efficiency in operation and consistency in oversight. Another proposal is to establish a separate fund for fees paid by health facilities to ensure that government openly accounts for the funds and uses these fees for the sole purpose of reviewing facilities for licensure. One proposal in this area is to avoid duplication in the review of managed health care plans by accepting private accreditation reviews in lieu of state reviews when the accreditation review covers the same items as a state review. This will provide for timely certification of plans and avoid duplication of both government and health plan costs and time.

Medi-Cal services

Ten proposals included in this chapter address operation and funding issues in the Medi-Cal Program. Three proposals secure increased federal funding for services provided by the program. One proposal adopts “wrap-around” rates for Intermediate Care Facilities for the Developmentally Disabled. Two other proposals to insure that full Medicare funds are collected for Medi-Cal beneficiaries who are also Medicare eligible. Another proposal calls for the use of smart card technology in the program to ensure integrity of services and billings. Technology is also proposed in two other proposals: one to ensure that services billed to Medi-Cal are checked for private insurance coverage before they are paid. Another utilizes technology to improve the efficiency of state staff reviewing treatment authorization requests. Finally, there is a proposal to review the payment of hospitals participating in the Disproportionate Share Program to ensure the payments are made to those facilities that are truly serving as a “safety net” provider in California’s health care system.



Transform Eligibility Processing

Summary

Medi-Cal, CalWORKs and Food Stamp eligibility processing performed by California counties is inefficient, costly, does not give good service and is inaccurate. Medi-Cal, CalWORKs, and Food Stamp eligibility processing should be centralized and consolidated at the state level to improve services and save a total of \$4 billion, including \$1.5 billion in State General Funds over the next five years.

Background

Medi-Cal, CalWORKs, and Food Stamps are three programs with overlapping customer populations.

- Medi-Cal, California's federal Medicaid program, provides health coverage to 6.7 million low-income Californians that are members of families with dependent children, or who are low-income aged, blind or disabled persons.¹ Of these, 3.9 million persons are eligible only for Medi-Cal, but not the other two programs.²
- CalWORKs is a benefit assistance program for low-income persons with dependent children, based on the federal Temporary Assistance to Needy Families (TANF) program. There are an estimated 1.2 million CalWORKs eligible persons with both Medi-Cal and CalWORKs eligibility.³
- The Food Stamp program provides resources for food for low-income persons. There are an estimated 1.2 million Food Stamp eligible persons who do not receive CalWORKs benefits.⁴

Applications for Medi-Cal, CalWORKs and Food Stamp eligibility are processed by California's 58 county welfare departments, mostly using face-to-face interviews. Only Medi-Cal applications can be received by mail. There are 16,921 full-time county eligibility workers.⁵ Eligibility application processing performed by county welfare departments was begun before there were faxes, computers or the Internet.

A fourth program, Healthy Families, provides health coverage to children from low-income families with incomes above Medi-Cal eligibility levels. Healthy Families is California's federal State Child Health Insurance Program (SCHIP) and is estimated to have 734,000 eligible persons in Fiscal Year 2004–2005.⁶ Healthy Families application processing, which is a combined Healthy Families and Medi-Cal application for children, has been contracted out and is administered through a contract. The Healthy Families program offers a more efficient approach to eligibility processing using Internet-based, as well as mail-in applications.

The eligibility determination processes for Medi-Cal, CalWORKs, and Food Stamps are inefficient, costly, slow and inconvenient for the customer.

Inefficient and costly

The counties' eligibility processing is inefficient compared to other states and to the Healthy Families program. The following chart shows that the county-operated eligibility costs range by program from \$308–\$493 per person, while Healthy Families cost only \$77.

Program	Eligible Persons	Administrative Cost	Average Cost per Eligible Person
Medi-Cal Only	3.9 million	\$1.2 billion ⁷	\$308
CalWORKS	1.2 million	\$591 million ⁸	\$493
Food Stamps Non-Public Assistance	1.2 million	\$571 million ⁹	\$476
Healthy Families	734,000	\$56.7 million ¹⁰	\$77

Other states' eligibility costs are lower than California eligibility costs across all three programs. California's current eligibility costs average \$337 per eligible person across all three programs. Pennsylvania's eligibility costs for the three programs average \$68 per eligible person.¹¹ Pennsylvania has adopted an Internet-based eligibility system.¹² Michigan's eligibility costs average \$79 per eligible person.¹³ Florida's eligibility costs average \$144 per eligible person. Florida is going through an eligibility vendor procurement process from which Florida estimates that it will reduce eligibility costs by 15–25 percent.¹⁴ New York state eligibility costs average \$171 per eligible person across the three programs.¹⁵ Texas is in the process of developing of an integrated eligibility system using Internet-based applications with significant savings to its current system.¹⁶

Multiple technologies used by counties

The counties use at least 19 different technological platforms for eligibility processing.¹⁷ While there are implementation plans underway to reduce the platforms to four, the current environment causes the state to maintain different eligibility systems and to develop additional interfaces for the state eligibility data files. The county systems do not automatically check for duplicates prior to enrollment.

The Los Angeles county system for application processing, LEADER, has not yet implemented eligibility policy changes that took effect in 1999. This requires a manual "work around" of the system that costs \$60 million annually.¹⁸

Not customer-friendly

The 45-day statutory time limit for Medi-Cal eligibility is often exceeded. Half of Medi-Cal eligible persons in a managed care plan are not enrolled for an additional 30 to 60 days. There is no penalty on counties for exceeding the statutory time requirement.¹⁹ Medi-Cal applicants frequently are required to visit a county welfare office to establish eligibility for Medi-Cal even when the original application is mailed. Medi-Cal eligibility policy permits a mail-in application.²⁰ Medi-Cal applicants cannot apply from a provider's office unless an outstationed



county eligibility worker is present, creating a hardship for providers and applicants. Medi-Cal applicants have no convenient call-in opportunity for assistance in developing an application. CalWORKs eligible persons who obtain jobs must return to the county welfare office to maintain Medi-Cal eligibility. This is counter-productive to their efforts to get off and stay off welfare. A survey of Medi-Cal eligible persons found that 92 percent of Medi-Cal eligible persons say the eligibility process needs improvement.²¹

What's wrong with this picture?

A woman with a sick child calls a welfare office in a county with a large population, seeking assistance for a Medi-Cal application. She is instructed to come to the welfare office with her sick child to pick up an application and receive a pre-application screening. She is not informed that she can apply by mail as authorized by state statute. She is informed that the wait in line in the county welfare office to receive the application is estimated to be one to three hours. When she asks if she can come at a time when she will not have to be absent from her 8:00 a.m. to 5:00 p.m. job that has no sick leave or vacation benefits, she is informed that the welfare office hours are weekdays 7:00 a.m. to 3:00 p.m. The woman estimates that it will take her at least two visits to the county welfare office to successfully complete the application.

Inaccurate or at-risk for performance audit

Medi-Cal eligibility quality control reviews of the 25 most populated counties where 94 percent of Medi-Cal eligible persons reside indicate that there is an average error rate of 11 percent. In addition, 18 percent of Medi-Cal applications had an error in processing that would not necessarily have resulted in ineligibility.²² The state is not penalized for error rates in Medi-Cal under the federal Geographic Sampling Plan Pilot Project.²³ The state is currently assessed over \$100 million in penalties, however, for errors in Food Stamp eligibility processing in Los Angeles County. Although currently being cleared, Los Angeles County is carrying 122,000 ineligible persons in Medi-Cal as a result of an inability to reconcile with the state data eligibility file, MEDS.²⁴ This is particularly undesirable because it results in premiums being paid to managed care plans on behalf of ineligible persons.

The state and federal governments pay for 100 percent of the cost of Medi-Cal eligibility processing done by counties.²⁵ No county has ever been penalized for non-performance. Counties have an 11 percent share in the cost of eligibility processing for CalWORKs and a 13 percent share in the cost of Food Stamp eligibility processing.²⁶

A better model: Healthy Families

The California HealthCare Foundation (CHCF) in conjunction with the Managed Risk Medical Insurance Board developed an Internet-based application for children applying for Healthy Families and Medi-Cal.²⁷ Healthy Families utilizes the *Health e App* which means that an applicant may apply from anyplace that has Internet access with the assistance of a Certified Application Assistant. The current Healthy Families contractor has a system that automatically assigns an eligibility designation depending on the information in the application. At least three counties are in the process of developing the capacity to use an enhancement of the *Health e App*, called *One e App* for Medi-Cal, CalWORKs, Food Stamps and other program eligibility.²⁸ The implications for utilization of an Internet-based application system in multiple programs are significant for better customer service, cost savings, and error prevention.

Healthy Families uses a single system to establish eligibility, and duplicate enrollment in both Medi-Cal and Healthy Families is automatically checked before enrollment.²⁹ Healthy Families eligibility processing for a complete application takes a maximum of seven days with an additional ten days for the effective date of coverage in a managed care health plan. If a pattern of exceeding these time frames develops, it can result in liquidated damages for the contractor.³⁰ Liquidated damages allow the state to partially withhold payments to the contractor until performance meets the contractual standard.

Healthy Families applicants may apply online using an Internet-based application that is continuously available or by mail-in application. People applying for Healthy Families may apply from a provider's office, from community-based organizations with assistance, and health plans may also help applicants in completing an application. Healthy Families applicants may call into a service center for assistance which has a contractual performance standard of the call being answered within 20 seconds, 85 percent of the time. Hours of operation of the Healthy Families call center are 8:00 a.m. to 8:00 p.m. weekdays and 8:00 a.m. to 5:00 p.m. on Saturday.³¹

Healthy Families eligibility processing has consistently passed federal audits for accuracy.³² Healthy Families is a single system owned and controlled by state staff though the contractor.³³ Changes are made in one system and are effective statewide. Healthy Families has a contract with a five-year guaranteed price, backed by liquidated damages for nonperformance.³⁴

The Healthy Families model can be applied to other programs

There are program differences between Healthy Families/Medi-Cal, share of cost Medi-Cal, CalWORKs, and Food Stamps. These program differences can be managed, however, within the context of the developing *One e App* and the underlying capacity of vendors to operate the system.³⁵ Medi-Cal/CalWORKs/Food Stamps income redeterminations are more frequent than in Healthy Families/Medi-Cal, but the Healthy Families program contacts the families of eligible persons once a month to collect premiums which is at least as administratively burdensome as income redetermination. The job development functions for CalWORKs



recipients and other activities of county welfare departments will remain with the county welfare departments.

Healthy Families applications do not require an asset disclosure and documentation of assets. The review of the asset documentation is a complicating and time consuming feature of much of Medi-Cal and all of CalWORKs and Food Stamps eligibility processing. It is generally understood that aged, blind and disabled applicants have more assets than the younger families that are applicants. A study of the “asset test” process for Medi-Cal eligibility for families indicates that allowing applicants to self-certify their assets under penalty of perjury would save more money in application processing efficiency than it would cost in services to an additional caseload caused by the self-certification.³⁶

Recommendations

- A. The Governor should work with the Legislature to centralize and consolidate eligibility processing for Medi-Cal, CalWORKs, and Food Stamps at the state level and to follow the model of California’s Healthy Families program utilizing a public-private partnership.**

- B. The state should adopt a self-certification process for the asset test for applicants other than the aged, blind, and disabled.**

To simplify eligibility processing for families, the asset test should use self certification by the applicant followed by electronic verification of income during eligibility processing. The data and systems exist to ensure accuracy.

- C. The State of California should have a public awareness program component for the transition to an Internet-based eligibility system.**

Pennsylvania’s start up experience with an Internet-based system indicates that a sufficient public awareness program is necessary to accomplish the transition to the transformed eligibility process. The estimated cost of the public awareness and outreach program is \$36 million total funds per fiscal year.

- D. The state should pay a one-time application assistance fee of \$50 for all four programs to certified application assistants which will enhance community-based assistance with the application process.**

In its early years, Healthy Families paid a one-time application assistance fee of \$35 to Certified Application Assistants for a completed application resulting in enrollment. Since discontinuing this payment more applications have been received that are incomplete.

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- E. The state entity responsible for the contract should be authorized in state statute to receive the same contracting authority as is now granted to the California Medical Assistance Commission, the Managed Risk Medical Insurance Board and Medi-Cal managed care contracts.**

This contracting authority has proven to be an effective contracting method for the successful public-private partnership for Healthy Families eligibility processing.³⁷

Implementation time-frame

New system eligibility processing could begin within 18 months. Two months will be required to develop the model contract. Firms will need two months to develop proposals. One month will be required to select a contractor. The selected contractor will require ten months to begin operations.

Fiscal Impact

Consolidating eligibility determination activities at the state level using an administrative contractor similar to the Healthy Families program eligibility processing would result in state General Fund costs of \$625,000 in Fiscal Year 2004–2005, and General Fund savings of \$189 million in FY 2005–2006 and \$453.1 million in FY 2006–2007 and ongoing. In addition, counties would save \$67.5 million in FY 2005–2006 and \$135 million in FY 2006–2007 and ongoing. It will reduce average eligibility costs in Medi-Cal, CalWORKs, and Food Stamps from \$337 to \$111 per recipient. It also would result in a reduction of 16,921 PYs at the county level.

In addition to the savings identified above, \$208.5 million would be saved in the CalWORKs program in FY 2005–2006, and \$467.1 million in FY 2006–2007 and ongoing. These savings, however, cannot be immediately achieved due to the federal maintenance-of-effort requirement. The 2004–2005 Governor’s Budget projected General Fund expenditures at the maintenance-of-effort level. There is, however, considerable pressure to spend more than the federally required level on an ongoing basis, as the cost of assistance payments and services continues to increase, and as an increasing share of people in the program have multiple barriers to employment. In addition, while Congress and the President will consider several key policy changes, federal reauthorization legislation introduced to date would significantly increase the number of CalWORKs recipients engaged in job training, community service employment and other work-related activities. Substantial investments in child care and employment services would be needed in order to meet increased participation rate requirements. The savings may be used to absorb these cost pressures.

The estimates above assume that there is a \$1 million shared cost to the state and federal government in state FY 2004–2005 to administer the contractor procurement. It is assumed that there is a one-time development cost of \$100 million paid to the contractor in the first year of operation. It also is assumed that there will be a \$36 million annual eligibility transformation



awareness program and ongoing outreach. The methodology used to estimate the cost of the new consolidated system assumes the same per eligible person cost of \$77 per year as experienced in Healthy Families for the Medi-Cal, CalWORKs, and Food Stamps programs.³⁸ For the Medi-Cal only aged, blind and disabled population, it is assumed that the cost will be twice (\$154 per eligible person per year) that of Healthy Families to compensate for the additional costs of asset documentation review. It is assumed that 50 percent of eligible persons will require application assistance for which the state will pay \$50 to a certified application assistant.

General Fund, Federal Funds and County Funds
(dollars in thousands)

Fiscal Year	General Fund Savings/(Costs)	Federal Fund Savings/(Costs)	County Savings/(Costs)	Total Savings/(Costs)
2004–05	\$(625)	\$(375)	\$0	\$(1,000)
2005–06	\$189,031	\$253,387	\$67,476	\$509,894
2006–07	\$453,060	\$581,772	\$134,951	\$1,169,783
2007–08	\$453,060	\$581,772	\$134,951	\$1,169,783
2008–09	\$453,060	\$581,772	\$134,951	\$1,169,783

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–2004 expenditures, revenues and PYs.

Endnotes

- ¹ Department of Health Services, "Medi-Cal May 2004 Local Assistance Estimate for Fiscal Years 2003–04 and 2004–05" (Sacramento, California, May 2004).
- ² Department of Health Services, "Medi-Cal May 2004 Local Assistance Estimate for Fiscal Years 2003–04 and 2004–05."
- ³ Department of Social Services, "May 2004 Revise for Fiscal Years 2003–04 and 2004–05" (Sacramento, California, May 2004).
- ⁴ Department of Social Services, "May 2004 Revise for Fiscal Years 2003–04 and 2004–05."
- ⁵ Interview with James T. Quinn, chief, County Administrative Expense Unit, Department of Health Services, Sacramento, California (March 10, 2004); and Department of Social Services, Estimates Branch, "FY 02/03 Actual Expenditures and FTEs" (Sacramento, California, April 2004).
- ⁶ California Managed Risk Medical Insurance Board, "Healthy Families Program Children's Eligibility Cost Estimate" (Sacramento, California, April 2004).
- ⁷ Department of Health Services, "Medi-Cal May 2004 Local Assistance Estimate for Fiscal Years 2003–04 and 2004–05."
- ⁸ Department of Social Services, "May 2004 Revise for Fiscal Years 2003–04 and 2004–05."

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- ⁹ Department of Social Services, "May 2004 Revise for Fiscal Years 2003–04 and 2004–05."
- ¹⁰ California Managed Risk Medical Insurance Board, "Healthy Families Program Children's Eligibility Cost Estimate."
- ¹¹ Interview with Bob Molnar, section chief, Pennsylvania Office of Budgeting for Income Maintenance Programs, Harrisburg, Pennsylvania (May 27, 2004); and interview with Dennis Brown, Pennsylvania chief of Client Information Systems Development and Maintenance, Harrisburg, Pennsylvania (June 7, 2004).
- ¹² Commonwealth of Pennsylvania Access to Social Services (COMPASS), "About COMPASS," [https://www.humanservices.state.pa.us/COMPASS/PGM/ASP/SC\)31.asp?hdn](https://www.humanservices.state.pa.us/COMPASS/PGM/ASP/SC)31.asp?hdn) (last visited April 6, 2004).
- ¹³ Interview with Neil Oppenheimer, financial specialist, Medical Services Division, Michigan Department of Community Health, Lansing, Michigan (June 11, 2004).
- ¹⁴ Interview with Ben Harris, deputy secretary for Operations and Technology, Florida Health and Human Services Agency, Tallahassee, Florida (May 11, 2004).
- ¹⁵ Telephone interview with Richard Radzyski, chief accountant, New York Office of Temporary Assistance and Disability, Albany, New York (May 25, 2004).
- ¹⁶ Texas Health and Human Services Commission, "Integrated Eligibility Determination: Business Case Analysis, Streamlined Services Will Expand Access to Services, Save Money" (Austin, Texas, March 2004).
- ¹⁷ Interview with Christine Dunham, assistant director, Systems Integration Division, Health and Human Services Agency Data Center, Sacramento, California (April 12, 2004).
- ¹⁸ Interview with James T. Quinn. 1931(b) is the provision of federal welfare reform that allows families to remain eligible for Medi-Cal following discontinuance of CalWORKs assistance.
- ¹⁹ Interview with James T. Quinn.
- ²⁰ Interview with Sharyl Shannon-Raya, chief, Medi-Cal Eligibility Policy Unit, Sacramento, California, March 17, 2004.
- ²¹ Medi-Cal Policy Institute, "Speaking Out . . . What Beneficiaries Say About the Medi-Cal Program" (Oakland, California, September 1999).
- ²² Department of Health Services, Medi-Cal Eligibility Branch, "Medi-Cal Review Summary by County Period: 04/2003–09/2003" (Sacramento, California, October 2003). The most common error is failure to perform eligibility redetermination based on income.
- ²³ Department of Health Services, Medi-Cal Eligibility Branch, "Medi-Cal Eligibility Quality Control Geographic Sampling Plan Pilot Project" (Sacramento, California, March 2004).
- ²⁴ Interview with James T. Quinn.
- ²⁵ Department of Health Services, "Medi-Cal May 2004 Local Assistance Estimate for Fiscal Years 2003–04 and 2004–05."
- ²⁶ Department of Social Services, "May 2004 Revise for Fiscal Years 2003–04 and 2004–05."
- ²⁷ Interview with Sam Karp, chief information officer, California HealthCare Foundation, Oakland, California (March 22, 2004).
- ²⁸ Interview with Sam Karp.
- ²⁹ Interview with Irma Michel, deputy director for Eligibility, California Managed Risk Medical Insurance Board, Sacramento, California (March 15, 2004).
- ³⁰ Interview with Irma Michel.
- ³¹ California Managed Risk Medical Insurance Board, "Standard Agreement with Maximus" (Sacramento, California, June 2003).
- ³² Interview with Irma Michel.



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- ³³ *California Managed Risk Medical Insurance Board, "Standard Agreement with Maximus."*
 - ³⁴ *California Managed Risk Medical Insurance Board, "Standard Agreement with Maximus."*
 - ³⁵ *Interview with Dick Callahan, client executive, Government, Western U.S., EDS, Rancho Cordova, California (April 14, 2004); and interview with Robert G. Britton, president, Health Operations Group, Western Region, Maximus, Rancho Cordova, California (April 8, 2004).*
 - ³⁶ *Medi-Cal Policy Institute Report, "Simplifying Medi-Cal Enrollments Options for the Asset Test," Lewin Group (Oakland, California, June 2003).*
 - ³⁷ *Ins. C. Section 12693.54.*
 - ³⁸ *California Managed Risk Medical Insurance Board, "Healthy Families Program Children's Eligibility Cost Estimate" (Sacramento, California, April 2004).*



Realigning the Administration of Health and Human Service Programs

Summary

The quality of indigent health care and children's services can be improved through a realignment of state and county program responsibilities. Realignment will improve program effectiveness and more clearly delineate authority and accountability for program outcomes or performance while potentially reducing program costs.

Background

In California, health and human services are provided and funded by state, county, and federal programs. In many programs, services are provided by one level of government, while funding and program rules are determined by another level of government. In many cases, there is no single entity with ultimate responsibility and authority for providing services. As a result, Californians are often confused as to whom they should contact when programs fail.

Previous efforts

In 1991, the state enacted a major realignment of services and funding between the state and counties. The realignment addressed growing concerns about the impact of health and welfare programs on local revenues, excessive state oversight of county operations, and inappropriate fiscal incentives for counties.¹ The centerpiece of this realignment was to shift mental health services to counties and make it largely a local program, with a dedicated revenue source. In addition, various cost sharing ratios for other programs were altered, again with revenues to back up the increased local share of cost.

Although the 1991 realignment was a positive step, particularly the mental health portion, problems with the state-county relationship still exist.² In a 1993 report, the Legislative Analyst identified the critical problems with this realignment—counterproductive fiscal incentives, inappropriate assignment of responsibilities, poor utilization of economies of scale, duplication of activities/programs, unproductive administrative oversight, excessive competition for scarce resources, erosion of local control and, most importantly, lack of accountability for program outcomes.³

In addition, the relationship between the state and counties continues to be marked by fiscal tension. Subsequent to the enactment of realignment, the state shifted property tax revenue from counties to the schools (\$1.3 billion in Fiscal Year 1992–1993 and \$2.6 billion in FY 1993–1994), reversing the shift of property tax revenues to counties enacted after Proposition 13.⁴ Since then, counties have sought to restore this funding to their budgets (now worth \$4.8 billion) with limited success.⁵

Since the 1991 realignment, there have been four major proposals for the further shift of health and human service programs between the state and counties. In 1993, the Legislative Analyst proposed a major restructuring of program and fiscal responsibility between the state and the counties in the report, *Making Government Make Sense*.⁶ The Wilson Administration proposed further realignments in 1993 and 1994.⁷ Most recently, the Davis Administration proposed a major shift of programs from the state to the counties in 2003.⁸ Each of these proposals sought to create a restructured system of programs that had as its goal a functioning set of inter-related parts.

The most far-reaching proposal was the Legislative Analyst's 1993 proposal in *Making Government Make Sense* which assigned all programs requiring uniformity in costs and services to the state. Examples include cash grant programs, public health, and child support enforcement. Linkage driven, community-based services such as mental health and foster care were assigned to counties. The 1994 realignment proposal made an effort at "starting over"—subsuming the 1991 realignment of mental health and medically indigent care into an encompassing realignment that included children's services and a larger county share of cost for Aid to Families with Dependent Children (AFDC). These proposals failed to gain traction due to the perceived fiscal risks and a general lack of trust between counties and the state.⁹ The 2003 proposal was designed to shift major portions of state government to the local level, and would have been funded by tax increases. The fast-growing Medi-Cal program was partially assigned to the counties, and concern over costs growing faster than revenues made this proposal unattractive to local government.

Which programs could be realigned?

Four health and human services programs could benefit significantly from realignment of state and county responsibilities: Medically Indigent Adults (MIA), In-Home Supportive Services (IHSS), Community Medi-Cal Mental Health, and Child Welfare Services (CWS). Each of these is described briefly below.

Medically Indigent Adults Program

In the current system, medical care for Medically Indigent Adults (MIAs) is a responsibility of county government under state statute.¹⁰ Large, urban counties each administer their own MIA program. Thirty-four small counties operate their MIA program under a consortium of counties known as the County Medical Services Program (CMSP).¹¹ MIAs are persons who have no dependent children living in the home and who are not aged, blind or disabled. Thus, they are not categorically eligible for the Medi-Cal program.

When Medi-Cal was started in the late 1960s, it included the MIA program. The MIA program was transferred back to the counties as part of the 1983 Medi-Cal reform, and county MIA budgets were supplemented from the state General Fund. This funding was realigned in the early 1990s. Proposition 99 Tobacco Tax Funds, which began to be used for MIAs in the late 1980s, have declined to less than \$40 million in the current year.



Although county reporting of MIA data has been sporadic since realignment, according to the Department of Health Services, 1.4 million patients (not including those served by the CMSP counties) were served by the MIA program in FY 2000–2001.¹² There is no reliable data source that reports the actual total expenditures by counties by funding source for MIAs, but in FY 2003–2004 estimated realignment revenue (Vehicle License Fee and Sales Tax) dedicated to MIAs and county public health program expenditures is \$1.5 billion.¹³ Counties are required to expend a minimum amount of their own funds (maintenance of effort) to be eligible to collect these state revenues. In FY 2003–2004, this amount is estimated to total \$341 million.¹⁴ The CMSP county consortium's budget for MIAs is estimated at \$238 million for FY 2003–2004.¹⁵ Reports indicate that counties exceeded their maintenance of effort requirement by \$448 million in FY 2000–2001.¹⁶ It is reported that the average annual expenditure per MIA patient is \$1,011.¹⁷ For cost reasons, Los Angeles County and some other counties are tending toward contracting for the delivery of services for MIA out-patient care to private community clinics, with the county acting as the purchasing agent for those services.

The urban counties have widely varying standards of eligibility and benefits. Each county operates its own MIA eligibility system. Eligibility income standards vary from a high of 275 percent of the federal poverty level guidelines (FPL) in Tulare County, with most at 200 percent of the FPL with a share of cost, to a low of the Medi-Cal Maintenance of Need Level which is approximately 80 percent of FPL (income of \$600 per month) in Fresno, Sacramento, San Bernardino, and Yolo counties.¹⁸ Some counties include coverage of undocumented persons in their MIA program while others do not.

From the client perspective, this variation means that there is a need to reapply for health coverage every time there is a change of residence to another county and people eligible for coverage in one county may not be eligible in another. For persons with serious health problems, there is the incentive to relocate to a county with generous eligibility standards or benefit packages. Taxpayers are differentially burdened depending upon the MIA program standards in their county of residence. In addition, counties or county consortia lack the leverage over costs and benefit packages available to the state.

In-Home Supportive Services

California's In-Home Supportive Services (IHSS) program is a county-administered/state-supervised program. IHSS provides supportive services to eligible individuals to allow them to remain safely in their own homes as an alternative to more costly institutional care. It is California's third largest and fastest growing social services program, with an average annual cost growth of approximately 19 percent from FY 1993–1994 to FY 2001–2002. The total cost of the IHSS program has more than doubled from \$1.39 billion in FY 1998–1999 to \$2.8 billion in FY 2002–2003.¹⁹

The IHSS program consists of two components: the Personal Care Services Program (PCSP) and the Residual IHSS program. The state (65%) and county (35%) funded IHSS (Residual)

program has been operating since 1973. In 1993, the Department of Health Services and the Department of Social Services developed the Medi-Cal PCSP to provide IHSS services to eligible Medi-Cal beneficiaries. PCSP operates as a Medi-Cal Plan benefit and is funded by a combination of federal (50%), state (32.5%), and county (17.5%) dollars. The current IHSS program is now about 80 percent PCSP recipients.²⁰ The administration is pursuing a federal waiver to include the residual program under Medi-Cal.²¹

Counties have a financial stake in IHSS, but no financial interest in Medi-Cal nursing facility costs. The state is responsible for funding nursing facilities, but has no control over the in-home services that might allow patients to avoid institutional care. This configuration provides no incentives to control service costs and results in neither level of government being ultimately accountable for patient outcomes.

Mental health

Community mental health services in California traditionally have been administered by counties in concert with local justice and welfare programs. Prior to the 1991 realignment, mental health was available through county-administered services known as Short-Doyle/Medi-Cal and through the regular Medi-Cal program. Funding for Short-Doyle/Medi-Cal mental health services was provided through the state budget, including federal funds and state general funds. With the 1991 realignment, the state general fund portion of Short-Doyle/Medi-Cal mental health was realigned to counties along with funds for mental health care not covered by Medi-Cal. Mental health care also remained available through regular Medi-Cal. Beginning in 1995, responsibility for Medi-Cal mental health service previously available through regular Medi-Cal was shifted to counties and consolidated with Short-Doyle/Medi-Cal mental health. Counties became responsible for virtually all mental health services funded under Medi-Cal. However, the state continues to support a portion of Medi-Cal mental health services through the state budget, with expenditures for that portion (\$222 million for FY 2004–2005) driven by changes in population and cost adjustments (medical component of consumer price index).

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mental health benefit is a required service under the federal Medicaid (Medi-Cal) program. Before 1995, publicly-funded mental health services for children were not widely available. EPSDT services were expanded in 1995 by the Department of Health Services (DHS) in accordance with federal regulations and statutes that require states to provide any medically necessary mental health treatment services needed to correct or ameliorate the mental health condition of a Medi-Cal beneficiary under the age of 21. To meet the requirement, the state provided county mental health programs with state funding to expand access to EPSDT mental health. State expenditures for EPSDT mental health services have grown as much as 30 percent annually to approximately \$384 million for FY 2004–2005. Counties have been required to contribute a 10 percent share. Several administrative activities are proposed in the Governor's FY 2004–2005 Budget to reduce the rate of program growth.²²



Mental health services are integral to the success of local human services with strong interaction between mental health and local justice services, services to the homeless, child welfare services, foster care, and CalWORKs. It is in large part the interrelation between mental health and local human services that has made the 1991 realignment so successful.

While the 1991 realignment of mental health to counties has been largely successful, it has not led to optimal flexibility for counties or real outcome measurement. Mental health funding increases which occurred since realignment (i.e., Medi-Cal mental health consolidation and EPSDT) have gone to counties in strict categories leaving counties no flexibility.

Child welfare services

California's child welfare services (CWS) system is the largest in the United States. One out of every five children in the country who receive child welfare services lives in California.²³ Services range from emergency response regarding allegations of child abuse or neglect, to parenting services aimed at preventing families from losing their children, to placing children in foster homes, either temporarily or until a permanent placement or adoption can be achieved.

In California, three levels of government are involved in CWS. Federal, state, and county governments provide program funding. Program rules are generally set at the federal and state levels, but counties deliver the bulk of the services. Between July 2002 and June 2003, California counties received child abuse or neglect allegations involving over 600,000 children. Nineteen percent of these allegations were substantiated.²⁴ Almost 98,000 of these children had been the subject of previous incidents of abuse or neglect.²⁵ During this same period, 27,740 children entered foster care for the first time.²⁶ In total, over 101,000 were under supervision in the state's foster care system in July 2002.²⁷

Since the late 1980s, poor outcomes in California's CWS system have been highlighted in numerous studies. The Little Hoover Commission issued reports on the subject in 1987, 1992, 1999, and again in 2003. The 1999 report analyzed recent trends and found that children were entering foster care at younger ages and staying longer.²⁸ In 2003, the Commission reported that children in foster care were not receiving required medical assessments on time, or in some cases, at all. Half were not receiving appropriate mental health services.²⁹ Forty-three percent of children entering non-relative foster care in 2000 were required to change foster care settings three or more times.³⁰

One of the recurrent themes of the many hearings held and studies published is the problematic relationship between the various levels of government involved in providing services to children. In 1993, a report by the Legislative Analyst put it this way:

Local governments complain that state requirements interfere with their ability to satisfy local community needs. The state, in turn, issues more requirements to ensure that its service objectives are uniformly achieved. Governments compete amongst themselves to obtain larger shares of dwindling resources. Citizens observe declining levels and quality of services and find that they cannot hold any particular agency accountable. In short, we find that California's existing 'system' of government is dysfunctional.³¹

In the ensuing decade, state budgets have proposed solutions, county agencies have implemented innovative reorganizations, pilot projects funded by governments and foundations have been implemented, but poor outcomes for children and frustration for service providers continue. In testimony before the Little Hoover Commission in April 2003, Raymond J. Merz, Director of Placer County's innovative Department of Health and Human Services, gave his view of the problem. "The major barriers [to redesign of the health and human service system] continue to be driven by state and federal categorical requirements for financial and service documentation and compliance."³² Accountability for the outcomes of children and families served in the CWS system cannot be determined because each level of government is able to assign blame to another when outcomes are poor.

Realigning health and human service programs

Further realignment of the state-county relationship is critical to improving service and accountability in the MIA, IHSS, mental health and CWS programs. By aligning programs with the most logical level of government, and by using savings generated from changes in eligibility processing, services can be enhanced for child welfare services and foster care. The status quo undermines accountability because the level of government with funding and authority often does not actually administer the programs. By placing authority and responsibility at the level of service delivery, true accountability will be achieved.

Realignment of health and human services programs should be based on five principles:

- *Consolidated purchasing responsibility.* The purchase of health care services should be aligned with the level of government that has maximum purchasing power and can promote statewide health care policy;
- *Local service provision.* Child and family services are best provided in the community through local government;
- *Stable funding.* Program responsibility should be supported by a reliable, predictable source of funding and control over how services are provided;
- *Outcome measures.* Program effectiveness should be determined by measuring outcomes, not by monitoring process; and
- *Performance management.* Policy and budget development should be guided by program outcomes.



This realignment will emphasize state level advocacy for better integration of programs and funding—especially federal funds, including those which may require waiver requests.

The relationship between the state and the counties is intended to be a partnership—a sharing of the responsibilities inherent in the various health and human services programs. Unfortunately, as shown in the recent report from the Little Hoover Commission, “. . . the relationship between the state departments and local agencies that provide most of the actual services is defined by distrust and suspicion. If these programs are ever to be successful, there must be a change in this relationship, and the change must start at the top.”³³

Recommendations

The Governor should convene a working group comprised of representatives of county governments, the Legislature, and the Administration and charge it to develop a realignment implementation plan for health and human services (HHS). The recommended elements of this realignment should include:

A. Amendments to the Welfare and Institutions Code to relieve counties of the responsibility for indigent health care and transfer responsibility for funding and administering the Medically Indigent Adult (MIA) program to the state.

A statewide MIA program would have a number of advantages. A single eligibility standard would be created, eliminating negative incentives for beneficiaries and disproportionate burden on taxpayers. The state could contract for MIA care in the same way it does for the Medi-Cal and Healthy Families program, using the leverage of a large patient population to maximize cost effectiveness. In addition, the state could design the program in such a way as to open up opportunities for federal financial participation by including the MIA population in Medi-Cal, which would minimize the drain on state revenues. Counties that operate facilities for providing health care would continue to do so. Finally, MIA program accountability, program control and funding would all be consolidated at the state level which would maximize the opportunities for improving participant outcomes.

B. Realignment of responsibility for administration and non-federal funding of the In-Home Supportive Services (IHSS) program to the state.

IHSS client assessments would be a state responsibility which could be handled directly by state staff, contracted out to the counties or other service providers. Eighty percent of IHSS is currently funded through Medi-Cal. Under the realigned program, all funding would come from state and federal revenues. There would be no county share. Increases

in state share would be offset to some degree by the 2004 May Budget Revision proposal to qualify the residual program for federal funding.

Moving full responsibility and funding for IHSS to the state would address the gap that currently exists in the continuum of services administered by the state for seniors and disabled persons who are at risk of institutionalization in a nursing facility. The realignment would centralize the full range of acute, in-home, day care and institutional services at the state level, thus facilitating the design of service packages that are both appropriate for client needs and consistent with the public policy goal of only placing patients in high cost nursing facilities when their needs cannot be met with community-based services. The success of the realignment should be evaluated based on the outcomes achieved for patients served in IHSS and institutional care.

C. Realignment of all remaining state-administered and funded mental health services to the counties.

The state should complete the realignment of mental health to counties. Medi-Cal provides approximately half of the funding for public mental health in California. While EPSDT has been one of the highest areas of growth in the past few years and the growth associated with the consolidation of Medi-Cal mental health has been steady, the risk to counties with the realignment of the remaining Medi-Cal mental health services would be more than offset by the relief to counties from realigning MIA and IHSS services to the state.

D. Realignment of Child Welfare Services (CWS) to give full responsibility for non-federal program and funding to the counties.

In the realigned system, counties would become fully responsible for non-federal funding of the CWS system. Increased county expenditures are made possible due to state assumption of MIA health care as recommended above. Concurrent with termination of the state funding, state requirements that restrict counties' ability to deliver client-responsive services would be eliminated. The state Department of Health and Human Services would function as the federally designated "single state agency" (the department with which the federal government would work relating to CWS). In this role the state would distribute federal funds to the counties; apply for waivers of federal rules, when appropriate; advocate to the federal government for removal of barriers to providing high quality services; and evaluate the realigned system using performance outcome measures.

The HHS realignment working group should negotiate the terms of the reconfiguration, develop an implementation schedule of no longer than three years, and develop the



statutory language necessary to accomplish the changes. If the group determines that a component of the recommended reconfiguration is not feasible or is not mutually beneficial, they should develop an alternate strategy. Any new alternative should be consistent with the five principles described in this proposal and not disproportionately burdensome to either the state or the counties.

Fiscal Impact

The recommended program shifts, as outlined in the exhibit below, would result in additional ongoing General Fund costs of \$29 million. The intent of this proposal, however, is to have no negative fiscal impact on the state or counties. The net difference in funding can be shifted from the counties to the state, or vice versa if alternate program shifts are adopted which result in additional costs to counties, through adjusting the allocation of property taxes at the local level so that the net fiscal effect of the realignment is neutral for both the state and the counties.

**Health And Human Services
Programs Funding Shifts Between State And Counties**
(dollars in millions)

Programs Shifting To State Responsibility

Program	State		Net Change to State	County		Net Change to Counties
	Current	Proposed		Current	Proposed	
Medically Indigent Services	\$0	\$1,500	\$1,500	\$1,500	\$0	(\$1,500)
IHSS	\$1,026	\$1,569	\$543	\$543	\$0	(\$543)
Subtotal, Shifts to State and Counties	-	-	\$2,043	-	-	(\$2,043)

Programs Shifting to County Responsibility

Program	State		Net Change to State	County		Net Change to Counties
	Current	Proposed		Current	Proposed	
Mental Health (Including Managed Care and EPSDT)	\$606	\$0	(\$606)	\$14	\$620	\$606
Child Welfare Services (Including Adoptions and Foster Care)	\$1,408	\$0	(\$1,408)	\$1,049	\$2,457	\$1,408
Subtotal Shifts to Counties	–	–	(\$2,014)	–	–	\$2,014
Net Change To State And Counties			\$29			(\$29)

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Improve the Performance and Reduce the Cost of California's Child Support Program

Summary

California's Child Support Enforcement Program continues to perform below the national average on critical federal measures, placing the program at risk for financial sanctions and reduced federal incentive dollars. California should implement competitive contracting for the delivery of child support services at the local level to reduce cost and improve the program's performance.

Background

The Child Support Enforcement Program's (CSEP) primary purpose is the collection of child support payments for custodial parents. In California, county child support departments, under the supervision of the state, administer the program for 1.8 million cases statewide.¹

CSEP was created in 1975 as a joint federal-state effort to contend with growing public welfare expenditures and the lack of legal establishment of fatherhood for children born outside of marriage (also called paternity establishment).² States were charged with locating the "absent parents" of children receiving welfare, establishing support orders (if none existed), and collecting the amounts due to reimburse federal, state and local governments for their respective share of welfare expenditures. In addition, Congress recognized that extending child support services to nonwelfare single parent homes would prevent many children from ending up on welfare.³

Effective October 1, 1975, state law was enacted to implement the federal law in California.⁴ State-level supervision of CSEP was initially placed within the state Department of Social Services (DSS), as one of ten departmental divisions reporting to a deputy director. The day-to-day responsibility for program administration, however, was delegated to each county district attorney.⁵

Previous program criticized as ineffective

During the late 1990s, the Legislature, child support advocates, CSEP's customers and its oversight agencies all criticized CSEP for not effectively collecting child support owed to families. The program was operated independently by 58 county district attorney offices, making it difficult for the state to ensure that it served parents and children in a fair, uniform and consistent manner.⁶ Another complaint was poor customer service provided at the local level. Critics also asserted that a major barrier to improving the program's performance was its

administrative structure, specifically the lack of state oversight over poorly performing local programs.⁷

In response to these concerns, DSS restructured its organization, elevating the program from a branch to a separate office within the department under a deputy director. Critics, however, said that this restructuring did not address the need for increased oversight of county child support collection programs.⁸

In addition, DSS came under increased scrutiny because of a failed attempt to implement a statewide automated child support system as required by the federal government.⁹ Termination of the contract with the system developer, Lockheed Martin Information Management Systems, resulted in negative media attention criticizing the state for wasting millions of taxpayer dollars.¹⁰ A series of reports from the Bureau of State Audits and the Little Hoover Commission also criticized the DSS Office of Child Support's leadership, county oversight system and automation efforts.¹¹

Legislative reform efforts target program improvement

In 1999, the state enacted legislation that created the Department of Child Support Services (DCSS) "to create a new paradigm for delivery of child support services and collection activities" administered uniformly and equitably throughout the state.¹² In addition, legislation signed in 1999 created local child support departments in the counties (removing this function from county district attorneys) and required DCSS to partner with the Franchise Tax Board to develop a statewide automated child support system.¹³ This legislation also imposed new performance requirements and implemented a formal complaint resolution and fair hearing program to address customer service issues.¹⁴

New federal requirements make improved program performance more critical

The federal Child Support Performance and Incentive Act of 1998 (CSPIA) enacted significant changes in the way CSEP performance is measured and federal funding incentives are paid to states. Between 1994 and 1998, the federal government based a state's incentives payment on a percentage of its Temporary Assistance for Needy Families (TANF) and non-TANF collections. The percentage of incentives paid was determined by calculating a state program's cost effectiveness, defined as the state's total collections divided by its total administrative costs. The new federal performance incentive and penalty system was fully implemented in Federal Fiscal Year (FFY) 2002. The federal performance system currently consists of measures in five program areas, including:

- paternity establishment;
- child support order establishment;
- percentage of current support collected;
- cases with arrearage collections; and
- cost effectiveness.



In addition, the federal incentive and penalty system sets high standards for data reliability.¹⁵ Under this incentive structure, California must now compete with the other states and territories for a limited pool of incentives. As a result, an increase in payments to one state results in a decrease in incentive funds to another state or states. The better the state performs on the federal measures, the more incentive dollars the state is potentially eligible to earn. Because national performance ranking is judged on statewide performance, individual county performance directly impacts California's success in obtaining federal incentive dollars.

In Federal Fiscal Year (FFY) 2002, California earned \$44.9 million in federal incentives.¹⁶ It is estimated that in FFY 2003, California will earn \$48.9 million in incentive dollars and in FFY 2004, \$53.7 million.¹⁷ These incentive funds take on added importance because when they are used for child support program expenditures they are matched two for one by federal funding. Therefore, a loss of one incentive dollar translates to a three-dollar loss of total program funding. Furthermore, the state also risks having to pay penalties to the federal government if it fails to perform at acceptable levels, or fails to submit complete and reliable data. These fines are taken from the state's TANF Block Grant, which supports the CalWORKs Program, the state's welfare-to-work program, based on established formulas.¹⁸

Child support program funding

The CSEP administrative costs are funded by federal funds (66 percent) and state general funds (34 percent). County child support agencies do not participate in funding of their administrative costs. The Governor's Budget for Fiscal Year 2004–2005 includes \$1.1 billion in local assistance funds (\$453 million from the state general fund).¹⁹ Any federal incentive dollars earned are used to reduce the state general fund share of child support administrative expenditures.

Program performance

As indicated in Exhibit 1, California's performance has improved in all areas since FFY 2000, with the exception of cost effectiveness (measured by the ratio of total collections to total administrative costs).

Exhibit 1

Federal Performance Measure	FFY 1999	FFY 2000	FFY 2001	FFY 2002	FFY 2003
Percent of Paternities Established	—	60.4%	69.0%	77.5%	87.0%
Percent of Court Orders Established	65.5%	69.1%	71.9%	75.3%	76.4%
Percent of Current Support Paid	40.5%	40.0%	41.0%	42.4%	45.2%
Percent of Cases Paying on Arrears	59.8%	53.4%	56.3%	54.9%	55.4%
Cost Effectiveness	\$2.78	\$3.23	\$2.61	\$1.91	\$2.31

Because statewide performance reflects the aggregate performance of county child support agencies, poor performance by individual counties places California's receipt of federal incentive funds at risk and the state at risk for incurring federal penalties. When the reformed CSEP was developed, a three-phase compliance process was initiated. This compliance process provides statutory authority to invoke progressively corrective actions against poorly performing counties, up to the state taking over management of the program. The statute states that local directors shall be responsible for reporting to and responding to the state director on all aspects of the child support program. In reality, however, local program directors report to elected Boards of Supervisors, and as a result, DCSS lacks real authority, making meaningful enforcement nearly impossible.²⁰

High local assistance costs, which are estimated at 80 percent of the program's total administrative costs, adversely impact CSEP's cost effectiveness.²¹ These high costs are primarily a result of the high salaries and benefits paid by county child support programs.²²

Overall, California's program performance, while improving, still ranks among the lowest in the nation in critical federal measures, ranking fourth from the bottom in both current support collected and cost effectiveness.²³ In FFY 2003, the minimum federal threshold for current support collections was 45.2 percent.²⁴ Seven counties in California performed below the minimum federal standard for this measure.²⁵ Counties, with no fiscal investment in the program, have little incentive to make program performance a priority. While some counties have successfully demonstrated higher levels of performance, other counties continue to perform poorly with few consequences, despite numerous attempts by state and private consultants to intervene.²⁶ Further, escalating administrative costs at the local level negatively impact the program's cost effectiveness, and have not translated into improved performance on other federal performance measures.

California's Child Support Program: a prime candidate for public-private competition

Competition will not solve all of our problems. But perhaps more than any other concept in this book, it holds the key that will unlock the bureaucratic gridlock that hamstringing so many public agencies.

*David Osborne and Ted Gaebler—Reinventing Government (1993)*²⁷

Competitive government fosters competition among service providers, including public sector agencies, for the right to deliver services. Competition induces both public and private service providers to deliver better service in order to satisfy customers and retain contracts.²⁸ Several states have achieved improved performance and greater cost effectiveness by contracting for specific child support enforcement functions or operation of entire programs within certain jurisdictions. These states include Arizona, Colorado, Kansas, Maryland, Oklahoma, North Carolina, Tennessee, Virginia, West Virginia and Wyoming.²⁹



According to a General Accounting Office report on child support enforcement privatization initiatives in three states, the privatized office in Virginia collected support payments at a rate almost twice that of the public office and was 60 percent more cost effective than the state-run office (based on the ratio of administrative costs to collections).³⁰

The Kansas Department of Social and Rehabilitation Services, Child Support Enforcement Agency, issued a Request for Proposals in 1997 for the establishment of operations for the enforcement of child support in several Judicial Districts. Seventy to 80 percent of contracts were awarded to incumbent government entities, and the remaining contracts to private attorneys, law firms or private corporations.³¹

During the five-year period from FY 1999–2000 through FY 2003–2004, California’s statewide total allocation for local child support agencies has increased by \$122.8 million (21 percent) from \$589.8 million to \$712.5 million. During the same time, child support cost effectiveness declined, and performance improvement has been marginal despite increased investment.

Conclusion

California’s CSEP has tremendous potential to promote family self-sufficiency and to reduce or avoid the expenditure of public funds. Families should receive the same level of service regardless of their county of residence. Yet there continues to be a disparate level of service between counties that not only impacts individual families but jeopardizes the program funding statewide. For example, in FFY 2003, the percentage of cases with collections ranged from a low of 30.4 percent in one county to a high of 76.8 percent in another, and the percentage of current support collected ranged from 37.3 percent to 62.8 percent.³² Given the critical role that child support plays in ensuring family self-sufficiency, alternative methods of program administration at the local level must be considered.

CSEP (more than most social service programs) meets the prerequisites for successful contracting of services cited by Emanuel S. Savas in his book *Privatization: The Key to Better Government* (1987).³³ These prerequisites are specificity and multiple suppliers. Specificity refers to the extent to which performance standards and service outcomes can be clearly stipulated. With the passage of federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), the federal government provided states with a concrete and consistent way of evaluating child support programs. These performance standards promote accountability and provide a strong incentive to improve program performance. Additionally, the federal Office of Management and Budget found that CSEP was the highest rated social services program among all programs reviewed governmentwide, because of its clear purpose and unambiguous mission linked to “salient and meaningful performance measures.”³⁴ The second prerequisite, multiple suppliers, is met due to the availability of private companies nationally that provide full-service child support operations and/or specific program functions such as call centers, service of process, etc.³⁵

Implementing private versus public competition for the delivery of child support services at the local level will provide high-performing counties an opportunity to continue operating child support programs while allowing the state to contract for the provision of these services in poorly performing counties.

Recommendations

- A. **The Governor should work with the Legislature to:**
 - **Remove the county child support departments as the designated entity to deliver Child Support Enforcement Program (CSEP) services at the local level;**
 - **Require child support services at the local level to be provided under contract;**
and
 - **Permit competitive bidding by public or private entities to administer local child support programs as determined by the Department of Child Support Services, or its successor entity.**

- B. **The Department of Child Support Services, or its successor, should develop specific contractual requirements and performance standards for any entity administering child support services at the local levels including overall performance, cost effectiveness and customer service standards.**

- C. **The Department of Child Support Services, or its successor, should develop guidelines and a work plan for a phased-in issuance of Requests for Proposals for operation of local CSEPs beginning with the poorest performing counties as measured by the federal performance standards.**

Fiscal Impact

Assuming a phased-in implementation initially targeting the poorest performing counties, an estimated 20 percent reduction in administrative expenditures would occur as a result of competitive bidding in those counties. A savings would be realized in FY 2005–2006, based on the FY 2003–2004 final allocation.³⁶ These savings do not include the expected increased revenue from improved performance or the savings that would result from avoiding potential federal penalties. This recommendation also assumes an initial two-year pilot with the poorest performing county in the state, with additional counties added as appropriate beginning in FY 2007–2008. Assuming a July 1, 2005 implementation date, savings could begin in FY 2005–2006. Any costs associated with issuance of the RFP would be minor and can be absorbed. The following charts show the projected Federal and General Fund savings:



General Fund
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	0
2005–06	\$2,552	\$0	\$2,552	0
2006–07	\$2,552	\$0	\$2,552	0
2007–08	\$12,190	\$0	\$12,190	0
2008–09	\$12,190	\$0	\$12,190	0

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Federal Fund
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	0
2005–06	\$4,954	\$0	\$4,954	0
2006–07	\$4,954	\$0	\$4,954	0
2007–08	\$23,664	\$0	\$23,664	0
2008–09	\$23,664	\$0	\$23,664	0

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Endnotes

- ¹ California Department of Child Support Services, *Child Support Program Statistics Table 2.D.1—Local Agency Caseload by Type (Rancho Cordova, California, Federal Fiscal Year 2003)*.
- ² Administration for Children and Families, Office of Child Support Enforcement, “Child Support Report (Washington, D.C., July 1995),” <http://www.acf.hhs.gov/programs/cse/new/csr9507.htm> (last visited on May 24, 2004).
- ³ Public Law 96–178 extended Federal financial participation for non-AFDC Services to March 31, 1980, retroactive to October 1, 1978. OCSE-AT-81-1 dated January 29, 1981. “Matching Payments to States for Non-AFDC Expenditures” <http://www.acf.hhs.gov/programs/cse/pol/AT/at-8101.htm> (last visited June 16, 2004).
- ⁴ Wel. & Inst. C. Section 11475 (1975).
- ⁵ Wel. & Inst. C. Section 11475.1 (1975).

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- ⁶ California Department of Child Support Services, "Restructuring California's Child Support Program—First Year Status Report" (Rancho Cordova, California, January 2001).
- ⁷ California Department of Child Support Services, "A New Beginning" (Rancho Cordova, California, August 2000).
- ⁸ California Department of Child Support Services, "A New Beginning" (Rancho Cordova, California, August 2000).
- ⁹ Superior Court Of The State Of California In And For The County Of Sacramento, "In Re Sacss Litigation Statement of Decision Case No. 98AS02910/98AS02912 dated May 23, 2000," Charles B. Renfrew, Referee.
- ¹⁰ Bethany Clough, "Tulare County May Pay for Delay," Fresno Bee (September 21, 2003).
- ¹¹ California Bureau of State Audits, "Health and Welfare Agency: Lockheed Martin Information Management Systems Failed to Deliver and the State Poorly Managed the Statewide Automated Child Support System," Report No. 97116 (Sacramento, California, March 1998) <http://www.bsa.ca.gov/bsa/pdfs/97116.pdf> (last visited May 24, 2004); and California Bureau of State Audits, "Child Support Enforcement Program: Without Stronger Leadership, California's Child Support Program Will Continue To Struggle," Report No. 99103 (Sacramento, California, August 1999), <http://www.bsa.ca.gov/bsa/pdfs/99103.pdf> (last visited May 24, 2004).
- ¹² California Department of Child Support Services, "A New Beginning" (Rancho Cordova, California, August 2000), p. 1.
- ¹³ By July 1, 2002, all local child support programs were transitioned from the local district attorneys' offices to separate county child support departments.
- ¹⁴ Reform legislation included: AB 196 (Kuehl) Chapter 478, Statutes of 1999; AB 150 (Aroner) Chapter 479, Statutes of 1999; SB 542 (Burton/Shiff) Chapter 480, Statutes of 1999; AB 1111 (Aroner) Chapter 147, Statutes of 1999; and AB 472 (Aroner) Chapter 803, Statutes of 1999.
- ¹⁵ Administration for Children and Families, Office of Child Support Enforcement, Title 42, Chapter 7, Subchapter 4, Section 658 Incentive Payments to States [Online regulations] <http://www.acf.hhs.gov/programs/cse/pol/prwora.htm> (last visited May 24, 2004). As of FFY 2001, states data must meet a 95 percent standard of reliability.
- ¹⁶ The incentives reported here for FFY 2002 do not include an adjustment made by the federal government for an overstatement of collections in FFY 2000. As a result, federal reports reflect incentives of \$39.8 million due to the negative adjustment for FFY 2000.
- ¹⁷ DCSS Financial Management Branch.
- ¹⁸ If the state falls below one or more of the performance standards, or does not meet the data reliability criteria, an automatic corrective action period of one year will ensue. If not corrected during that period, then at the end of the year the penalty will be imposed. The penalty level by which payments will be reduced is 1 to 2 percent of the TANF grant for the first finding; 2 to 3 percent for the second consecutive finding; and 3 to 5 percent for the third or a subsequent consecutive finding. Total penalties may not exceed 25 percent of the TANF block grant.
- ¹⁹ This amount includes automation penalties that are budgeted as local assistance funds.
- ²⁰ California Department of Child Support Services, "Final Report: Analysis of the Los Angeles County Child Support Program," by Policy Studies Incorporated (Rancho Cordova, California, February 6, 2002) (consultant's report); and California Department of Child Support Services, "Final Report: Analysis of the San Bernardino County Child Support Program," by Policy Studies Incorporated (Rancho Cordova, California, January 24, 2003) (consultant's report).
- ²¹ California Department of Child Support Services, Financial Management Branch.
- ²² Telephone interview with Annette Siler, chief financial services branch, California Department of Child Support Services (Rancho Cordova, California, May 24, 2004).
- ²³ FFY 2003 Federal Performance Data based on CS 157 data submitted by each state to the federal Office of Child Support Enforcement (OCSE) and provided to Policy Studies Inc. (PSI). Subsequent revisions to 157 data provided to OCSE but



not provided to PSI is not included in this document. This information is preliminary and not reviewed by OCSE. OCSE as of June 4, 2004, had not yet formally released the FFY 2003 national data.

- ²⁴ The current support collection percentage is measured as the amount of current support collected as compared to the current support owed, expressed as a percentage.
- ²⁵ The counties were Los Angeles (37.3%), San Bernardino (37.6%), San Diego (40.6%), Kern (41%), Imperial (42.4%), Riverside (42.8%) and Yuba (43%).
- ²⁶ California Department of Child Support Services, "Final Report: Analysis of the Los Angeles County Child Support Program," by Policy Studies Incorporated (Rancho Cordova, California, February 6, 2002 (consultant's report); California Department of Child Support Services, "Final Report: Analysis of the San Bernardino County Child Support Program," by Policy Studies Incorporated (Rancho Cordova, California, January 24, 2003) (consultant's report); and California Department of Child Support Services, Performance Improvement Plan prepared for Los Angeles County (Rancho Cordova, California, January 2003).
- ²⁷ David Osborne and Ted Gaebler, "Reinventing Government—How the Entrepreneurial Spirit is Transforming the Public Sector" (New York: Penguin Group, 1993), p. 79.
- ²⁸ Administration for Children and Families, "A Guide to Developing Public-Private Partnerships in Child Support Enforcement" (Washington, D.C., June 1997), <http://www.acf.hhs.gov/programs/cse/rpt/pvt/contents.htm> (last visited May 12, 2004).
- ²⁹ Policy Studies Incorporated, "Trends in Child Support Privatization" (Denver, Colorado, May 2004); and Commonwealth of Virginia General Assembly, Joint Legislative Audit and Review Commission, "Interim Report: Child Support Enforcement Senate Document No. 42" (Richmond, Virginia, 2000).
- ³⁰ United States General Accounting Office, "Child Support Enforcement, Early Results on Comparability of Privatized and Public Offices" (Washington, D.C., December 1996).
- ³¹ Telephone interview with Ralph Malott, chief of administrative services, Kansas Department of Social and Rehabilitation Services, Child Support Enforcement Program (Topeka, Kansas, May 24, 2004).
- ³² Department of Child Support Services Program Statistics for FFY 2003: Percentage of Cases with Collections, 30.4% for San Bernardino County and 76.8% for San Luis Obispo County. Current support collected for FFY 2003 was 37.3 percent for Los Angeles County and 62.8 percent for Mariposa County.
- ³³ Emanuel S. Savas, "Privatization: The Key to Better Government" (New Jersey: Chatham House Publishing, 1987) pp. 109–112.
- ³⁴ Federal Office of Management and Budgeting, Department of Health and Human Services. "PART Assessments Office of Child Support Enforcement" (February 2004), <http://www.whitehouse.gov/omb/budget/fy2005/pma/hhs.pdf> (last visited May 22, 2004).
- ³⁵ United States General Accounting Office, "Child Support Enforcement, States' Experience with Private Agencies' Collection of Support Payments" (Washington, D.C., October 1996).
- ³⁶ While the percentage difference between the cost per case for the private vendor versus the Los Angeles and San Bernardino Counties is 38 percent to 50 percent, a more conservative cost savings of 20 percent is used in this estimate to account for higher costs in California versus the other states with the private contractor. The allocation for the counties is from the revised FY 2003–2004 Final Administrative (Non-EDP) Allocation dated 1/14/04—Department of Child Support Services. The sharing ratio for the child support program administrative costs is 66% federal funds and 34% state general funds.



Simplify California's Subsidized Child Care System to Deliver Better Service to Families

Summary

California's subsidized child care "system" is cumbersome and complicated due to the division of responsibilities for administering CalWORKs' child care between two state agencies, different agencies at the local level with responsibility for different parts of the system, and state budget and operational policies. Simplifying the system would reduce unnecessary administrative burdens and better serve families and children.

Background

CalWORKs child care administration

The California Department of Social Services (DSS) and the California Department of Education (CDE) share responsibilities for child care under California's family welfare program known as CalWORKs. Historically, DSS has viewed child care as a support service necessary for the welfare parent to be able to work. CDE, on the other hand, has primarily viewed child care from the perspective of a child's development or education. This philosophical difference drives the emphasis each agency places on such questions as the type of care, the cost of care, and the quality of care that should be funded. The departments' philosophical differences affect ongoing negotiations over policies and practices that impact the entire subsidized child care system including CalWORKs child care.

California's CalWORKs child care system is probably the most complicated in the country.¹ It is administered through three stages split between DSS and CDE. The split in CalWORKs child care administration between DSS and CDE arose during the CalWORKs legislative negotiations in 1997 to implement the new federal Temporary Assistance for Needy Families (TANF) program. DSS and CDE had historically been involved in the delivery of child care to welfare and low-income families, respectively. DSS is the single state agency for TANF, and CDE is the single state agency for federal Child Care and Development Funds (CCDF) from the federal Health and Human Services Department. Concerns about ensuring parental choice and ready access to child care led to the three-stage system and the involvement of both departments.² The existing child care system administered by CDE provided a ready infrastructure on which to build.³

Under the CalWORKs legislation, county welfare departments administer Stage 1 child care, which begins when a CalWORKs recipient starts working or participating in a CalWORKs

work-related activity. Thirty-two welfare departments contract with alternative payment agencies (CDE's payment agencies) to administer Stage 1 child care, and the remainder of the county departments do it themselves.⁴

The CalWORKs family is transferred to Stage 2 child care when the family situation is determined by the welfare department to be stable or after six months, depending on individual welfare department policy. CDE administers Stage 2 through contracts with alternative payment agencies—agencies that also administer CDE's voucher child care programs for the working poor.⁵ Stage 2 continues until two years after the recipient no longer receives cash assistance, at which point the family is transferred to Stage 3, which is still under CDE and most of the same alternative payment agencies, and is eligible for child care until the family's income reaches 75 percent of state median income or until the family's children receiving child care reach age 13.

Stage 3 is budgeted as a subset of the larger working poor child care system, and to date, does not have separate time limits. According to the RAND evaluation of CalWORKs implementation, state and county staff hoped for a simpler child care system than had existed under the prior welfare-to-work system, while child care advocates hoped for a more unified system that would lead to child care entitlement for the working poor. Neither hope was realized.⁶

For Fiscal Year 2004–2005, the total state-subsidized child care budget is \$3 billion. Of that amount, the total CalWORKs child care budget is \$1.2 billion; the DSS CalWORKs child care budget for Stage 1 is \$530 million and the CDE CalWORKs child care budget for Stages 2 and 3 is \$665 million.⁷ Stages 1 and 2 are entitlements under state law with capped appropriations; Stage 3 is subject to annual budget determinations, which to date have fully funded the child care needs of families leaving Stage 2. CDE's non-CalWORKs child care budget is \$1.8 billion, of which \$422 million is for voucher programs.⁸

Annually, DSS provides the state's 58 county welfare departments with a single block grant for CalWORKs, which includes an allocation for Stage 1 child care. Welfare departments have the flexibility to spend their child care dollars not just on child care but on other CalWORKs priorities, although their future child care allocations are now based on prior child care expenditures. CDE administers its Stage 2 and 3 funds through four different contract types, and contracts with 81 alternative payment agencies. Most agencies have four contracts with CDE for CalWORKs.⁹

CalWORKs child care system problems

Funding issues cause friction between DSS and CDE as well as between welfare departments and alternative payment agencies, and result in agencies not being able to manage their funds effectively. The full appropriation for Stages 1 and 2 is not allocated to DSS and CDE at the beginning of the year. Five percent is held back in a reserve for Stages 1 and 2 to cover any



estimating errors between the stages. Because the process of obtaining approval to access this reserve takes several months, money doesn't flow to the local level until spring, often too late for the local alternative payment agencies to hire staff to transfer in backlogged cases. In the interim, without an assurance of additional funds, alternative payment agencies—which are often nonprofits—have sometimes been forced to send cases back to Stage 1 from Stage 2, requiring notices to the affected families and more paperwork, even if the same agency is administering Stages 1 and 2. More often, when Stage 2 does not have enough money, Stage 2 agencies have simply refused to accept more families for fear of overspending their contracts. This raises concerns among welfare departments that they will overspend their Stage 1 allocations.¹⁰

Other differences between CDE's and DSS's administration of CalWORKs child care increase the complexity of the program. Welfare departments report to DSS on expenditures and caseload on a quarterly basis while alternative payment agencies report to CDE on expenditures, caseload, and individual cases monthly.

Alternative payment agencies contracting with welfare departments must meet the welfare departments' reporting requirements. Alternative payment agencies under CDE's administration apply Fair Labor and Standards Act requirements to license-exempt care, requiring payment of minimum wage.¹¹ As a result, certain Stage 1 providers serving approximately 9,300 children cannot be transferred to Stage 2 due to their inability to meet Fair Labor and Standards Act requirements.¹² When the families' Stage 1 eligibility expires, they have to change their child care arrangements in order to continue receiving child care under Stage 3. In addition, there are some differences in counting income between Stages 1 and 2. Because of the categorical eligibility of CalWORKs recipients, this income treatment impacts only families that no longer receive cash assistance.

A major budget issue for the past several years has been the increased funding needed as families reach the Stage 2 two-years-off-aid time limit. Because there are long waiting lists for the working poor child care system administered by CDE, the Legislature has had to direct new funds to Stage 3 to ensure that former CalWORKs recipients are served. Stage 3 has been treated like a parallel alternative payment program with all the same rules as the general population alternative payment program but under separate contracts.

Waiting lists for non-CalWORKs child care give priority for service to the lowest income families—after child protective services families. Under the current priorities for service, if former CalWORKs recipients weren't guaranteed child care, they would be unlikely to get service since their income had to be high enough to no longer receive cash assistance. The current waiting list priority provides little or no incentive for families to increase their earnings, since increased income would move them further down on the waiting list.

Many organizations and people familiar with CalWORKs child care have identified the bifurcation and “stages” as a problem. The 2000 RAND report on CalWORKs implementation identified a long list of child care service problems stemming from the split, including the philosophical issues between DSS and CDE (parent focus versus child development focus), funding issues, and equity issues such as guaranteed child care for CalWORKs recipients and long waiting lists for the working poor served by CDE, as well as administrative and policy issues.¹³ Many of the administrative and policy issues have been addressed by DSS, CDE, and county work groups, but not all.

Some welfare departments have suggested that splitting CalWORKs child care between DSS and CDE should occur when families no longer receive cash assistance. The County Welfare Directors Association (CWDA) recently recommended that child care administration be consolidated in one state agency to prevent “duplicate efforts and disruption for families and children.” At the same time, however, the CWDA’s Executive Director indicated that CDE would not be acceptable as the single agency unless it had a stake in meeting federally mandated participation rates.¹⁴

The County Welfare Directors Association also cited the annual reserve process as a problem resulting from splitting the administration of the program between CDE and DSS. Others have recommended that a single agency administer CalWORKs child care, but have raised reservations about both of the possible agencies. Concern has been expressed about CDE’s contracting process and whether it could be responsive to the needs of county welfare departments. On the other hand, the 2002 State Master Plan for Education adopted by the Joint Master Plan Committee recommends that all child care and development funding be consolidated under CDE, and some alternative payment agencies have expressed the desire to keep the current split instead of giving all CalWORKs child care responsibilities to DSS to administer, in part because of the child development focus of CDE.¹⁵ Consolidation under either DSS or CDE is complicated because CDE is overseen by the Superintendent of Public Instruction, a constitutional officer.

Administration in other states

Split responsibility is not an issue in other states because almost all other states administer their federal Child Care Development Fund (CCDF) programs through the same agency that administers federal Temporary Assistance for Needy Families funding.¹⁶ Both funds are often merged at the state level to provide child care services with priority for TANF recipients. Other states, however, are now experiencing increasing complexities due to the new national emphasis on preschool and school readiness. In some states with preschool initiatives, preschool is overseen by the department of education while in other states it remains part of the human services agency with an advisory role for education. Increasingly, to address the federal CCDF “Good Start, Grow Smart” initiative, states are developing early learning standards in consultation with their departments of education or under their leadership.¹⁷



Non-CalWORKs child care administration

CDE administers the rest of California's subsidized child care programs either through contracts for direct center care services with nonprofits and local education agencies, or through contracts for vouchers administered by most of the same alternative payment agencies that administer CalWORKs child care.¹⁸ If a program is funded by the state's General Fund and federal funds, agencies administering the programs sign two contracts based on these two fund sources, which have slightly different rules. CDE uses 15 different contract types for its non-CalWORKs programs and four for its CalWORKs programs, each with separate funding terms and conditions that contractors must follow. One agency has 15 different contracts with CDE, including CalWORKs contracts.¹⁹

CDE's center contracts provide high quality full or part-day programs for low-income children from infancy through age 12.²⁰ These programs include the following:

- Part-day preschool and wrap-around preschool;
- Year-round, full-day general child care and development programs in centers or family child care home networks for infants through age 12 with varying priorities for service by age and location, such as community colleges or HUD housing;
- Migrant child care centers; and
- Year-round before- and after-school programs known as latchkey programs.

The main voucher program serves low-income working poor with a smaller voucher program for migrants in the Central Valley. In addition, CDE administers one very small contract in the Bay Area for non-income-based child care for severely handicapped children.

Administering 15 separate contracts requires CDE to maintain separate funding terms and conditions, process more contracts for approvals and amendments, and track more contracts. It does allow the state to specifically track and control federal funds and General Funds although the federal government permits pooling of state and federal funds and reporting on pooled funds. Separate federal and state contracts also allow the state to maintain eligibility standards that are slightly different from federal standards, although over time the differences have decreased. The only difference that cannot be eliminated by state law is the state constitutional prohibition on providing sectarian child care services. However, the federal government does not require separate state and federal contracts for federal and state funds; they require that contracts be legal under state requirements.²¹

At the contractor level, the same issues arise with separate state and federal fund contracts. Local agencies must process more contracts for approvals and amendments, and track expenditures against each contract ceiling. Agencies must make sure that expenditures stay under *each* contract ceiling—the maximum reimbursement amount. Consolidating contracts would allow for greater utilization of funds by local agencies.

In total, CDE's Child Development Division administers approximately 2,100 contracts with 850 agencies ranging in size from small nonprofits to the Los Angeles Unified School District.²²

CDE has already eliminated two types of contracts and is planning to eliminate two more in FY 2004–2005 in order to further simplify state and local administration.²³ CDE spends an estimated 1.1 percent of total child care expenditures on child care administration, ranking California 49th among all states and well below the 5 percent maximum allowed under federal Child Care and Development Fund rules.²⁴

Recommendations

- A. By January 2005, the California Health and Human Services Agency, or its successor, should work with the Secretary of Education and the California Department of Education to seek state legislation to merge CalWORKs child care Stages 1 and 2, and place responsibility for administration of child care for CalWORKs recipients under county welfare departments until families leave aid, effective July 1, 2006. When families no longer receive cash assistance, they would transition to a single set-aside in CDE’s voucher program for low-income families.**

This would clarify the administration of CalWORKs child care by placing responsibility for CalWORKs child care in one agency and responsibility for non-CalWORKs child care in the other, and simplify it by eliminating one of the three stages. Alternative payment agencies would be required to serve families leaving aid (and be funded to serve them), and county welfare departments could not change their criteria for keeping or sending families to Stage 2 based on funding availability.

- B. By January 2005, the Health and Human Services Agency, or its successor, should seek legislation directing CalWORKs agencies to urge families to get on waiting lists when they begin participating in CalWORKs, but specifying that CalWORKs families would not become eligible to move out of the set-aside funding until they had been off cash aid for two years. The legislation would have an effective date of January 1, 2006.²⁵**

This legislation also should make the waiting list priority for subsidized child care “first come, first served” (after child protective services cases) for families with incomes up to 50 percent of state median income instead of the current system where applicants with the lowest income are first priority.

Allowing the waiting list to be “first come, first served” treats CalWORKs and non-CalWORKs applicants equally. Keeping the priority for service within a band of up to 50 percent of state median income still focuses priority on lower income families. The Legislature would continue to have the option to fully fund former CalWORKs families after they reach the end of their two-years-off-aid time period.



- C. By January 2005, the Health and Human Services Agency, or its successor, should work with the Secretary of Education and the California Department of Education to seek state legislation to give it the authority to reduce the number of CDE contracts by consolidating all dual-contract programs (federal/state) into single contracts; eliminating the latchkey program (with the option for agencies to convert their latchkey program to a general child care and development program); and converting the wrap-around preschool program into a general child care and development program, effective July 1, 2006. Legislation would include elimination of the relatively minor differences between the federal and state programs. Cost neutrality would be achieved by holding total contract maximum reimbursement amounts constant.**

This recommendation, together with Recommendation A, would reduce the number of contract types from 17 to 10. The additional time for implementation recognizes that CDE has to issue contracts prior to the start of the fiscal year and would not have sufficient time to do that by July 1, 2005. This would provide CDE time, in consultation with impacted agencies and the Department of Finance, to revise regulations and contract funding terms and conditions, and ensure that budget schedules and provisions conform.

Fiscal Impact

After implementation, these recommendations will achieve minor administrative savings from contract administration in CDE and at the local level. These costs cannot be estimated at this time.

Endnotes

- ¹ Telephone interview with Bob Garcia, program specialist, Child Care and Development Fund programs, Administration for Children and Families, Region IX, Health and Human Services (San Francisco, March 23, 2004). Three other states had an agency outside of social or human services administering Child Care and Development Funds according to their last state plans: Florida had the Partnership for School Readiness, Massachusetts had the Office of Child Care Services, and Minnesota had the Department of Children, Families, and Learning. However, Minnesota's Department of Human Services is now administering Child Care and Development Funds. Telephone interview with Cherrie Kotilinek, manager, Child Care Assistance, Minnesota Department of Human Services, St. Paul, Minnesota (April 12, 2004).
- ² Jacob Alex Klerman, Gail L. Zellman, Tammi Chun, Nicole Humphrey, Elaine Reardon, Dona Farley, Patricia A. Ebener, Paul Steinberg, "Welfare Reform in California: State and County Implementation of CalWORKs in the Second Year," 2000, <http://www.rand.org/publications/MR/MR1177/MR1177.ch7.pdf>, p. 199 (last visited June 8, 2004).
- ³ Telephone interview with Bruce Wagstaff, deputy director, California Department of Social Services, Sacramento, California (May 10, 2004).
- ⁴ Counties that Contract out Their Stage One to an APP [Alternative Payment Agency] (32), summary sheet dated February 9, 2003, provided by Lyn Vice, chief, Child Care Programs Bureau, California Department of Social Services.

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- ⁵ Parents receive vouchers that can be used for child care at a provider of their choice. Payments are made from the alternative payment agency to the child care provider under written agreements or contracts.
- ⁶ Jacob Alex Klerman, Gail L. Zellman, Tammi Chun, Nicole Humphrey, Elaine Reardon, Dona Farley, Patricia A. Ebener, Paul Steinberg, "Welfare Reform in California: State and County Implementation of CalWORKs in the Second Year," 2000, <http://www.rand.org/publications/MR/MR1177/MR1177.ch7pdf>, p. 199 (last visited June 19, 2004).
- ⁷ Governor's Budget May Revision FY 2004–2005, California Department of Education, Child Development Funding Charts, "Child Care and Development Funding," FY04-05-Gov-Budget-May Revise.xls, May 17, 2004, and CalWORKs Child Care Funding FY 2001–02 through FY 2004–05 (as of May Revise), CalWORKs-Bar-Chart-4 years, May 14, 2004. The estimates for Stage 1 and Stage 2 include the 5 percent reserve that is held back from the departments' allocations. California Department of Social Services funding is federal Temporary Assistance for Families funds and General Fund, California Department of Education's is Temporary Assistance for Families funds that convert to Child Care and Development Funds, General Fund, and federal Child Care and Development Funds.
- ⁸ Governor's Budget May Revision FY 2004–2005: California Department of Education, Child Development Division Funding Chart: "Child Care and Development Funding," FY04-05-Gov-Budget-May Revise.xls (May 17, 2004).
- ⁹ Email from Phyllis Savage, manager, Child Development Fiscal Services, California Department of Education (April 8, 2004).
- ¹⁰ Email from Lyn Vice, chief, Child Care Programs Bureau, California Department of Social Services (May 25, 2004).
- ¹¹ Telephone interview with Bob Garcia, program specialist, Child Care and Development Fund programs, Health and Human Services Department, Region IX (March 23, 2004). Although Health and Human Services provided this direction to Child Care and Development Fund agencies, it did not provide the same guidance to Temporary Assistance for Families agencies.
- ¹² Email from Lyn Vice, chief, Child Care Programs Bureau, California Department of Social Services, May 25, 2004.
- ¹³ Jacob Alex Klerman, Gail L. Zellman, Tammi Chun, Nicole Humphrey, Elaine Reardon, Dona Farley, Patricia A. Ebener, Paul Steinberg, "Welfare Reform in California: State and County Implementation of CalWORKs in the Second Year," 2000, pp. 204–209, <http://www.rand.org/publications/MR/MR1177/.ch7.pdf>, pp. 204–209 (last visited June 8, 2004).
- ¹⁴ Letter from Frank Mecca, executive director, County Welfare Directors Association, to Governor-Elect Arnold Schwarzenegger, dated November 5, 2003; and meeting with Frank Mecca (Sacramento, California, April 8, 2004).
- ¹⁵ The California Master Plan for Education, Senator Dede Alpert, Chair, Assemblywoman Elaine Alquist, Co-Vice Chair, Assemblywoman Virginia Strom-Martin, Co-Vice Chair, 2002. Recommendation 53.1. "The State should consolidate, under the California Department of Education, all child development funding sources, including those from the departments of Education and Social Services . . .," p. 145. The Master Plan also recommends that the Department of Education should be under the Governor. Recommendation 26, p. 92.
- ¹⁶ Telephone interview with Bob Garcia, program specialist, Child Care and Development Fund programs, Department of Health and Human Services (March 23, 2004).
- ¹⁷ From interviews with state Child Care and Development Fund program directors and reviews of Child Care and Development Fund state plans (Pennsylvania, North Carolina, Wisconsin, Florida, New York, Illinois, Ohio, and Minnesota). Telephone interview with Kathryn J. Holod, child care administrator, Pennsylvania Department of Public Welfare, Harrisburg, Pennsylvania (April 6, 2004); North Carolina Child Care and Development Fund Plan for FFY 2004–2005, http://149.168.194:8000/pdf_forms/2003_CCDF_Final.pdf (last visited June 8, 2004); Wisconsin Child Care and Development Fund Plan for FFY 2004–2005;



http://www.dwd.state.wi.us/dws/programs/childcare/pdf/ccdf_plan051003.pdf (last visited June 8, 2004); Florida Child Care and Development Fund Plan for FFY 2004–2005, http://www.schoolreadiness.org/files/ccdf_final_version1.pdf (last visited June 8, 2004); New York Child Care and Development Fund Plan for FFY 2004–2005 (received via email from Ann Haller, May 6, 2004); Illinois Child Care and Development Fund Plan for FFY 2004–2005, <http://www.dhs.state.il.us/newsPublications/plansReports/pdfs/StatePlan> (last visited June 8, 2004); Ohio Child Care and Development Fund State Plan for FFY 2004–2005, http://jfs.ohio.gov/ocf/fund_plan/fund_plan2004.pdf (last visited June 8, 2004); Cherrie Kotilinek, manager, child care assistance, Minnesota Department of Human Services, St. Paul, Minnesota (April 12, 2004).

- ¹⁸ This does not include the before- and after-school programs administered by California Department of Education's Learning Support and Partnerships Division that are not based on family eligibility criteria nor designed to meet family child care needs. These include the 21st Century Community Learning Centers program and the After-School Education and Safety program. Neither of these programs is administered through contracts.
- ¹⁹ Memo from Cliff Marcussen, executive director, Options (May 25, 2004).
- ²⁰ Disabled children are served up to age 22.
- ²¹ Telephone interview with John McGee, financial operations specialist, Child Care and Development Fund programs, Federal Health and Human Services Department (June 7, 2004).
- ²² California Department of Education Fact Book 2003, Child Care and Development Programs, <http://www.cde.ca.gov/re/pn/fb/yr03childcare.asp> (last visited June 8, 2004).
- ²³ E-mail from Cecelia Fisher-Dahms, consultant, Child Development Division, California Department of Education, Sacramento, California (May 21, 2004).
- ²⁴ Letter from Sharon M. Fujii, regional administrator, Administration for Children and Families, Department of Health and Human Services, Region IX, to Jack O'Connell, California Superintendent of Public Instruction, December 23, 2004, p. 2. "The State spends about 1.1 percent of total expenditures on administration although up to 5 percent of the total grant is allowed. We believe the cap on administrative costs is negatively affecting the State's ability to use available grant funds . . ." This is based on the federal Child Care and Development Fund grant expenditures plus state match expenditures.
- ²⁵ Because the elimination of Stage 2 wouldn't occur until July 1, 2006, from January through June 2006, the limitation on moving out of the set-aside funding would apply to families in both Stage 2 and Stage 3.



Improving Protection for Children Receiving Child Care from Unlicensed Providers

Summary

Current state policies regarding criminal background clearances for unlicensed, subsidized child care do not provide adequate protections for children due to delays in obtaining information on providers with criminal or child abuse backgrounds. Limiting payments to providers prior to completing the background screening process will improve protection for children receiving child care.

Background

California's welfare-to-work program, CalWORKs, provides families with paid child care while they are working or participating in CalWORKs activities. Families may choose unlicensed—or license-exempt—child care providers who are either relatives or individuals taking care of their children and one other family's children in the child's or provider's home.¹

Sixty-two percent of CalWORKs recipients in the initial stage of participation choose license-exempt care.² License-exempt providers who wish to receive payments for subsidized child care under CalWORKs or California Department of Education programs are required to be screened for the TrustLine registry—the state's registry of in-home child care providers who have passed a criminal and child abuse background check. County welfare departments and other subsidized care payment agencies use the TrustLine program to request background investigations.³ The state pays the cost of the TrustLine background checks at \$155 per person.⁴

The California Department of Social Services (DSS) estimates that in Fiscal Year 2004–2005, it will use the TrustLine program to screen 26,844 cases for CalWORKs and other subsidized child care.⁵ The estimated cost for the TrustLine program in FY 2004–2005 is \$4.5 million.⁶

The TrustLine system is designed to protect children being cared for by unlicensed providers while giving parents the choice of using family, friends and neighbors to care for their children. At the same time, CalWORKs endeavors to make sure that parents have access to child care as quickly as possible so that they can work or participate in CalWORKs activities.

The Health and Human Services Team has found that parents participating in the CalWORKs program may obtain services from providers who are being paid by the state for providing child care services for a year or more while their background check is being completed.⁷ This situation has come about primarily because the state is subject to federal fiscal sanctions for

not achieving specified CalWORKs work/participation rates, which are expected to increase under the Temporary Assistance for Needy Families (TANF) program reauthorization this year.⁸

TrustLine processes

To continue getting paid, unlicensed providers must apply to the TrustLine Registry through their local child care resource and referral (R&R) agency within 28 days from the date they begin providing DSS CalWORKs child care.⁹ Providers must complete a paper TrustLine application and be fingerprinted at the R&R agency or a local law enforcement office. Applicants also must state on their application under penalty of perjury whether they have been convicted of a crime, and then must provide specific information about that crime.

Although providers may be fingerprinted manually, 90 percent are fingerprinted via an electronic technology that transfers images of fingerprints in seconds through the Live Scan system run by Sylvan/Identix, a private vendor.¹⁰ The local R&R agencies mail the TrustLine application and manual fingerprints to the DSS Community Care Licensing Division, which then sends the fingerprint cards to Sylvan/Identix to be scanned and electronically transmitted to the California Department of Justice (DOJ). DSS manually enters TrustLine application information into its TrustLine database.

DOJ matches fingerprints against its California Criminal History system and matches names against the Child Abuse Central Index, then electronically transmits fingerprints to the FBI for matching against the FBI Criminal History system.¹¹ Eighty-five percent of all child care fingerprints have no criminal record match. DOJ processes these fingerprints in one-to-three days. Eight percent of the time there is a match with complete information, which DOJ processes within 7–14 days. The other 7 percent of the time, there is a match with incomplete information, which can take from one month to a year or longer to process depending on the ability of local agencies to provide the missing information.¹²

DSS receives match or clearance information back from DOJ electronically and then, in the case of a criminal record match, determines whether the crime is exemptible or requires further investigation before making that determination. Sometimes DSS needs information from an applicant, but because the provider is receiving payment for child care, he or she has little incentive to assist in expediting the application. DSS may take from one-to-seven days to process applications with no criminal match, and up to six months for cases requiring further investigation or additional information.¹³ In the case of a child abuse record match, DSS must investigate each one to determine whether the provider poses a risk to the child.¹⁴

The current system experiences delays due to several factors including the manual inputting of TrustLine applications, the necessity of retrieving information from local agencies, and the time it takes to investigate convictions, child abuse reports and arrests. Follow-up on child



abuse reports is labor-intensive. Arrests are especially problematic, requiring on-site interviews with victims, witnesses, and alleged perpetrators. DSS is unable to investigate certain types of arrest-only cases due to the amount of time they take and their overall workload. In the meantime, these providers continue to receive child care payments.¹⁵

TrustLine results

Of the 24,097 applications for TrustLine in 2003, 12 percent were denied clearances due to criminal or child abuse records that were not exempted. These applicants received child care payments for between two months to a year because of the policy of paying unlicensed providers for child care services pending background check clearance.¹⁶ Another 2,170 applications were still pending clearance as of May 27, 2004, presumably because the state was still investigating the applicants' criminal or child abuse records.¹⁷

Between January 1, 1998, and December 8, 2003, the Kern County Office of Education paid more than \$2.8 million to 650 providers who were ultimately denied TrustLine registration.¹⁸ No data could be found on whether any children were harmed pending TrustLine's denial of an applicant due to a criminal record or history of child abuse.

Notifications of background check results

Community Care Licensing electronically notifies the California Child Care Resource and Referral (R&R) Network weekly with information on applications it has cleared, denied, or closed.¹⁹ Licensing also generates an automated letter to the applicant. The R&R Network notifies the local R&R agency by letter if the record is clear. If the case is denied or closed, the network notifies the local R&R agency and the payment agency—either the county welfare department or another payment agency—via UPS to document that they received the information, and then follows up with the payment agency to make sure payment has stopped. The network doesn't use e-mail because of confidentiality concerns.²⁰ UPS notifications cost almost \$18,000 per year.²¹ Costs for U.S. mail notifications cannot be broken out separately.

If Community Care Licensing has not yet entered the application data into its database, its notification to the R&R Network does not include any associated child care payment information. In those cases, the network notifies the county welfare department, the local R&R agencies, and all subsidized child care payment agencies in the applicant's county so that no future referrals are made to that provider, and payment is stopped.²²

Automation improvements

Community Care Licensing plans to implement a process that was tested in Kern County where Sylvan/Identix inputs the TrustLine application with the fingerprints at the front end of the process.²³ When the provider application and fingerprints are entered upfront, the application data will be on Community Care Licensing's database at the time DOJ information is received.

Community Care Licensing indicated that the documents to change the current Sylvan/Identix contract to implement the new process are in the approval process. DSS, the Health and Human Services Agency, the Department of General Services and the Department of Finance must approve the contract.²⁴

The R&R Network wants to update its database to add fields to match those in the Community Care Licensing TrustLine database including the name of the licensing analyst, and the reasons for closures such as incomplete application.²⁵ Now, providers call the network to get information, which requires network staff to call Community Care Licensing and then call the provider back. If the network's system had the information, network staff would not have to call DSS, and the customer would get better service. For the past two years, DSS has declined to share this information with the Network over concerns about confidentiality. Community Care Licensing reports that it is now working with the network to determine if it can electronically release the information to them.²⁶

Other states' practices

Other states' practices and licensing standards for unlicensed child care providers vary widely. Background checks are one part of how states address license-exempt care. For example:

- Wisconsin requires criminal background checks before child care begins except for "provisional" providers who may provide care under limited circumstances for up to six months followed by an in-home inspection;²⁷
- Florida requires only child abuse screenings on license-exempt providers, but only has 10 percent license-exempt care;²⁸
- Illinois requires only a child abuse background check and pays pending the results; however, the child abuse check takes only 10 days;²⁹
- Minnesota requires all license-exempt providers, including relatives, to have child abuse and criminal background checks, and counties have the option of paying providers pending the results;³⁰
- In Michigan, exempt providers must pass child abuse and criminal background checks before payment;³¹
- Pennsylvania requires both child abuse and criminal background checks, and pays pending background check results;³² and
- North Carolina has only 3 percent unlicensed care.³³ License-exempt providers can get paid pending the results of the criminal background check only if no other child care is available. North Carolina also does background checks on relatives.³⁴

Conclusions

The current system does not meet one of its key objectives—protecting children from providers with criminal or child abuse backgrounds that put children at risk. The manner in which the state has implemented this process is inconsistent with this objective because it allows persons with prior criminal or child abuse records to provide subsidized child care until their records are obtained and investigated, processes that can take more than a year to complete.



Recommendations

To make the TrustLine process operate as it was intended, the state should limit payments pending TrustLine background check clearances, and make the background clearance process more efficient.

- A. The Governor should work with the Legislature to limit approval of child care provider reimbursements pending TrustLine clearance to the standard processing time for *clear* records (60 days to allow for manual fingerprint delays).**
- B. By March 2005, the Health and Human Services Agency, or its successor, should amend its regulations (Eligibility and Assistance Standards Manual Section 47-620.11) to require applications for TrustLine clearance—including fingerprints—be made within two weeks of the beginning of child care service instead of the current requirement of 28 days.**

These recommendations would shorten the period of time child care is paid while the state is waiting for additional information on crimes or child abuse, or investigating individual circumstances. These recommendations will affect only 15 percent of all applicants—those who have criminal or child abuse records (and possibly some minimal number with manual fingerprints). The CalWORKs goal is met for 85 percent of the caseload, and parents have additional time to consider other child care choices. Changing the payment policy will encourage providers to get fingerprinted more quickly and use Live Scan, and will increase pressure on administrative agencies to make Live Scan more readily available statewide.

- C. The Governor should work with the Legislature to deny payment to providers pending background check clearance if the applicant has declared on his or her application that he or she has been convicted of a crime.**

This recommendation would increase protection for children. Although the state may exempt some convictions, local agencies cannot make these distinctions. If parents are informed upfront that child care will not be paid to persons convicted of a crime prior to a TrustLine clearance, they can make other arrangements pending receipt of the clearance, which could take several months.

- D. The Department of Social Services (DSS) should expedite the approval of the expanded TrustLine contract—based on the Kern County test program—to eliminate delays in processing and matching applications and fingerprints, improve data quality, and free staff resources for other higher priority work.**
- E. DSS should share additional information electronically with the California Child Care Resource and Referral Network that would allow the network to help applicants**

to better understand their rights and resolve their questions.

This information includes the name of the licensing analyst who can answer the applicant's questions about his/her application and whether the violation is exemptible.

This recommendation would improve customer service and would not compromise confidentiality since DSS contractually requires the network to meet the same standards of confidentiality that are required of the department.³⁵

- F. DSS should inform the California Child Care Resource and Referral Network to use e-mail for notifications of clear or closed status to expedite notifications and save money. E-mails could be sent with receipts to ensure that payment agencies received and opened them.**

This recommendation would save \$18,000 by eliminating UPS and some undetermined additional cost savings by eliminating U.S. Postal Service notifications.

Fiscal Impact

These recommendations will improve program effectiveness and customer service. There are no savings from earlier denials of child care providers since child care would be provided by a different provider. Minimal savings would derive from a reduction in telephone calls by the R&R Network to DSS, a reduction in manual data entry in DSS, and elimination of mailing costs for the network associated with denials and clearances. The total savings cannot be estimated at this time.

Endnotes

¹ *Health & S.C. Section 1596.792.*

² *Percentage of Children in CalWORKs Stage 1 License Exempt Child Care by County (SFY 2001–2002), Source: CW 115 and CW 115A, released August 26, 2003. California Department of Social Services.*

³ *Aunts, uncles, and grandparents are exempt from TrustLine requirements under Health & S.C. 1596.66 and 1596.67.*

⁴ *Telephone interview with Karen Cagle, chief, CalWORKs and Food Stamp Bureau, Estimates and Fiscal Policy Branch, California Department of Social Services (Sacramento, California, May 19, 2004).*

⁵ *Child Care—Trustline, Local Assistance Estimates—May Revise of the 2004–05 Governor's Budget, Estimate Methodologies, Fiscal Policy & Estimates Branch, Financial Management & Contract Branch, Administration Division, California Department of Social Services, page 135 (annualized), <http://www.dss.cahwnet.gov/localassistanceest/may04/EstimateMethodologies.pdf> (last visited June 8, 2004). Fifteen thousand are CalWORKs Stage 1 (California Department of Social Services), and 12,000 are California Department of Education subsidized child care including CalWORKs Stages 2 and 3.*



- ⁶ The \$4.5 million cost is funded by \$3 million federal funds, \$300,000 General Fund, and \$1.2 million reimbursements from CDE federal funds. May 2004 Revise, Fiscal Policy & Estimates Branch, Financial Management & Contract Branch, Administration Division, California Department of Social Services, Child Care—TrustLine, page 135, <http://www.dsswnet.gov/localassistanceest/may04/EstimateMethodologies.pdf> (last visited June 8, 2004). Source of reimbursement information is from telephone interview with Karen Cagle, chief, CalWORKs and Food Stamp Bureau, Estimates and Fiscal Policy Branch, California Department of Social Services, Sacramento, California (May 19, 2004).
- ⁷ By contrast, in the licensed child care system, providers must have their criminal records and child abuse records cleared before they are authorized to provide care (Health & S.C. 1596.871).
- ⁸ Presentation by Mark Greenberg, Director of Policy, Center for Law and Social Policy, March 11, 2003, to California Department of Social Services. CalWORKs is the name of California's TANF program.
- ⁹ California Department of Social Services regulations, Eligibility and Assistance Standards Manual Section 47-620.11, <http://www.dss.cahwnet.gov/getinfo/pdf/eas15.pdf> (last visited June 14, 2004). Resource and Referral agencies are local agencies designated by statute with the responsibility for taking initial TrustLine applications. They perform a variety of other responsibilities in the child care system, including referring families to child care providers. California Department of Education CalWORKs applicants have 14 days pursuant to Alternative Payment Agency Funding Terms and Conditions, Definition of Registration, according to e-mail from Cecelia Fisher-Dahms, consultant, Child Development Division, California Department of Education (April 19, 2004).
- ¹⁰ Telephone interview with Linda Nissen, manager, Allied Office Support Section, Community Care Licensing, California Department of Social Services, Sacramento, California (March 19, 2004).
- ¹¹ If there is no criminal record, the FBI takes one–two days to respond. If there is a criminal record, because the FBI is dealing with 50 different state systems, the process can extend out for a very long time. Department of Justice does not know what the hit rate is for FBI records, but believes it is a lower percentage than in California because fewer people have lived out-of-state. Telephone interview with Tina Medich, assistant bureau chief, Division of Criminal Justice Information Systems, Bureau of Criminal Identification and Information, Department of Justice, Sacramento, California (March 24, 2004). According to telephone interview with Debbie Hesse, assistant bureau chief, California Justice Information Services Division, Department of Justice, Sacramento, California, less than 4 percent of the applications are matches with the Child Abuse Central Index records (April 13, 2004).
- ¹² Summary chart from Tina Medich, assistant bureau chief, Division of Criminal Justice Information Systems, Bureau of Criminal Identification and Information, Department of Justice (March 24, 2004).
- ¹³ Telephone re-interviews with Linda Nissen, manager, Allied Office Support Section, Community Care Licensing, California Department of Social Services (April 13, 2004), and Sophie Cabrera, chief, Bureau of Investigations, Community Care Licensing, California Department of Social Services, Sacramento, California (April 14, 2004).
- ¹⁴ Health & S.C. Sections 1596.607(3) and 1596.877.
- ¹⁵ Telephone re-interview with Sophie Cabrera, chief, Bureau of Investigations, Community Care Licensing, California Department of Social Services, Sacramento, California (April 19, 2004).
- ¹⁶ Telephone re-interview with Cindy Mall, senior program manager, California Resource and Referral Network, San Francisco, California (April 15, 2004).
- ¹⁷ Two e-mails from Cindy Mall, senior program manager, California Resource and Referral Network (May 27, 2004).
- ¹⁸ Letter from Larry E. Reider, Kern County superintendent of schools, to Jack Scott, California State Senator (April 14, 2004).

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- ¹⁹ *The California Child Care Resource and Referral Network is a private, non-profit organization designated by State law as the intermediary for handling TrustLine clearances and denials from the California Department of Social Services. It also follows up with the department on application status checks in response to inquiries and provides support to local Resource and Referral agencies that are the intake agencies for TrustLine. Applications may be closed for administrative reasons such as failure of an applicant to respond to information, bad fingerprints with additional fingerprints taken, application withdrawn, etc.*
- ²⁰ *Telephone interview with Cindy Mall, senior program manager, California Resource and Referral Network, San Francisco, California (March 23, 2004).*
- ²¹ *E-mail from Cindy Mall, senior program manager, California Resource and Referral Network, San Francisco, California (April 15, 2004).*
- ²² *Telephone interview with Cindy Mall, senior program manager, California Resource and Referral Network (March 23, 2004).*
- ²³ *Telephone interview with Cindy Mall, senior program manager, California Resource and Referral Network, San Francisco, California (March 23, 2004), for description of pilot system. Telephone interview with Linda Nissen, manager, Allied Office Support Section, Community Care Licensing, California Department of Social Services, Sacramento, California (March 19, 2004), for department's intentions.*
- ²⁴ *E-mails from Linda Nissen, manager, Allied Office Support Section, Community Care Licensing, California Department of Social Services (June 15, 2004).*
- ²⁵ *Telephone interview with Cindy Mall, senior program manager, California Resource and Referral Network, San Francisco, California (March 23, 2004).*
- ²⁶ *Telephone re-interview with Linda Nissen, manager, Allied Office Support Section, Community Care Licensing, California Department of Social Services, Sacramento, California (April 13, 2004).*
- ²⁷ *Wisconsin Child Care and Development Fund State Plan (2003–2005). http://www.dwd.state.wi.us/dws/programs/childcare/pdf/ccdf_plan051003.pdf, pp. 28, 30 (last visited June 15, 2004).*
- ²⁸ *Florida Child Care and Development Fund Plan for FFY 2004–2005, draft, http://www.schoolreadiness.org/files/ccdf_final_version1.pdf, p. 18 (last visited June 8, 2004).*
- ²⁹ *Telephone interview with Linda Saterfield, bureau chief, Office of Child Care & Family Services, Illinois Department of Human Services, Springfield, Illinois (April 21, 2004).*
- ³⁰ *Telephone interview with Cherie Kotilinek, manager, Child Care Assistance, Minnesota Department of Human Services, St. Paul, Minnesota (April 12, 2004), and follow-up e-mail (June 16, 2004).*
- ³¹ *Child Care and Development Fund Plan for Michigan for FFY 2004–2005, http://www.michigan.gov/documents/FIA-CDC-State_Plan_64017_7.pdf, p. 47 (last visited June 8, 2004).*
- ³² *Telephone interview with Kathryn J. Holod, child care administrator, Pennsylvania Department of Public Welfare, Office of Children, Youth & Families, Bureau of Child Day Care Services, Harrisburg, Pennsylvania (April 6, 2004).*
- ³³ *Percentages of license-exempt care are from federal (FFY 2001) Child Care and Development Fund reports to the Administration for Children and Families, Health and Human Services Department, ACF 800, <http://www.acf.hhs.gov/programs/ccb/research/01acf800/FY2001Tables1.xls>, (Table 4) (last visited June 15, 2004).*
- ³⁴ *North Carolina Child Care and Development Fund Plan for FY 2004–2005, http://149.168.194.28:8000/pdf_forms/2003_ccdf_final.pdf, pp. 17, 55, 57 (last visited June 8, 2004).*
- ³⁵ *Telephone interview with Linda Nissen, manager, Allied Office Support Section, Community Care Licensing, California Department of Social Services, Sacramento, California (April 13, 2004).*



Foster Care Criminal Background Checks

Summary

Before someone can adopt a foster child, the government must perform a background check to ensure that the prospective parent does not have a criminal history. Currently, this is often done by counties, which each maintain separate databases of approved individuals. Because the county databases are not linked, people who have already passed a background check in one county must be checked again before they can care for a foster child in another county. All of these checks are paid for by the state.

Background

The Department of Social Services (DSS) is responsible for licensing people who want to provide foster care to children and for ensuring that homes are safe.¹ However, DSS can contract with counties to perform this licensing function.² Forty-two of 58 counties, containing about 800 foster homes, have entered into such a contract with DSS.³

Criminal background checks

A part of the foster parent licensing function requires that a criminal background check must be conducted on each prospective foster parent and person who will be interacting with the child. About 13,500 criminal background checks were performed during Fiscal Year 2002–2003.⁴ Either DSS or the county, if under contract with DSS, is required to obtain the criminal background checks.⁵ Prospective foster parents and anyone else who will have contact with a foster child must provide two sets of fingerprints to the Department of Justice (DOJ); one set is to perform a state record check and one set is to perform a Federal Bureau of Investigation (FBI) national check.⁶ In addition to the check of the person's criminal history, DOJ checks the Child Abuse Registry and reports to DSS for investigation of any prior complaints.⁷ Responses from the state must be received, identified criminal records cleared, and a Child Abuse Registry cleared before a license for the care of foster children can be issued.⁸ The same clearances are required of a person living in a foster home or providing child care to a foster child.⁹

When DSS performs a background check of an individual living in a county not under contract, that individual, once approved, is licensed to care for foster children anywhere in the state.¹⁰ In contrast, if an individual is approved by a county under DSS contract, he or she is licensed to care for foster children only in that county. And, because county computer systems are not linked and because counties cannot disclose confidential information, counties cannot readily determine if a prospective foster parent has already gone through a background check in another county. As a result, people who are licensed to be a foster parent by a county under

contract with DSS must get multiple background checks, potentially for each county under DSS contract.

Multiple background checks, duplicate costs

Multiple background checks are a direct budgetary cost to the state, because the state is responsible for reimbursing the county and DOJ for the costs.¹¹ In addition, duplicate background checks make it harder for foster parents to care for some of California's most needy foster children. A foster parent relocating to another county must wait for approval from the new county. While the approval is pending the child must be transferred to another foster parent, disrupting the lives of both parent and child. It is also harder for foster parents to get temporary child care from a family member or friend, since the new caregiver may not have a background check from the right county.¹² Moreover, this system makes it harder for a foster child to permanently move in with a relative because it requires the relative to pass a background check in both the county where the relative lives and the county where the child lives.¹³

Foster parents and associations complain about the inconvenience and delays associated with duplicate fingerprinting.¹⁴ Parents must wait for an individual to be cleared before allowing contact with a child notwithstanding a current clearance. The state and county appear inflexible and bureaucratic in requiring the second background check after a person has already been cleared, and this practice provides no additional safeguard.

While it may seem simple for counties to share information with each other, there are a number of valid reasons why they do not. Sharing information might violate restrictions on the confidentiality of criminal background records.¹⁵ Also, counties arguably need to conduct new background checks to make sure that they are notified by DOJ of any subsequent arrests.

Recommendation

The Health and Human Services Agency, or its successor, should modify existing county foster care licensing contracts to remove the responsibility to conduct criminal background checks, and make the necessary arrangements to conduct the background checks by the state. In addition, the HHS or its successor should review for other opportunities to take over criminal background checks required for other programs, such as for county-licensed child care.

Fiscal Impact

This proposal would have two offsetting fiscal impacts. It would result in a savings of funds currently provided to the county to conduct the background checks of \$195,000 and an unknown budgetary savings because the number of background checks would be reduced as duplicate checks were eliminated. It would also result in a cost for new staff, including one associate governmental program analyst, a part-time office technician, and one special investigator at a total cost of \$195,000.¹⁶



Other Funds
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	0
2005–06	\$195	\$195	\$0	2.5
2006–07	\$195	\$195	\$0	2.5
2007–08	\$195	\$195	\$0	2.5
2008–09	\$195	\$195	\$0	2.5

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Endnotes

- ¹ Health & S. C. 1501.
- ² Health & S. C. 1511.
- ³ Interview with Gary Levenson Palmer, bureau chief, Community Care Licensing Administrative Support Bureau, Sacramento, California (June 9, 2004). California LIC 181 “Licensing of Facilities for Children, Monthly Statistical Report.”
- ⁴ E-mail from Tina Medich, assistant bureau chief, Department of Justice, Sacramento, California, to California Performance Review (June 9, 2004).
- ⁵ Health & S. C. 1522.
- ⁶ Health & S. C. 1522(a)(5).
- ⁷ Health & S. C. 1522.1.
- ⁸ Health & S. C. 1522.
- ⁹ Health & S. C. 1522.
- ¹⁰ Interview with Bill Jordan, chief, Caregiver Background Check Bureau, Department of Social Services, Community Care Licensing Division, Sacramento, California (May 18, 2004).
- ¹¹ In some counties, the county requires the person to pay for the Federal Bureau of Investigation check and the child abuse index check, about \$39.00. Interview with Gary Levenson Palmer, bureau chief, Community Care Licensing Administrative Support Bureau, Sacramento, California (June 9, 2004). The Department of Justice may charge a fee to cover its costs pursuant to Health & S. C. 1522.03.
- ¹² Interview with Yolo County foster parents, Woodland, California (May 3, 2004).
- ¹³ Interview with Dana Sugiyama, Social Worker III, Santa Clara County, Santa Clara, California (April 29, 2004).
- ¹⁴ Interview with Yolo County foster parents, Woodland, California (May 3, 2004); interview with Hilda Navarro, president of Hispanic Foster Parents Association of Sacramento, Sacramento, California (April 24, 2004); interview with Cora Pearson, state foster parent association president, Los Angeles, California (June 3, 2004).
- ¹⁵ Pen. C. 11077.
- ¹⁶ Interview with Gary Levenson Palmer, bureau chief, Community Care Licensing Administrative Support Bureau, California Department of Social Services, Sacramento, California (June 9, 2004).



Increase Subsidized Child Care Quality

Summary

California spends \$3 billion a year subsidizing child care for low-income and at-risk families. Research has identified key elements of high quality child care and shown the importance of such care to outcomes such as school readiness, school success, and life success. The state should reform its reimbursement rates to encourage and reward high quality child care.

Background

California spends \$3 billion a year on subsidized child care for low-income and at-risk families.¹ Approximately \$1.6 billion of these funds are for vouchers which families can use to obtain child care from licensed centers, licensed family child care homes, or license-exempt care (typically provided by family, friends, or relatives in a home). The remaining \$1.4 billion are spent in contracts between the California Department of Education (CDE) and local agencies where CDE pays the agencies for a specific number of classrooms or slots for eligible children.

A substantial and increasing body of research has established the link between high quality early education programs and long-term positive child outcomes.² High quality child care significantly increases children's cognitive development, improves later school attendance and performance, and reduces grade retention.³

California has done more than any other state to require high standards of the child care centers it contracts with directly.⁴ However, the state has not taken steps to measure the quality of child care provided through its voucher program or to tailor its reimbursement rates accordingly. By being inconsistent in its requirements and reimbursements for child care, state government is missing an opportunity to improve the school readiness of its most at-risk children.

California's categories of child care

California's child care providers can be divided into five broad categories:

- Licensed centers;
- Licensed family child care homes;
- Licensed centers that also meet Title 5 standards;
- Licensed family child care homes that also meet Title 5 standards; and
- License-exempt home-based providers.

The Title 22 child care licensing regulations issued by the California Department of Social Services (DSS) provide minimum health and safety standards for centers and family child care homes, but high quality child care requires far more than that. Licensed centers and family

child care home networks that directly contract with CDE must also meet standards under CDE's Title 5 regulations. These impose higher standards such as low child/adult ratios and increased education and training requirements for staff and managers. License-exempt providers do not have to meet any requirements except for criminal background checks and self-certification that they meet some health and safety standards.

A recent California study found that the centers (primarily those contracted with CDE) were generally of the highest quality, followed by licensed family child care, and finally license-exempt care.⁵ The exempt care setting raised serious concerns about a lack of oversight and the variability and instability of the environment. For instance, 69 percent of the license-exempt providers were no longer providing subsidized care after one year.⁶ This difference in quality has a socioeconomic impact because higher income children are most likely to be placed in centers by their parents while the lowest income children are more likely to be placed in exempt care with relatives.⁷

Similarly, a study of low income families in three locations, including two California cities, found that participation in centers had a "strong, significant and positive effect . . . on almost all cognitive outcomes, relative to children who remained with [friends or relatives]."⁸

Despite these problems, license-exempt child care is here to stay. Half of California's voucher-funded child care is license-exempt care, and fully 62 percent of CalWORKs families choose exempt care in the initial stages of CalWORKs.⁹ Many parents choose these arrangements because of irregular work hours that do not fit the schedule of a center or licensed care providers. There may be a lack of licensed care in the area. And many parents prefer a relative, often for cultural reasons. So a key issue is how to encourage these providers to develop the skills and capabilities to provide higher quality care.

Licensing is not enough to create high quality child care. Research in California has shown that even among licensed providers there is a great deal of variation in quality. Centers were of relatively high quality, with two-thirds rated "good" or higher, while family child care homes fell within the barely adequate to mediocre range.¹⁰

California's reimbursement structures

The state has different reimbursement structures for its voucher and direct contract systems. Voucher reimbursements are based on an annual survey of regional market rates of unsubsidized child care.¹¹ On the other hand, contracted centers are reimbursed using a statewide reimbursement rate that may be increased annually by a cost of living increment established by the California Department of Finance. However, because cost of living increments were not provided for several years in the past, these statewide rates have not kept up with the increased costs of care.



California's subsidized child care system does not create incentives for service providers to offer high quality child care. There is no extra reimbursement for those that provide high quality care. In fact, the system often has the opposite effect because license-exempt providers are automatically reimbursed at 90 percent of the maximum rate for family care homes, while many family care homes are reimbursed at rates less than that. In 21 counties, including Los Angeles, San Diego, most Bay Area counties, and Sacramento, Title 5 contracted center care for preschool age children is reimbursed at a lower rate (often substantially lower) than the regional market rate ceiling for licensed centers.¹² And in eight Bay Area counties, the current reimbursement rate for an exempt provider for a preschool child exceeds the rate for a Title 5 contracted center.¹³ One contracting child development provider in the Bay Area quipped that California does indeed have tiered reimbursement rates—"they're just upside down."¹⁴

Low reimbursement rates for contracted child care centers meeting higher standards results in some not being able to stay in business, especially local education agencies and community colleges. When they are not adequately compensated for the costs to meet high standards and lose supplemental funding, they may be forced to close classrooms, cancel contracts, or reduce the number of children served.¹⁵

California initiatives

California has undertaken a number of initiatives to promote high quality child care. This includes investments by CDE, DSS, and State and County Children and Families (First 5) commissions. Together they help child care providers upgrade the quality of services they offer through training and education, licensing assistance, and accreditation support.¹⁶ The Los Angeles First 5 Commission is launching a universal preschool initiative this fall with the help of state First 5 incentives. The program uses a rating system that ties child care quality to reimbursement rates and eligibility to participate in the program.¹⁷ But there is no statewide system that does this.

The Governor's Budget for Fiscal Year 2004–2005, as amended by the May Revise, attempts to create a statewide reimbursement system that encourages high quality child care by reducing the reimbursement rates of lower quality care. It would establish a tiered reimbursement system for voucher child care, ranging from exempt care, exempt care with training, to accreditation/high quality. Reimbursement rates would be lowered for all child care providers except for the estimated fewer than 5 percent of providers that are accredited and those that are rated as high quality using "accepted environmental rating scales."¹⁸ The proposal also reduces reimbursement rates for license-exempt care to the 40th percentile of the regional market rate unless specified health and safety training and use of child development principles are demonstrated, in which case it would be reimbursed at the 50th percentile.¹⁹

Comparison to other states

Others states address the quality of license-exempt child care in a variety of ways. Some states severely limit the use of license-exempt care, while others develop strategies to improve its

quality, restrict the reimbursement rates, or accept it “as is.” Reimbursement rates in several large states ranged from 50 to 80 percent of the licensed family child care home rate.²⁰ North Carolina, often touted as a model in raising the state’s quality of child care, does not pay relatives and pays in-home and unlicensed providers 50 percent of the lowest rate in their five-level payment structure.²¹

The Early Childhood Environment Rating Scale (ECERS), which is now used by several states, has been linked by numerous research projects to program quality and child outcome measures.²² Thirty-four states (including the District of Columbia) have embraced systemic reimbursement structures that reward improved quality as measured by outcomes and standards that the state supports. Twenty states use two levels of reimbursement, four use three, eight use four, and two use five.²³ Many use accreditation and/or ECERS to measure quality.²⁴ The California Department of Education uses ECERS in assessing its Title 5 child care centers but does not tie reimbursements to higher ratings.

Recommendations

- A. The Governor should work with the Legislature to change the reimbursement rate for exempt care to 50 percent of the appropriate family child care home regional market rate ceiling. When the budgetary situation permits it, savings should be used to help providers improve the quality of care they provide and increase reimbursement rates for higher quality care.**

This would reduce the incentives to stay unlicensed, and would more appropriately reimburse child care that has the lowest quality, oversight, and costs in the subsidized system.

- B. The Governor should work with the Legislature to require health and safety training for exempt providers within the first three months of providing subsidized care. The reimbursement rate would be increased to 60 percent of the appropriate family child care home regional market rate ceiling for the first full month following training. Eliminate the current self-certification process, which costs the state \$1.2 million to administer.²⁵**

This proposal would help ensure that license-exempt providers can adequately address the health and safety of the children in their care and would be a new requirement for license-exempt providers wishing to continue to provide subsidized child care.

- C. The Governor should work with the Legislature to increase levels of child care quality that licensed providers can reasonably attain over time. The standards should be based on research linking the standards to measured outcomes. This voluntary system should publicly recognize providers of high quality child care.**

When the budget permits, increased reimbursements should be tied to the higher quality levels. The system should ensure that centers which meet the higher standards



required to contract with the California Department of Education (CDE) are reimbursed above the comparable market rate ceiling. The highest rating (and reimbursement) should apply to accredited providers and providers that meet the highest standards.

- D. The Governor should direct the Health and Human Services Agency, or its successor, to work with the Superintendent of Public Instruction to convene a task force with representatives from California Department of Education (CDE), California Department of Social Services (DSS), First 5 Commissions (state and county), the Legislature, the research community, the child care community (private and public sector), and the business community to develop the legislation and implementation plan, focusing first on child care for children ages 0–5.**

This recommendation enhances the Governor’s Budget proposal and follows in the footsteps of many states that have established tiered reimbursement systems that reward improved quality. The recognition, increased supports, and increased reimbursements will help child care providers meet higher standards. Higher quality will benefit children whose parents pay for child care themselves because some of these will be served by the same providers. Efforts should be coordinated with First 5 Commission programs that provide support and funding for providers to increase their quality of care.

Fiscal Impact

There are no anticipated long-term savings because reductions in license-exempt reimbursement rates will be used to fund training and higher reimbursement rates for providers of high quality child care. There will be implementation costs for additional state staff to develop and carry out the plan and contractors to provide health and safety training to exempt providers. Savings from the elimination of the health and safety self-certification program will be used for the state and county administrative costs to administer the license-exempt changes including rate changes and training requirements.

General Fund
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	0
2005–06	\$42,572	\$1,555	\$41,017	.5
2006–07	\$67,886	\$410	\$67,476	1
2007–08	\$67,886	\$67,886	\$0	1
2008–09	\$67,886	\$67,886	\$0	1

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Other Funds
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	0
2005–06	\$42,573	\$1,555	\$41,018	.5
2006–07	\$67,886	\$410	\$67,476	1
2007–08	\$67,886	\$67,886	\$0	1
2008–09	\$67,886	\$67,886	\$0	1

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Endnotes

- ¹ This \$3 billion includes \$284.4 million in after school programs, which do not meet Title 5 center-based program requirements. CDE-contracted center-based care includes Title 5 centers and family child care home networks. The networks provide support to the family child care homes to ensure that they meet Title 5 standards. Voucher child care is care in which eligible parents (generally low income working families or CalWORKs recipients) choose their provider who is then reimbursed by either an alternative payment agency or a county welfare department. Agencies operating under contracts with CDE (known as alternative payment agencies) determine family eligibility and establish contracts with the chosen providers and then reimburse them monthly based on time sheets. Welfare departments may perform the same function as an alternative payment agency or contract with an alternative payment agency to handle child care payments/provider relationships after the welfare department has determined the family is eligible for child care. Governor’s Budget May Revision 2004–2005, California Department of Education, Child Development Division Funding Chart, May 17, 2004.
- ² Rachel Schumacher, Kate Irish, and Joan Lombardi, “Meeting Great Expectations: Integrating Early Education Program Standards in Child Care,” August 2003, *The Foundation for Child Development Working Paper Series*, http://www.clasp.org/DHS/Documents/1061231790.62/Meeting_rpt.pdf, pp. 3–5 (last visited June 8, 2004).
- ³ Undated summary prepared by the Child Development Division, California Department of Education, titled “Research on the Effects of Quality Child Care on Young Children.”
- ⁴ Rachel Schumacher, Kate Irish, and Joan Lombardi, “Meeting Great Expectations: Integrating Early Education Program Standards in Child Care,” *The Foundation for Child Development Working Paper Series, Center for Law and Social Policy*, August 2003, http://www.clasp.org/DHS/Documents/1061231790.62/Meeting_rpt.pdf, pp. 13, 28. (last visited June 8, 2004).
- ⁵ Marcy Whitebook, Ph.D., Deborah Phillips, Ph.D., Dan Bellm, Nancy Crowell, Mirella Almaraz and Joon Yong Jo, “Executive Summary: Two Years in Early Care and Education: A Community Portrait of Quality and Workforce Stability,” Alameda County, California, Center for the Study of Child Care Employment, Institute of Industrial Relations, University of California at Berkeley, Department of Psychology, Georgetown University, 2004, http://www.iir.berkeley.edu/cscce/pdf/twoyears_exec.pdf, p. 14 (last visited June 8, 2004).
- ⁶ Marcy Whitebook, Ph.D., Deborah Phillips, Ph.D., Dan Bellm, Joon Yong Jo, Nancy Crowell, Mirella Almaraz, “Two Years in Early Care and Education, A Community Portrait of Quality and Workforce Stability,” Center for the Study of



Child Care Employment, Institute of Industrial Relations, University of California at Berkeley, Department of Psychology, Georgetown University, 2004, http://www.iir.berkeley.edu/cscce/pdf/twoyears_final.pdf, p. 89 (last visited June 8, 2004).

- ⁷ Jeffrey Capizzano and Gina Adams, “Children in Low-Income Families Are Less Likely to Be in Center-Based Child Care,” *SNAPSHOTS 3 of America’s Families*, No. 16, Urban Institute, November 2003, p. 1.
- ⁸ Susanna Loeb, Bruce Fuller, Sharon Lynn Kagan, and Bidemi Carrol, “Child Care in Poor Communities: Early Learning Effects of Type, Quality, and Stability,” *Child Development*, January/February 2004, Volume 75, Number 1, pp. 55–56, 63.
- ⁹ Based on CDD-801A *Child Care Monthly Reports (July 2002–June 2003)*, Child Development Division, California Department of Education, dated November 19, 2003; CW 115 and CW 115A data (SFY 2001–2002), Research and Development Division, California Department of Social Services, dated August 26, 2003; and Legislative Analyst Office caseload estimates, FY 2004–05 Budget Analysis. CalWORKs is the California Work Opportunity and Responsibility to Kids program established by state law in August 1997 under the federal Personal Responsibility and Work Opportunities Reconciliation Act of 1996 (PRWORA), which replaced the Aid to Families with Dependent Children (AFDC) with the Temporary Assistance for Needy Families (TANF) program. “Welfare Reform in California, Early Results from the Impact Analysis, Executive Summary,” <http://www.rand.org/publications/MR/MR1358.1/MR1358.1.pdf>, p. 1 (last visited June 8, 2004).
- ¹⁰ Marcy Whitebook, Ph.D., Deborah Phillips, Ph.D., Dan Bellm, Nancy Crowell, Mirella Almaraz and Joon Yong Jo, *Executive Summary: Two Years in Early Care and Education: A Community Portrait of Quality and Workforce Stability*, 2004, http://www.iir.berkeley.edu/cscce/pdf/twoyears_exec.pdf, pp. 10–11 (last visited June 8, 2004).
- ¹¹ The Results Group, Michael Wright, M.A., Ellen Moratti, M.P.P., Susan Bassein, Ph.D., Steven Moss, M.P.P., “Child Care Fiscal Policy Analysis,” A Report to the State of California State and Consumer Services Agency, May 22, 2001, p. 20. The annual regional market rate survey looks at rates for different types of care (centers and family child care homes), different time periods (hourly, weekly, monthly), and different age groups (infant-toddler, preschool, school-age). The regional market rate survey (RMR) is the average cost of care in each region of the state for different types of care. Under state law, a ceiling is established relative to the market rate, and providers are reimbursed at the rates they charge private pay clients up to the ceiling, except that license exempt providers are reimbursed at 90 percent of the family child care home ceiling. The current maximum reimbursement rate for voucher child care is the 85th percentile of the regional market rate, which means that the state provides fully subsidized access to approximately 85 percent of all child care in the region.
- ¹² “Comparison of 2003–04 RMR Full-time Center-based Monthly Preschool Ceilings to SRR as Monthly Amount,” Chart prepared by Cecelia Fisher-Dahms, consultant, Child Development Division, California Department of Education, March 10, 2004.
- ¹³ “Comparison of 2003–04 RMR Full-time License-Exempt Monthly Preschool Ceilings to SRR as Monthly Amount,” Chart prepared by Cecelia Fisher-Dahms, consultant, Child Development Division, California Department of Education, March 10, 2004.
- ¹⁴ Telephone interview with Paul Miller, executive director, Kidango, Fremont, California (May 8, 2004).
- ¹⁵ E-mail from Lucy Berger, coordinator, Foster & Kinship Care Education/Child Development, Chancellor’s Office, California Community Colleges (May 27, 2004), and e-mail from Greg Hudson, education administrator, Child Development Division, California Department of Education (May 27, 2004).
- ¹⁶ California Children & Families Commission website, <http://www.ccfcc.ca.gov/stateinfo.htm> (last visited June 2, 2004) and Proposition 10 Statutes, Health & S.C. Section 130100. The State and County Children and Families Commissions were

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- created by a 1998 statewide initiative to enhance early childhood development and ensure children are ready for school.
- ¹⁷ Telephone interview with Karen Hill-Scott, Ed.D., president, Karen Hill-Scott & Company, Los Angeles, California (May 23, 2004). Ms. Hill-Scott is author of the *Universal Preschool Master Plan for the Los Angeles First 5 Commission*.
- ¹⁸ *Child Care at the Cross-Roads, An Analysis of the Governor's FY 2004–2005 Budget Proposals*, Child Development Policy Institute, Sacramento, California, March 2004, <http://www.cdpi.net/crossroads.pdf>, p. 31 (last visited June 10, 2004) and *Governor's Budget May Revision 2004–2005, "Child Care Reform Revisions,"* p. 26, http://www.dof.ca.gov/html/BUD_DOCS/May_Revision_04_www.pdf (last visited June 10, 2004).
- ¹⁹ In addition, providers who serve only subsidized children would receive reimbursement up to the 50th percentile unless they are accredited/high quality; then they would receive reimbursement up to the 75th percentile. All other licensed providers would receive reimbursement up to the 75th percentile unless they are accredited/high quality, in which case, reimbursement would be up to the current ceiling (85th percentile). Source: "Child Care at the Cross-Roads, An Analysis of the Governor's FY 2004–2005 Budget Proposals," <http://www.cdpi.net/crossroads.pdf>, p. 31 (last visited June 10, 2004).
- ²⁰ Wisconsin reimburses county-certified license-exempt providers at 50 percent of the licensed family child care home rate (or 75 percent with health and safety training), Florida at 50 percent, Ohio at 60 percent, Illinois at less than 50 percent, Minnesota at 80 percent (and only hourly) and Pennsylvania at 65 percent (or 75 percent if a background check is completed). E-mail from Laura Saterfield, director, Bureau of Workforce Solutions, Wisconsin Department of Workforce Development (May 5, 2004), and telephone interview (May 5, 2004). In addition, Wisconsin allows unregulated care for up to two weeks if the authorized provider is unable to provide care due to illness, vacation, etc. Florida Child Care and Development Fund Plan for FFY 2004–2005, Draft, http://www.schoolreadiness.org/files/ccdf-_final_version1.pdf (last visited June 8, 2004); Ohio Child Care and Development Fund Plan for 2004–2005, http://jfs.ohio.gov/ocf/fund_plan/fund_plan2004.pdf (last visited June 8, 2004); telephone interview with Terrie Hare, bureau chief, Bureau of Child Care Services, Ohio Department of Job and Family Services (April 19, 2004); telephone interview with Linda Saterfield, bureau chief, Office of Child Care and Family Services, Illinois Department of Human Services, Springfield, Illinois (April 21, 2004); telephone interview with Cherie Kotilinek, manager, Child Care Assistance, Minnesota Department of Human Services, St. Paul, Minnesota (April 12, 2004); telephone interview with Kathryn J. Holod, child care administrator, Pennsylvania Department of Public Welfare, Harrisburg, Pennsylvania (April 6, 2004).
- ²¹ North Carolina Child Care and Development Fund Plan for FFY 2004–2005, http://149.168.194.28:8000/pdf_forms/2003_CCDF_final.pdf, p. 17 (last visited June 8, 2004).
- ²² "Development of the ECERS-R," FPG Child Development Institute, the University of North Carolina at Chapel Hill, <http://www.fpg.unc.edu/~ecers/ecers> (last visited June 8, 2004).
- ²³ National Child Care Information Center, "Tiered Strategies: Quality Rating, Reimbursement, Licensing," November 2002, <http://www.nccic.org/poptopics/tieredstrategiesstable.html> (last visited June 8, 2004).
- ²⁴ Tiered Reimbursement Systems: States with Systems to Pay Higher Reimbursement Rates to Programs that are Accredited and/or Meet Other Quality Standards, Updated April 2003, http://www.naeyc.org/childrens_champions/criticalissues/accred-reimburse/chart1.asp (last visited June 8, 2004).
- ²⁵ Self-Certification, Local Assistance Estimates—May Revision of the 2004–2005 Governor's Budget, Estimate Methodologies, Fiscal Policy & Estimates Branch, California Department of Social Services, <http://www.dss.cahwnet.gov/localassistanceest/may04/EstimateMethodologies.pdf>, p. 128 (last visited June 8, 2004).



State Leadership Needed to Repair a Foster Care System in Crisis

Summary

Providing safe and effective foster care for over 100,000 children continues to be a major challenge for California.¹ The challenges in the system includes confusing funding streams, seemingly inequitable foster care payment rates, lack of qualified social workers, too few foster homes, and fragmented service delivery. Although various state and local agencies and thousands of dedicated individuals are working on these issues, no one has the authority to coordinate efforts, ensure accountability, and resolve the problems that continue to plague California's foster children. The state should make one entity responsible for coordinating efforts across state agencies to address these issues.

Background

Each of California's 58 counties administers its own foster care program. The state, through numerous departments, is responsible for ensuring that foster children receive a wide variety of mandated health, social, and educational services. Recent state laws enacted to meet the needs of foster children include efforts to support relative placements, keep siblings together, increase transitional housing and support services, and establish a foster care ombudsman's office and a bill of rights for children in foster care.² Even more recently, California passed legislation to ensure appropriate health care, mental health services and educational opportunities for foster children as well as the development of a county review process to identify strengths and weaknesses in local child welfare services programs.³

Problems in the foster care system: what goes wrong

Twenty-five percent of the children in foster care in California do not receive timely medical care and half do not receive needed mental health services.⁴ Nearly 50 percent of foster children and youth suffer from chronic health conditions and many require ongoing medical treatment.⁵ Half of all children in foster care are not receiving dental care.⁶ Foster children often fail to receive preventive and consistent health services due to inadequate medical records and limited access to care. They rarely enter the system with useful health records, resulting in over-immunization and under-treatment of chronic conditions.⁷ Access to full documentation is restricted by confidentiality issues, bureaucratic requirements or limited parental knowledge and unavailability. Burdened by heavy workloads, social workers frequently lack the time and training to track elusive health data.⁸ Frequent mobility of foster children impedes continuity of care and Medi-Cal cards are not always available immediately to children who require urgent services and are not universally accepted by physicians. Thorough screening and assessment does not always occur. Foster care providers do not typically receive training on how to access complex county-based health systems.

The incidence of emotional, behavioral, and developmental problems among foster children is three to six times greater than among non-foster children.⁹ Children with mental health issues commonly exhibit disruptive behaviors, delinquency, hyperactivity, and aggression. When they do not get the critical services they need, they often start acting out and then get moved to a higher, more costly level of care and/or end up in the criminal justice system.¹⁰ There are frequent complaints that a child's medication is not provided when the child is moved from one foster home to another. In a tragic case a year ago, a child was placed in a foster home in Tulare County without her psychotropic drugs. The foster parents called the social worker several times to inquire about the delivery of the medications, which they had been promised would occur within a day of the placement. The child, too, called the worker and complained that she was "feeling weird" without her medications. During the second night, without medications, the child stabbed another child in the bedroom 23 times, then left the home with the knife. Fortunately, the victim survived.¹¹

The school experience for many foster children includes repeated transfers, and loss of academic credits. School files and immunization records are often missing, which delays enrollment and results in lost school time. With each move, the child must learn different curricula, standards and rules, and make new friends.¹² Some schools view foster children as "temporary" and are reluctant to provide enhanced services to meet their individual needs. Other schools lack the resources to meet the special needs of foster children.¹³ Foster parents report that they cannot access critical school records, and school administrators can be rude and insensitive in dealing with foster children.¹⁴

Despite the fact that California has more than 100,000 children in foster care, there is no statewide standard assessment for the removal of these children from their biological homes, which leads to questions regarding the validity of these removals.¹⁵ Pre-placement visits that are supposed to occur in order for the foster family and the youth to determine if this is an appropriate match frequently do not take place.¹⁶ Foster parents are frustrated by the inaccessibility of services and caseworkers, and bewildered and frequently angry about inconsistencies in payment rates, lack of childcare and respite care.¹⁷

Multiple improvement efforts, but little ground gained

Child welfare professionals, officials at state and local levels, advocates, and communities continue to look for new ways to improve the system. Some are designed to improve the service delivery process, some seek to make social workers more effective, and others involve families as partners in shaping plans.¹⁸ State and local agencies are increasingly coordinating efforts to meet the multiple needs of children and families. They participate on multi-disciplinary teams, use collaborative service models, and reorganize administrative structures to better support integrated services.¹⁹ There are stakeholder groups, program improvement plans, task groups and interagency collaborations that continue to seek solutions through research, program evaluation, and consensus building. Pilot projects have been launched to test solutions and pockets of localized excellence have emerged.²⁰ Still, progress is incremental, problems remain unresolved, and the state's children still suffer. State program administrators



report that implementation of state laws is behind schedule and state oversight reviews have either been eliminated or greatly reduced.²¹

Who's responsible?

One important source of problems is the lack of coordination among the key entities responsible for foster care. In their 1999 report entitled *Now In Our Hands: Caring for California's Abused and Neglected Children*, the Little Hoover Commission stated there was no overarching state management that is accountable for the protection and care of foster children and summarized the problem as "so many agencies have a role that no one has responsibility."²² For example, the following five departments within the California Health and Human Services Agency (CHHSA) handle parts of the foster care system:

- The California Department of Social Services (CDSS) monitors and provides support to counties through regulatory oversight, administration, and the development of program policies and laws. CDSS also licenses and monitors facilities for out-of-home placement. Within CDSS is the Foster Care Ombudsman's Office, which was established by legislation in 1999 as an autonomous entity responsible for resolving concerns related to the care, placement and services provided to children in foster care and investigating complaints about state and local agencies;
- The Department of Health Services partially funds preventative, diagnostic, and treatment health care services for Medi-Cal eligible foster children;
- The Department of Mental Health administers mental health services for foster children and their families;
- The Department of Developmental Services provides services to foster children with developmental disabilities; and
- The Department of Alcohol and Drug Programs funds and oversees state substance abuse programs administered at the county level.²³

Other departments having a role in foster care but located outside the authority of the CHHSA, include the Department of Justice, which administers the Child Abuse Central Index and conducts criminal background checks of caregivers; the California Department of Education, which administers special education and mentor programs, foster youth services grants to counties, and child care programs; and the Office of Criminal Justice Planning, which funds child abuse prevention and treatment programs, provides training and technical assistance to child abuse professionals and administers programs to increase prosecution of child abuse cases and reduce trauma to child sexual abuse victims.²⁴

What gets measured gets done

Another problem with the state's foster care system is that it has not adequately incorporated performance measures into planning, budgeting, or oversight activities.²⁵ Collecting and publishing outcome data is a national trend. Governments (from the federal government right down to counties) are recognizing the importance of collecting meaningful data to help evaluate and improve services. For example, the Administration for Children and Families

(ACF), an organization within the federal Health and Human Services Agency, has established a performance-based review of states to determine the success of their children's programs. ACF measures seven safety, permanency and well-being outcomes, and displays the results of these outcome measures by state on its website. These are presented as a kind of "report card."²⁶

California did not fare well in this federal performance review. In 2002, the first year it was conducted here, California failed to meet standards on any of the seven outcomes measured. In addition, the data collection system used by California counties to provide a statewide database, case management tools, and a reporting system does not meet federal standards. These deficiencies are likely to result in reduced federal funding to the state unless these issues can be addressed successfully.²⁷

In 2001, the California Legislature, acknowledging the need for good performance data, called for the development of a county review process to identify strengths and weaknesses in local child welfare services and programs and assist in sharing and implementing best practices.²⁸ In response, a Child Welfare Stakeholders Group (also known as CWS Redesign) recommends implementing a new outcomes-based review system called the California Children and Family Services Review (C-CFSR). Under this system, the state would develop county-based performance targets based on a set of indicators and would expect the counties to provide quarterly reports to establish continuous measurement and feedback.²⁹ But the efforts of this group have been criticized for being behind schedule and for presenting high-level recommendations that lack necessary implementation details.³⁰

California's Little Hoover Commission also stresses the value of performance measures in improving outcomes. In a May 2004 report entitled *Real Lives, Real Reforms: Improving Health and Human Services*, it recommends adopting performance indicators, outputs and efficiency measures, and creating real-time web-based reporting on goals for children, adults and families.³¹

Report cards can help

Nationwide, the number of adoptions more than doubled between 1998 and 2002. This came as a result of measuring desired outcomes and providing incentives.³² Illinois, with the worst performing child welfare system in the country in 1996, used the data to drive reform efforts and has made more progress than any other state, according to one researcher who dubbed it the "Illinois Miracle."³³

There are caveats and challenges with respect to using data. Perhaps most important is identifying what to measure; measuring outcomes instead of only transactions or processes is important. Independent collection of the data by an outside entity that has no vested interest helps to ensure that it is accurate and reliable. And trends over time are ultimately more valuable than single data points. An organizational culture that uses data to improve, not to



punish, is helpful. Finally, measuring is not enough. There must be clear vision at the top, and buy-in from front-line managers and staff.³⁴

What is the answer?

There can be challenges in attempting to centralize foster care issues, including the fact that a constitutional officer, who does not report to the Governor, leads the state educational system, which makes it difficult to coordinate policy. The benefits, however, would be substantial. Designating state leadership for foster care would bring clarity to the issue of roles and responsibilities; improve quality assurance and accountability; help ensure statewide legislative compliance; eliminate state duplication; help ensure best use of local assistance funding; move toward adopting statewide performance indicators, outputs and efficiency measures; bolster the state's response to weak county performance; help eliminate or reduce \$18.2 million in pending federal penalties from the federal performance review; and create meaningful reporting for the public.

Recommendations

- A. By September 1, 2004, the Health and Human Services Agency (HHS), or its successor, should designate one organization or individual as the state leader for foster care, vested with the responsibility and authority to coordinate efforts across state agencies to resolve issues and encourage accountability.**

- B. HHS, or its successor, should direct this newly designated organization or individual to work with appropriate agencies to develop, by July 1, 2005, an appropriate assessment tool to measure foster care outcomes in California and mechanisms to address poor county performance.**

This organization or individual should ensure that local systems can accurately and reliably collect and maintain the necessary information. This organization or individual should also publish an annual report that provides statewide and county-specific data on foster care outcomes by July 1 of each year.

Fiscal Impact

The recommendations can be achieved by redirection of existing staff to these new functions. No new funds are necessary.

Endnotes

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- ⁴ Little Hoover Commission, *“Real Lives, Real Reforms: Improving Health and Human Services”* (May 2004), p. 11.
- ⁵ California Center for Research on Women and Families, *“Understanding the Child Welfare System in California”* (November 2002), p. 21.
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- ¹⁰ Interview with Karen Grace Kaho, California Foster Care Ombudsman, Sacramento, California (May 2004).
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- ¹⁵ Interview with Karen Grace Kaho, California Foster Care Ombudsman, Sacramento, California (May 2004).
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- ¹⁸ California Center for Research on Women and Families, *“Understanding the Child Welfare System in California”* (November 2002), p. 25.
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- ²⁴ California Center for Research on Women and Families, *“Report on Understanding the Child Welfare System in California”* (November 2002), p. 2.
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Finding Permanent Homes for Foster Children

Summary

At any given time in California, more than seven thousand children live in temporary foster homes. These children are in need of a permanent home because they cannot be returned to their parents.¹ California can increase the number of children adopted by improving public outreach and by streamlining the application process for prospective adoptive parents. In addition to the invaluable benefits for children who find permanent homes, California would also receive a fiscal incentive from the federal government if it increased the number of adoptions of older children.

Background

Children who have been removed from their own home by a child protection agency because they are at risk of harm may be placed into a foster home if a suitable relative is not available.² A foster home is a residence providing temporary, 24-hour care by a foster parent in whose care the child has been placed.³ California's Department of Social Services (DSS) administers a statewide adoption program to find permanent homes for children who cannot return to their own home.⁴ The DSS adoptions program provides adoption services through five state offices and 28 licensed county adoption agencies and conducts home recruitment activities through directly-provided and contracted services.⁵ There are different types of adoptions in the state: agency adoptions (public or private) inter-county adoptions, and international adoptions. Children who have been removed from and cannot be returned to their parents' care are generally placed through public adoption in a permanent home by an adoption agency.⁶

In 1997, Congress passed the Adoptions and Safe Families' Act (ASFA). ASFA requires states to move quickly to find permanent homes for children in foster care.⁷ In addition, ASFA provides annual bonuses to states that increase their adoptions from one year to the next.⁸ President George W. Bush recognized the challenge of finding permanent homes for older children in December 2003, when he extended the Adoption Incentive Program for five years.⁹ The bill authorizes \$43 million in performance-based incentives for states that are successful in increasing the number of children, age nine and older, who are adopted. States are entitled to approximately \$4,000 per child adopted over the number of children adopted in the previous year.¹⁰

California has had success in increasing the number of adoptions since ASFA. California received an Adoption Excellence Award from the United States Department of Health and Human Services and \$17.6 million in federal adoption incentive funds for increasing adoptions by 140 percent in 2000.¹¹ California received the award again for increased adoptions in 2001, along with \$4,388,000 in federal adoption incentive funds.¹²

In recent years, however, there has been a decline in adoptions. California's adoptions have fallen short of the numbers needed to qualify for federal incentives and meet the goal of permanency for foster children.¹³ The federal incentive funds received in federal Fiscal Year 2003 for increasing adoptions in 2002, were not passed through to the counties for fiscal year 2003–2004. These funds were given to the counties in lieu of state general funds, resulting in a loss to the counties because they could not receive matching funds from the federal government.¹⁴ The Fiscal Year 2004–2005 budget proposes an increase of \$5.2 million in General Fund to backfill the loss of federal incentive funds for the adoptions program.¹⁵ In federal FY 2004–2005, California must find permanent homes for at least 2,248 children age nine and older in order to qualify for federal adoption incentives.¹⁶

The most difficult children for whom to find permanent homes are foster children over age nine.¹⁷ Children under age ten are most likely to be adopted, with children between the ages of two and five having the highest likelihood of adoption.¹⁸ Children who leave the foster care system without being adopted are less likely to succeed: 50 percent will leave foster care without finishing high school, 45 percent will not have a job, 30 percent will go on welfare and 25 percent will become homeless.¹⁹ Finding children a permanent home and support system before they age out of the foster care system could help children have financial, societal and individual benefits.²⁰ Improving recruitment and streamlining its process, California could find more homes for older children, improve the outcomes for foster children, reduce costs and maximize federal grants.

Adoption outreach

Counties use many different approaches to recruit foster or adoptive parents.²¹ Counties report that they most often use event booths, newspaper advertisements and brochures to recruit foster and adoptive parents.²²

Recruitment efforts at the state level are limited and the state has been criticized by the U.S. Department of Health and Human Services for failing to have a state-wide recruitment plan.²³ DSS has a contract with San Mateo County, which works with three other counties, to recruit individuals to adopt children from the San Francisco Bay Area.²⁴ San Mateo County uses the state funds, along with three other counties' funds, to support a multi-media adoption campaign which includes two and a half minutes per month on a local television station's evening program.²⁵ DSS has a contract for an "adoptions exchange," an on-line photo-listing of adoptable children as required by federal and state law.²⁶ DSS also has a contract with an



organization that has a toll free telephone number for adoptions information and referral. Through the toll free number, an interested person is promised informational material, the telephone number of the local foster care or adoptions office and a follow up call from the county in which the person resides. The toll free number does not provide consistently high quality service, however. Materials sent to callers do not consistently include the name and telephone number of the child welfare agency to contact to obtain an application, and follow-up from a county representative, which is promised on the recorded message, is intermittent.²⁷

Many states have increased the number of children adopted through state-wide recruitment efforts that include televised public service announcements.²⁸ Successful states and counties have found that a media campaign is most successful when it spotlights adoptive parents as well as a child with the ethnic background most common among children needing homes.²⁹ Involving celebrities in outreach efforts is also an effective recruitment strategy. Many celebrities have adopted children or have been adopted themselves.³⁰ The power of a media campaign including support from celebrities, is evident from the thousands of adoptions that have come from The Dave Thomas Foundation's "Home for the Holidays," annual CBS prime-time special that spotlights older foster children.³¹

Print media is also an effective recruitment tool. Diana Griego Erwin, a columnist for the *Sacramento Bee* newspaper, recently spotlighted a teen-aged foster child who was looking for a permanent home. The article resulted in over 400 families contacting the foster family agency, a permanent home for the foster child, and a pool of over 400 potential parents for other similarly situated children.³²

Working with the public sector and privatizing adoptions are other strategies that have increased adoptions in other states.³³ Pennsylvania recently received an Adoption Excellence Award from the U.S. Department of Health and Human Services for increasing its adoptions of older children. Pennsylvania's success is due in part to a partnership with the private sector which helped shape public perception through a toll free helpline and a television program featuring waiting children.³⁴

A state campaign could also provide information about the minimal costs involved in adopting a foster child given the state-subsidies and waivers that are available when a person adopts through foster care rather than through an independent adoption.³⁵ A foster care adoption may cost up to \$500 while an independent adoption, in contrast, usually costs more than \$3,000.³⁶ Adoption assistance is another incentive for people who have the commitment to raise an adopted child, but limited financial resources to meet the daily expenses of an older child or a child with special health needs.³⁷ This financial support, equal to that paid to a foster parent, is necessary for many families who could not otherwise afford to meet the needs of another child in their home without a subsidy.³⁸

Adoption approval process

Many prospective adoptive parents turn to international adoptions instead of domestic adoptions because of the delays and uncertainty tied to a state, public adoption.³⁹ California could streamline its adoption process to reduce the time it takes for a prospective adoptive family to be approved, thereby reducing the drop-out rate and improving outcomes for children. The County Welfare Directors' Association has requested that the Governor streamline the approval process and expedite the adoption home study process.⁴⁰

Before a person may be considered as a potential adoptive parent, the person must undergo an approval process that can take up to a year.⁴¹ The process includes an orientation, at least three interviews, training, and a criminal background check.⁴² Although the law requires that a prospective adoptive parent undergo a criminal background check by the agency, foster parents have already undergone the check and passed as a condition of foster care licensure.⁴³ A second background check inconveniences a foster parent and is an unnecessary expense from the foster parent's perspective.⁴⁴ A person convicted of any one of about 50 crimes cannot be a licensed foster parent.⁴⁵ By contrast, no particular crime absolutely bars a person from adopting a child. The state, or county, receives up-to-date information on any arrest following a foster parent's licensure so there are no additional safeguards brought about by a second background check.⁴⁶

Florida has made significant improvements in its adoptions program by streamlining the process.⁴⁷ Florida now takes an average of eight months including orientation, background check, home study and court processes for approval. One district completes adoptions in about five months by using a team approach rather than assigning a single adoptions worker to each family. Florida funded its recruitment and streamlining efforts by investing its \$3.2 million federal bonus for increasing adoptions in a "No Place Like Home" campaign. In the first four months of the campaign, Florida adoptions increased by 60 percent.⁴⁸

Conclusion

Adoptive parents provide the greatest gift to a child in foster care and to this state. In addition to the investment in its most valuable resource, the state also stands to gain financial incentives by changing its approach to recruiting prospective adoptive parents and to streamlining its adoptions procedures. Our children are our most valuable resource, and efforts should continue to focus on improving the efforts we are making to reduce the number of children who will end up homeless and jobless because they did not have a family to provide the guidance and support necessary to succeed.



Recommendations

- A. The Department of Social Services, or its successor, should improve recruitment efforts by:**
 - a. Issuing public service announcements featuring adoptive parents, using sponsorship and appearances by celebrities, focusing recruitment for foster children age nine and older;
 - b. Issuing the televised public service announcements in November (National Adoption Month) in two targeted regions each year.

- B. The State Controller's Office should notify state employees, in their paychecks during November (National Adoption Month), of the existence of the photo-listing of children eligible for adoption.**

- C. The Department of Social Services, or its successor, should pass through federal incentive dollars to counties that may be awarded to the state because of an increase in adoption. These funds should supplement rather than take the place of county funding for adoptions.**

- D. The Department of Social Services, or its successor, should adopt regulations by January 1, 2004, providing for a waiver of the criminal background check if the applicant is a foster parent whose criminal background is current through the department's licensing program.**

- E. The Department of Social Services, or its successor, and counties should pilot using teams to conduct home studies and other duties associated with an adoptions application to shorten the amount of time in approving a family for adoption.**

- F. The Health and Human Services Secretary should establish a workgroup to explore whether privatizing adoption would improve outcomes.**

Fiscal Implications

Production costs for a television station to create a suitable, 30-second commercial, are about \$2,500, so long as it is acquired along with an advertising commitment for a media adoption campaign. Cost for showing the 30-second announcements on television over six weeks in the Sacramento area is approximately \$50,000.⁴⁹ A similar campaign in Los Angeles is \$250,000.⁵⁰ The costs are assumed to be constant over the next five years. This analysis assumes that the state could draw down federal funding for half of these costs.⁵¹

General Fund
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	0
2005–06	\$0	\$151	(\$151)	0
2006–07	\$0	\$151	(\$151)	0
2007–08	\$0	\$151	(\$151)	0
2008–09	\$0	\$151	(\$151)	0

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Endnotes

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- ⁴ Fam. C. Sections 8500–9340; Title 22, California Code of Regulations, Sec. 35000–35409.
- ⁵ Department of Finance, “Governor’s Budget 2004–2005” (January 2004, Sacramento, California), p. 166.
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- ¹⁵ Department of Finance, "Governor's Budget 2004–2005," p. 167
- ¹⁶ Department of Social Services, "2003 Federal Adoption Incentives." Based on submissions for federal fiscal year 2002.
- ¹⁷ Child Welfare Services Redesign Conference II "The C-CFSR or Some of My Best Friends are Outcome Measures," by Barbara Needell, MSW, PhD, Center for Social Services Research, University of California at Berkeley, (Sacramento, California, May 27, 2004); interview with Joe Magruder. While the percentage of children over age 9 is about 20 percent of the total children, the younger children who make up the majority find adoptive homes much faster while the older children remain in foster care longer.
- ¹⁸ Department of Social Services, Child Welfare Services/Case Management System, "Termination of Child Welfare Supervised Children Out-of-Home Placements, Calendar Year 2002" (Sacramento, California).
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- ²² Department of Social Services, "Foster and Adoptive Parent Recruitment, Training and Retention, Annual Report, July 1, 2001–June 30, 2002" (Sacramento, California, August 2003).
- ²³ U.S. Department of Health and Human Services, Administration for Children and Families, "California Child and Family Services Review" (January 2003), pp. 18 and 85.
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- ²⁹ Interview with Lorrie Deck, acting director, Statewide Adoption Network, Pennsylvania Department of Public Welfare, Harrisburg, Pennsylvania (June 18, 2004); Community Task Force on Homes for Children, "Adoption, Foster Care and Concurrent Planning: A study of awareness, Attitudes, Motivations, Barriers and Implications for Communication,"

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- ³⁸ North American Council on Adoptable Children, "Adoption Subsidies as an Affordable Option," <http://www.nacac.org/subsidyfactsheets/affordable.html> (last visited June 9, 2004); Interview with Cherie Schroeder, director, foster and kinship care education program, Woodland Community College, Woodland, California (May 3, 2004); and interview with Rena DeLacey, foster and adoptive parent, Woodland, California (May 3, 2004).
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⁴³ Fam. C. Section 8712. This section requires every prospective adoptive parent to undergo a background check by the Department.

⁴⁴ Interview with Cora Pearson, president of state foster parent's association, Los Angeles, California (June 1, 2004).

⁴⁵ Health & S. C. Section 1522.

⁴⁶ E-mail from Francisco Sanchez, manager, Adoption Service Branch, Department of Social Services to California Performance Review (May 11, 2004); and e-mail from Tammy Riveria, county liaison, Department of Social Services to California Performance Review (May 21, 2004.) Department adoptions and licensing staff revealed no case in which an arrest that could be reported to the department for adoptions lead to a denied adoptions application. Conviction information provided by the Department of Justice is the same for the adoptions program as it is for the foster care licensing program.

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Align State Law Regarding the \$50 Child Support Disregard Payments

Summary

Despite a change in federal law in 1996, California has continued to pay the first \$50 of a Child Support collection directly to Temporary Assistance for Needy Families (TANF) recipients. Aligning state law with federal law will allow for the redirection of county resources to core child support enforcement activities.

Background

The Child Support Enforcement Program (CSEP) collects child support payments for custodial parents. In California, county child support departments, under the supervision of the state, administer the program.

Federal law establishes child support disregard payments

Title IV-D of the Social Security Act established the federal CSEP in 1975.¹ Key provisions of the Act gave states primary responsibility for operating CSEP pursuant to a state plan and charged them with the responsibility for locating absent parents, establishing paternity, and securing support for individuals receiving Aid to Families with Dependent Children (AFDC) and others who applied directly for child support enforcement services.² The Act also contained a provision that 40 percent of the first \$50 collected on the monthly support obligation would be paid to the family without affecting AFDC eligibility or payment. Congress, in enacting this provision, intended the payment to promote cooperation of both absent parents and custodial parents and to encourage voluntary and timely compliance with child support orders.³

The Deficit Reduction Act of 1984 amended the Social Security Act to require states to pay the first \$50 of support collected on the monthly support obligation to the AFDC family.⁴ This statute also required states to disregard this payment when determining AFDC eligibility and the amount of the AFDC payment.⁵ As a result, AFDC families affected by this statute had up to \$50 of additional disposable income each month.⁶

The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) repealed the federal law requiring states to make the \$50 disregard (also called pass-through) payment. As a result, the issuance of a child support disregard payment became

a “state option” effective October 1, 1996.⁷ At the same time, the PRWORA increased the burden on parents to cooperate with child support or risk having benefits denied.

California law maintains disregard payments

Assembly Bill 1542 (Chapter 270, Statutes of 1997) allowed California to continue the \$50 disregard provision. Pursuant to Family Code Section 17504, California pays to recipients of aid the first fifty dollars (\$50) of any amount of child support collected and exempts this payment from consideration as income or resources in determining the amount of assistance to which they are entitled.

As of December 2003, only 14 states or territories have maintained the \$50 disregard that originated under AFDC. Thirty-seven states or territories changed the disregard amount significantly. Of those, 27 states or territories discontinued the child support disregard payment completely. The remaining states: 1) retain all child support collected while increasing the TANF grant up to \$50; or, 2) pass through all of the child support while disregarding some or all of the payment for the purposes of determining TANF eligibility.⁸

From October 1, 1996 (the date the federal government ceased participation in the disregard payment), through December 31, 2003, California has expended a total of \$234.4 million (state general fund) to provide disregard payments to TANF recipients.⁹ The amount forecast to be expended in Fiscal Year 2004–2005 is 29.5 million.¹⁰

Original intent of the disregard payments is accomplished in other ways

The original intent of the disregard payment was to encourage cooperation with child support enforcement. While some argue that continuation of the \$50 disregard payment enhances cooperation, recent published research on the effects of pass-through and disregard policies does not support this hypothesis.¹¹ Further, TANF regulations mandate cooperation by custodial parents in the establishment and enforcement of child support orders and impose financial sanctions for failure to cooperate without good cause. Additionally, California has implemented other means to remove barriers to cooperation such as co-location of Child Support staff in the welfare offices and state directed outreach efforts to educate customers on the benefits of paternity and support order establishment.

Administering disregard payment diverts county resources from core enforcement activities

Local child support agencies contend that the issuance of the disregard payments require staff to spend considerable time explaining to customers the disregard eligibility requirements and payment history. In some counties the disregard payments are issued by the TANF agency. In many of these counties there is a lack of an effective electronic interface to exchange data needed to correctly issue the disregard payment resulting in manual completion and transmission of records/documents.¹²



Given the limited resources at the local level to provide core child support enforcement activities and the lack of evidence that directly correlates the payment of the \$50 child support disregard payment with increased cooperation, the state should reconsider continuation of these state-only payments.¹³ While this will result in less disposable income available to TANF recipients, the disregard income will no longer be counted as unearned income in determining food stamp eligibility, as currently required, and will result in a slight increase in the food stamp allotment.

Exhibit 1

In a household consisting of a mother and two children, the CalWORKs grant in Region 1 is \$704.00. A standard deduction of \$134.00 is applied in calculating the food stamp allotment. The food stamp benefit amount for a family receiving the \$50.00 disregard would be \$185 and \$200 for the household not receiving the \$50.00 disregard; a difference of \$15.00 in food stamp benefits.

Recommendation

The Governor should work with the Legislature to repeal the requirement for the payment of the \$50 disregard payment to TANF recipients.

Fiscal Implications

Elimination of the Child Support Disregard payment may result in some minimal cost related to revising the monthly notice of collection and distribution, which currently contains language specific to the Child Support disregard. However, these costs would be minor and absorbable.

This recommendation would result in annual General Fund savings of \$29.5 million beginning in Fiscal Year (FY) 2005–2006.¹⁴ These expenditures, however, are counted towards the federal maintenance-of-effort requirement for the TANF program. As a result, these savings would not be immediately achieved, but instead would be redirected.

The FY 2004–05 Governor’s Budget projected General Fund expenditures at the maintenance-of-effort level. There is, however, considerable pressure to spend more than the federally required level on an ongoing basis, as the cost of assistance payments and services continues to increase, and as an increasing share of people in the program have multiple barriers to employment. In addition, while Congress and the President will consider several key policy changes, federal reauthorization legislation introduced to date would significantly increase the number of TANF recipients engaged in job training, community service employment and other work-related activities. Substantial investments in child care and employment services would be needed in order to meet the increased participation. These savings may be used to absorb these cost pressures.

Endnotes

- ¹ Pub. L. 93-647.
- ² *After enactment of the federal "Personal Responsibility and Work Opportunity Reconciliation Act of 1996" (P.L. 104-193) (PRWORA), the AFDC program was subsequently renamed Temporary Assistance for Needy Families (TANF) at the federal level and CalWorks in California.*
- ³ *Administration for Children and Families, Office of Child Support Enforcement, "OCSE-AT-84-9 Disregard of Child Support Payments; AFDC Regulations Implementing the Deficit Reduction Act of 1984," (September 19, 1984) <http://www.acf.hhs.gov/programs/cse/pol/AT/at-8409.htm> (last visited April 13, 2004); and Administration for Children and Families, Office of Child Support Enforcement, "OCSE-AT-88-11, Disregard of Child Support Payments—Final Regulation," (July 1, 1988) <http://www.acf.hhs.gov/programs/cse/pol/AT/at-8811.htm> (last visited April 13, 2004). This provision expired September 30, 1976. Until the Deficit Reduction Act of 1984, no other similar provision was enacted.*
- ⁴ Pub. L. 98-369.
- ⁵ *Pub. L. 100-485; and, Administration for Children and Families, Office of Child Support Enforcement, OCSE-AT-91-02, Final Rule—\$50 Pass-through; Presumptive Support Guidelines," (May 16, 1990) <http://www.acf.hhs.gov/programs/cse/pol/AT/at-9102.htm> (last visited April 13, 2004).*
- ⁶ *Administration for Children and Families, Office of Child Support Enforcement, "OCSE-AT-91-02, Final Rule—\$50 Pass-through; Presumptive Support Guidelines," (May 16, 1990) <http://www.acf.hhs.gov/programs/cse/pol/AT/at-9102.htm> (last visited April 13, 2004). Subsequent to the Deficit Reduction Act of 1984, the Family Support Act of 1988 revised the disregard regulations to provide technical clarification of disregard eligibility requirements.*
- ⁷ *Pub. L. 104-193. The PRWORA eliminated the requirement to distribute the "\$50 pass-through" portion of a child support collection. States were given the option to continue the "pass-through" distribution using state only funds.*
- ⁸ *Center for Law and Social Policy, "State Policy Regarding Pass-Through and Disregard of Current Month's Child Support Collected for Families Receiving TANF-funded Cash Assistance as of December 2003," by Paula Roberts and Michelle Jordan (Washington, D.C.), pp. 2-4.*
- ⁹ *Interview with Joyce Coles, staff services manager I, Budget Support Unit-Local Assistance, California Department of Child Support Services, Rancho Cordova, California (April 14, 2004). Note: Counties participated in the cost of the disregard during the months of October 1996 and November 1996 at a sharing ratio of five percent.*
- ¹⁰ *Department of Finance, "Governor's Budget May Revision, 2004-2005" (Sacramento, California, May 13, 2004).*
- ¹¹ *Wisconsin Department of Workforce Development, "Exploring Potential Effects of a Child Support Pass-Through and Disregard: Did Formal Child Support Payments Change when Mothers went on and off AFDC?" by Daniel R. Meyer and Maria Cancian (Wisconsin, December 1999) (consultant's report). This report found that while there is some indication of increased paternity and support order establishment when the entire child support payment is passed through to the family there was not "definitive evidence to support or reject the hypothesis that [the \$50] pass-through and disregard policy affects child support payments."*
- ¹² *Interviews with George Holbrook, director, Imperial County Department of Child Support Services, El Centro, California (April 13, 2004); Brenda Morris, supervising child support distribution specialist, Ventura County Department of Child Support Services, Ventura, California (April 14, 2004); Stephen H. Kennedy, director, Monterey County Department of Child Support Services, Salinas, California (June 1, 2004); and Veronica Potter, child support specialist III, Ventura County Department of Child Support Services, Ventura, California (June 8, 2004).*



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- ¹³ Catherine Saillant, “65 County Workers Get Pink Slips,” *Los Angeles Times*, May 27, 2004; and Les Mahler, “San Joaquin Officials Warn of Layoffs, Cuts” *Lodi News Sentinel*, May 18, 2004; and Helen Gao, “Budget-Cut Layoffs Hit Collections of Child Aid,” *San Diego Union Tribune*, May 3, 2004.
- ¹⁴ Department of Finance, “Governor’s Budget May Revision, 2004–2005.”



Use Technology to Promote Ease of Use and Improve Efficiency in the Women, Infants and Children Supplemental Nutrition Program

Summary

The use of technology to provide benefits electronically to recipients of the Women, Infants and Children Supplemental Nutrition Program (WIC) and the Food Stamp program has been praised by recipients, retailers and the financial industry. Nationwide, start-up costs have delayed most efforts to implement an electronic benefits transfer (EBT) system for the WIC program.¹ California WIC should use the EBT system created by the State Department of Social Services (DSS) for the Food Stamp program to promote ease of use and program efficiency.

Background

In California, the Women, Infants and Children Supplemental Nutrition Program (WIC) is administered by the California Department of Health Services (DHS). WIC is a 100 percent federally funded nutrition education and supplemental food program for low-income pregnant, breastfeeding and postpartum women, and children under age five who are at nutritional risk. The WIC mission is to promote proper nutrition as a way to decrease the risk of poor birth outcomes and improve the health of children during critical times of growth and development. To meet this goal, WIC provides nutrition education, breastfeeding promotion, medical care referrals, and supplemental food that is high in protein and/or iron. Specific foods provided to participants include peanut butter, beans, milk, cheese, eggs, iron-fortified cereal, iron-fortified infant formula and juices. WIC participants generally receive services for about two years.²

California's WIC program receives about \$900 million in federal funding from the United States Department of Agriculture (USDA) and more than \$200 million in rebates from juice, infant formula and infant cereal manufacturers. These rebates allow the program to increase the number of women and children served by more than 200,000 annually. WIC is expected to serve 1,285,000 recipients per month during Fiscal Year 2003–2004.³

WIC benefits are delivered through a manual process implemented through contracts with 82 county and private non-profit agencies that operate 650 local WIC centers. Upon receiving food vouchers from the WIC centers, clients redeem the vouchers at one of California's

4,189 approved WIC grocers.⁴ In FY 2002–2003, 69,282,012 WIC paper vouchers were redeemed at California grocers. The grocers process each voucher as they would a personal check or money order and deposit the redeemed vouchers in the bank. The bank redeems the vouchers with the State Treasurer’s Office.⁵

The state WIC program does not have detailed data on the administrative costs of producing and distributing WIC vouchers.⁶ WIC does provide annual information to USDA about the combined administrative costs of producing and distributing vouchers and determining eligibility. In FY 2002–2003, the cost of these combined activities was \$88.3 million.⁷

WIC voucher production costs include the costs for State Treasurer’s Office redemption services. Under a long-standing interagency agreement with DHS, the State Treasurer’s Office processes between 250,000 and 300,000 WIC vouchers per day, representing 60 percent of the their daily processing volume, but only 1 percent of the total dollar value processed. California’s WIC program reimburses the State Treasurer’s Office \$0.0335 per redeemed voucher, or about \$2.3 million per year.⁸

Efforts to implement an electronic benefits process

Health and Safety Code Section 123302 allows WIC to implement EBT under certain conditions.⁹ Assembly Bill 313 (2001) amended Health and Safety Code Section 123302 to require DHS to develop a plan to determine the feasibility of implementing a WIC EBT system, by January 1, 2003, and report its findings to the Legislature by July 1, 2003. The report is currently in draft form and is pending review and release by DHS.¹⁰

The USDA Federal Nutrition Services (FNS) has selected a contractor to work closely with the WIC state agencies to design, develop and perform a functional demonstration of a WIC EBT system similar to the California Food Stamp program delivery process. California, Washington, New Mexico and Washington, D.C. were chosen for this project, and FNS selected the State of Washington to conduct the final demonstration project.¹¹

A number of other states have initiated EBT statewide or through pilots to provide WIC services. These include Wyoming, Nevada, Ohio, New Mexico, Texas, the New England Partnership (a consortium of New England states) and Michigan. These EBT systems use a system known as “off-line.” In contrast, the system used by the California Food Stamp program is an “online” system. An online system is based on the use of an EBT card that works like an ATM bank card. The card is swiped through a reader that executes a real time transaction to verify the account is “live” and has sufficient funding to proceed with the transaction. Transactions are deducted from an online database. An off-line system utilizes an EBT card that has an embedded chip on it that stores information on the users benefit level. Transactions are not recorded in “real time,” but are uploaded at the end of each day to a central computer that tracks benefits and transactions.¹²



Existing pilots and statewide implementation have shown that EBT results in cost savings and increases ease-of-use for most participants in WIC and Food Stamp programs. Retailers gain from EBT because the cost of handling vouchers is eliminated. According to FNS studies, retailers saved between 20 and 38 percent as measured in three different Food Stamp program EBT demonstration projects. Savings are generated through reduced administrative and cashiering costs associated with voucher handling and bank fees, elimination of returned vouchers and timely reimbursements. The same FNS studies showed financial institutions realizing cost savings of more than 90 percent through the elimination of handling, sorting and transporting paper vouchers. Recipients benefit because using a benefits card reduces the stigma associated with the use of WIC paper vouchers. EBT can eliminate the perceived stigma by making it appear that recipients are purchasing food with a debit or credit card. Additionally, WIC recipients enjoy greater benefit security and increased freedom of choice in where and when they make WIC purchases with their EBT cards.¹³

Recommendations

- A. The Department of Health Services, or its successor, should utilize the existing Food Stamps electronic benefits transfer network to implement an EBT system for WIC.**
- B. California WIC should seek a grant from the USDA to provide funding for implementation of an EBT system.**
- C. California WIC should actively pursue public/private funding partnerships to achieve a state cost-neutral or cost-savings EBT solution.**

Fiscal Impact

A conservative approach to determining the savings gained by implementing EBT for WIC is to use the cost/savings estimate from a 1997 USDA study of EBT and then reducing it by one-half. The USDA estimate is based upon a standard of a medium- to large-sized state. Given the number of California WIC recipients and the extensive cultural and geographical issues in California, it is estimated the costs associated with implementing WIC EBT will be greater than other states.

Using this methodology, savings of up to \$17.5 million annually can be expected. Initial savings will be reduced by an indeterminate amount for start-up costs. These costs are estimated to be reduced by using the EBT infrastructure used by the Food Stamp program in California. As WIC is 100 percent federally funded, all savings will be utilized to expand the number of WIC recipients in California. The \$17.5 million in estimated savings will allow for an additional 25,000 recipients to receive services per year.

A portion of the savings is for the anticipated elimination of retailer overcharges that arise under the current paper system. In addition, WIC EBT pilot projects have shown a

documented reduction in monthly food purchases by WIC recipients. These savings are estimated at between \$5 million and \$14 million each year.¹⁴

An alternative estimate of administrative savings based upon DSS's implementation of EBT for the Food Stamp program indicates annual WIC EBT savings of \$19.6 million.¹⁵

Private industry will also benefit financially if EBT is implemented for WIC in California. Information from WIC EBT pilot projects indicates the financial industry and the retail grocer industry will achieve combined administrative savings of more than \$12 million annually.¹⁶

Endnotes

- ¹ *United States Department of Agriculture, Food and Consumer Service, Office of Analysis, "Costs and Impacts of the Wyoming Smartcard EBT System" (Alexandria, Virginia, May 1997), p. xi; United States Department of Agriculture, Economic Research Division, "All Food Stamp Benefits to be Issued Electronically," by Victor Oliveira and J. William Levendahl (Alexandria, Virginia, April 1998), p. 36; and interview with Katie Donahue, director, Farmers Market Nutrition, Women, Infants and Children Supplemental Food Program, Ohio State Department of Health, Columbus, Ohio (April 8, 2004).*
- ² *In the WIC program, low income is defined as those who are "at or below 185 percent of the federal poverty level." The income guidelines for a family of four are \$33,485 annually or \$2,791 monthly. California Department of Health Services, About WIC—Detailed Description, "Program Eligibility," <http://www.wicworks.ca.gov/about/detailed.html> (last visited June 18, 2004).*
- ³ *Interview with Linnea Sallack, chief, WIC Supplemental Nutrition Branch, Women, Infants and Children Supplemental Food Program, California Department of Health Services, Sacramento, California (March 10 and 30, April 7 and 22, May 27 and 28, and June 3 and 18, 2004); and interview with Michele Van Ichen, Women, Infants and Children Supplemental Food Program, California Department of Health Services, Sacramento, California (March 10, 16 and 30, April 7 and 22, and May 27, 2004).*
- ⁴ *Interview with Linnea Sallack, chief, WIC Supplemental Nutrition Branch, Women, Infants and Children Supplemental Food Program, California Department of Health Services, Sacramento, California (March 10 and 30, April 7 and 22, May 27 and 28, and June 3 and 18, 2004); and interview with Michele Van Ichen, Women, Infants and Children Supplemental Food Program, California Department of Health Services, Sacramento, California (March 10, 16 and 30, April 7 and 22, and May 27, 2004).*
- ⁵ *Interview with Steve Matranga, program manager, Treasury, Item Processing Section, California State Treasurer's Office, Sacramento, California (March 16, 2004).*
- ⁶ *In order to produce and distribute WIC vouchers the administrative tasks include purchasing paper check stock, printing, storing, transporting, processing and destroying vouchers, and performing extensive anti-fraud activities.*
- ⁷ *Interview with Linnea Sallack (March 24, 2004).*
- ⁸ *Interview with Steve Matranga.*
- ⁹ *California Health & S.C. Section 123302(a)(1), (a)(2) and (b).*
- ¹⁰ *Interview with Linnea Sallack (May 28, 2004).*
- ¹¹ *Interview with Linnea Sallack (May 28, 2004).*



- ¹² United States Department of Agriculture, Food and Nutrition Service, "WIC EBT Status Report (as of June 2004)," <http://www.fns.usda.gov/wic/EBT/wicebtstatus.htm> (last visited June 18, 2004).
- ¹³ United States Department of Agriculture, Economic Research Division, "All Food Stamp Benefits to be Issued Electronically," by Victor Oliveira and J. William Levendahl (Alexandria, Virginia, April 1998). p. 36.
- ¹⁴ United States Department of Agriculture, Food and Consumer Service, Office of Analysis, "Costs and Impacts of the Wyoming Smartcard EBT System" (Alexandria, Virginia, May 1997), p. 38.
- ¹⁵ Health and Human Services Data Center, Electronic Benefits Transfer Project (FSR 4130-116), *Advanced Planning Document, Section E* (Sacramento, California, November 2002).
- ¹⁶ United States Department of Agriculture, Economic Research Division, "All Food Stamp Benefits to be Issued Electronically," by Victor Oliveira and J. William Levendahl (Alexandria, Virginia, April 1998), p.87; United States Department of Agriculture, Food and Consumer Service, Office of Analysis, "Costs and Impacts of the Wyoming Smartcard EBT System" (Alexandria, Virginia, May 1997), p. 35; and online is central computer dependent and real time, off-line is chip on card dependent and not real time.



Simplify Public Health Funding Agreements

Summary

The California Department of Health Services enters into more than 1,000 separate contracts with 61 city and county health departments for public health services. City and county health departments report that the multiple contracts are unnecessarily burdensome and complex. The state should streamline administrative processes for funding local public health programs, reduce processing times for execution of agreements and consolidate multiple public health funding sources where appropriate.

Background

The mission of the Department of Health Services (DHS) is to protect and improve the health of all Californians.¹ The department administers public health and health care service programs in partnership with hospitals, clinics, health plans, community-based organizations as well as city and county health departments.² The department funds many of these partnerships through contracts.

The California Department of Health Services has too many separate contracts with each local health department

DHS funds most of its public health services through county and city local health departments. The 61 city and county health departments receive public health funding through more than 1,000 categorical agreements that total less than half a billion dollars in local assistance funds.³ One large county recently complained that it had 29 contracts with DHS, while Alpine County, the smallest county in the state with a population of 1,200, has nine contracts. The department's Contracts Management Unit (CMU), which processes all contracts, estimates that contracts with local health departments represent 30–45 percent of its annual workload (or more than 3,000 contracts or contract amendments annually).⁴

The department's contracts are administratively burdensome

City and county health departments face competing application and reporting deadlines from DHS programs and report that the administrative burden of managing contracts with the state significantly reduces the time staff can devote to program activities.⁵ Many city and county health department policies require the approval of elected officials for each agreement and subsequent amendment.

City and county health departments report minimal flexibility from DHS to address existing and emerging local health issues. They complain that most existing contracts are overly complicated and focused on spending allocations rather than measurable public health goals.

The department's contracting process is slow, and city and county health departments bear the financial burden for the delays

City and county health departments are government entities with legal responsibility for public health functions, and the state relies upon them to carry out these responsibilities.⁶ However, several DHS programs were waiting to execute several Fiscal Year 2003–2004 contracts with local health departments as of April 2004.⁷ Such delays place a financial burden on local health departments, which provide services on faith that the state will execute contracts. The state's burdensome contracting procedures interfere with the delivery of public health services.

Some department programs use allocations and avoid lengthy, multiple reviews

Several public health programs have statutory authority to fund local health departments through allocation or subvention agreements instead of contracts. (See Exhibit 1.) These programs require plans from local health departments to assure appropriate use of funds and include or incorporate by reference the elements of a contract in an allocation or subvention agreement. The DHS/CMU and Department of General Services do not review allocation and subvention agreements, thereby reducing processing times. Though these agreements are not subject to additional review, the allocation agreements with city and county health departments do not pose a financial risk to the state or eliminate local health departments' accountability for performance.⁸

Exhibit 1

DHS Program	Method	FY 03–04 Awards
Maternal and Child Health	Allocation	\$64.1 million
Tobacco Control	Allocation	\$19.5 million
Bioterrorism Preparedness and Emergency Response	Allocation	\$59.3 million
Tuberculosis Control	Subvention	\$9.9 million
California Children's Services (County administration)	Allocation	\$111.2 million
Child Health and Disability Prevention (County administration)	Allocation	\$58.6 million (23 million is for the Health Care Program for Children in Foster Care)

Allocations have been exempt from recent contract freezes that have delayed contracts beyond the normal timeframes, assuring the funding and delivery of public health services. In comparison, several department programs and their local counterparts report delays in the



current year for contracts that were to begin in July 2003, but were still not executed as of April 2004, ten months into the state's fiscal year. (The department generally executes allocation agreements earlier than contracts unless the program causes the delay.)

Combining program agreements reduces the number of documents processed by the state and local health departments

Some public health programs have further streamlined the processing of agreements with city and county health departments by bundling programs and services into one grant. For example, the department's Maternal and Child Health Branch incorporates five programs in its allocation process in addition to the Maternal and Child Health program.⁹ The Office of AIDS funds up to 19 separate projects in a single contract, called the master agreement, with local health departments.¹⁰ In both cases, the department's Contract Management Unit processes only one agreement per local health department instead of multiple agreements. This consolidation significantly reduces the contract processing workload for the state and local health departments. By contrast, if all 61 local health jurisdictions received separate contracts for all 19 AIDS projects, the result would be 1,159 separate contracts for AIDS funding across the state. The Department of Alcohol and Drug Program also bundles agreements where feasible and reduces the number of agreements processed with local health departments.¹¹ Combined contracts also allow an easy transfer of funds among projects where programs permit such flexibility.

Programs can further streamline processing of agreements by using technology

The department's Online Tobacco Information System (OTIS) is an example of programs' use of technology in the review and processing of allocations. OTIS is a unified, interactive web-based system that is accessible to program staff and contractors.¹² Local lead agencies use OTIS to submit applications online, thereby improving the quality of their submitted plans by guiding users in making correct selections. The Tobacco Control program reviews, processes and manages the agreements online, thereby reducing paper processing and improving processing and response times.¹³ The program engaged the services of a contractor to design and build the system and provide training at a cost of \$200,000, and is contracting for the servers and maintenance for an approximate annual cost of \$240,000.

The Placer County Consolidated Contract integrates several programs, organized around core public health functions and focused on outcomes

Senate Bill 1846 (1996) permitted Placer County to pilot an integrated health and human services system. To accompany the integrated services model, Placer County asked DHS to collaborate on developing a streamlined contracting, accounting, reporting and claiming process for 16 state and federally funded public health programs.¹⁴

The Placer County contract has a single scope of work based on the "Ten Essential Public Health Functions," incorporates the programs' policies and procedures by reference, standardizes language and terms and replaces the 16 programs' quarterly and annual reports

with a single annual report.¹⁵ Placer County submits a single invoice with program detail that all programs review and approve. Placer County and DHS staff met over a three-year period to develop the consolidated contract framework. The Placer County consolidated contract demonstrates that contracts can integrate multiple programs, organize around core public health functions common to all and simplify reporting requirements.¹⁶ Further work would be required to use the consolidated contract framework with other city and county health departments.¹⁷

Recommendations

- A. The Governor should work with the Legislature to authorize allocations, exempt from the Public Contract Code, for provision of public health services by city and county health departments.**

Public health programs should work with legal counsel and Contract Management Unit (CMU) staff to ensure that allocation agreements contain the essential elements of a contract and incorporate appropriate state guidelines by reference. The allocation method will reduce CMU's contract processing workload by 30 to 45 percent.¹⁸

This new method will significantly reduce processing time and provide greater stability at the point of service delivery.

- B. The Health and Human Services Agency, or its successor, should reduce the number of public health agreements by combining multiple programs and reporting requirements, no later than July 1, 2005.**

Department of Health Services (DHS) programs should combine agreements for similar programs. DHS has a model for combined services with Placer County, which, with significant advance planning and coordination, could be considered as an option for other city and county health departments.¹⁹

- C. The Health and Human Services Agency, or its successor, should simplify public health agreements and emphasize public health outcomes no later than July 1, 2005. Specifically:**

1. Agreements with local health departments should focus on the core public health functions and outcomes and give greater flexibility to local health departments in providing public health services,
2. Agreements should establish minimum public health performance measures and give counties greater freedom to determine how best to meet them, and
3. The state should hold local health departments accountable for the outcomes.

Combined agreements will reduce the administrative burden the state imposes on local health departments.



D. The Health and Human Services Agency, or its successor, should pursue expanding the use of web-based applications to allow submission and review of local health department funding applications, invoices and reports.

This recommendation would streamline the state's business practices, improve the timeliness of communication and the efficiency of processing agreements.

E. The Health and Human Services Agency, or its successor, should perform a desk audit of the DHS Contract Management Unit after implementing recommendations A and B to determine appropriate staffing levels.

Fiscal Impact

Recommendations A and B reduce the number of contracts written and processed by the department, though no staffing reduction is proposed because the department's Contract Management Unit is significantly understaffed compared to units in other state departments.

Recommendation D requires the department to expand its use of web-based systems that local health departments can use for funding applications, invoices and reports. The cost to expand these systems cannot be estimated at this time.

Recommendation E proposes a desk audit of the contracts unit to determine the appropriate staffing levels. Costs for this activity are minimal and absorbable by the agency.

There will be savings to county governments attributable to these recommendations; however, these savings cannot be estimated at this time. There also may be offsetting costs to collect and report program performance measures.

Endnotes

- ¹ California Department of Health Services, "Strategic Plan Highlights," <http://dhs.ca.gov/home/aboutDHS/strategicplan.htm> (last visited June 2, 2004).
- ² California Department of Health Services, "Overview of DHS," <http://dhs.ca.gov/home/aboutDHS/> (last visited June 2, 2004).
- ³ E-mail from Mark Hutchinson, California Department of Health Services, Administration Division (April 2, 2004). The approximate \$444 million amount includes agreements from Prevention Services, Primary Care and Family Health, and Health Information and Strategic Planning and excludes Medi-Cal; there are 58 county and three city (Long Beach, Berkeley and Pasadena) health departments, for a total of 61 city and county health departments.
- ⁴ E-mail from Terri Anderson, California Department of Health Services, Contracts and Purchasing Services Section (April 8, 2004).

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- ⁵ Telephone interview with Martin Fenstersheib, M.D., health officer, Santa Clara County, Santa Clara, California (March 22, 2004); and telephone interview with Jonathan Fielding, M.D., health officer, Los Angeles County, Los Angeles, California (March 23, 2004); and telephone interview with Scott Morrow, M.D., health officer, San Mateo County, and President, California Conference of Local Health Officers, San Mateo, California (March 22, 2004).
- ⁶ Health & S. C. §§101025 and 101030.
- ⁷ Interviews with various staff in the California Department of Health Services, Sacramento, California (March and April 2004). While Executive Order S-4-03 imposed a contract freeze and affected processing timelines, the contracts would not have been subject to the freeze if they had been fully executed as of December 4, 2003, more than five months into the state's fiscal year. The department does not have a management information system that tracks contracts' progress through all approval mechanisms and provide estimates of processing time from beginning to end.
- ⁸ Interview with Joe Perez, California Department of Health Services, Sacramento, California (April 6, 2004). The Maternal and Child Health program pursued allocations after conducting a risk analysis. The program determined that in the case of contracting with local health departments, funding was stable, financial risk was almost nonexistent when contracts were on a cost reimbursement basis, and the contractor was a stable entity that would not legally dissolve.
- ⁹ Interview with Les Newman, Nancy Smith, Amy Blandford, and Liz Gaffrey, California Department of Health Services, Sacramento, California (April 6, 2004). The Maternal and Child Health allocation agreements also include Adolescent Family Life, Adolescent Sibling Pregnancy Prevention, Black Infant Health, Childhood Injury Prevention and Fetal Infant Mortality Review.
- ¹⁰ Interview with Chris Nelson, California Department of Health Services, Office of AIDS, Sacramento, California (April 7, 2004).
- ¹¹ Interview with Barbara Howard, California Department of Alcohol and Drug Programs, Sacramento, California, May 5, 2004.
- ¹² Interview with April Roeseler and Cathy Palmer, California Department of Health Services, Tobacco Control Section, Sacramento, California (April 26, 2004).
- ¹³ April Roeseler, California Department of Health Services, Tobacco Control Section, "The California Online Tobacco Information System (OTIS)."
- ¹⁴ The consolidated contract did not require a change in statute or regulation.
- ¹⁵ Interview with Les Newman and Ellen Buchanan, California Department of Health Services, Maternal and Child Health Branch, Sacramento, California (April 15, 2004). The contract is a "fixed price" agreement and has separate program budgets with no provisions for pooling or mixing funds and requires specific program components in the single quarterly invoices.
- ¹⁶ Foundation Consortium for California's Children and Youth, "The Placer County Consolidated Model Health Contract—A State-County Partnership to Improve Public Health Systems," by Lynn Delapp (Sacramento, California, December 2002) pp. 6–7; and e-mail from Ellen Buchanan, California Department of Health Services, Maternal and Child Health Branch (May 13, 2004). The Fiscal Year 2003–2004 contract is for \$2.7 million and was not fully executed as of May 13, 2004.
- ¹⁷ Interview with Sharon Long and Jayna Querin, California Department of Health Services, Sacramento, California (May 6, 2004); and e-mail from Nancy Hutchinson, California Performance Review (May 14, 2004); and interview with various staff from the California Department of Health Services, Sacramento, California (May 6, 2004). Placer County staff support the current model, but there is no evaluation to date. DHS programs have varied positions on the merits of the consolidated contract and the process of developing it.



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- ¹⁸ *Staff from the Department of Health Services' Contract Management Unit, with assistance from legal staff, should help programs set up allocations for the first time, so first year savings may be less.*
- ¹⁹ *Interview with various staff from the California Department of Health Services, Sacramento, California (May 6, 2004); and California Department of Health Services, Maternal and Child Health Branch, "State and County Readiness Guidelines—Consolidated Health Contract Pilot" (Sacramento, California, February 2003), pp.11–12.*
- The success of developing the Placer consolidated contract can be attributed to Placer County's commitment to consolidated services and concordant reorganization of its health and human services agencies; other interested counties must have the same level of commitment and effort to implement the Placer model.*



Create a State Public Health Officer to Strengthen Public Health in California

Summary

California’s public health system has been criticized for inadequately protecting the public’s health. Creation of a statutorily identified state public health officer is a key step in improving the effectiveness of California’s public health system and protecting the public’s health through coordinated leadership and science-based decision-making.

Background

Public health is the science and practice of protecting and improving the health of a community through preventive medicine, health education, control of communicable diseases, application of sanitary measures, and monitoring of environmental hazards. Public health focuses on the health of communities rather than individuals, emphasizes prevention of illness over treatment, and recognizes multiple determinants of health beyond individual behavior.

The core functions of public health are to assess and monitor the health of communities, formulate public policies designed to solve health problems and determine priorities, and assure that all populations have access to appropriate and cost-effective care.¹ Public health carries out these core functions through ten essential services. (See Exhibit 1.)

Core Function	Essential Public Health Services
Assessment	<ul style="list-style-type: none"> • Monitor health status to identify community health problems • Diagnose and investigate health problems and hazards in the community
Policy Development	<ul style="list-style-type: none"> • Inform, educate and empower people about health issues • Mobilize community partnerships to identify and solve health problems • Develop policies and plans that support individual and community health efforts
Assurance	<ul style="list-style-type: none"> • Enforce laws and regulations that protect health and ensure safety • Link people to needed personal health services and assure provision of health care when otherwise unavailable • Assure a competent public health and personal health care workforce • Evaluate effectiveness, accessibility and quality of personal and population-based health services • Research for new insights and innovative solutions to health problems

Exhibit 1. Source: Centers for Disease Control and Prevention, Public Health Functions Steering Committee, 1994.

Life span in the United States increased 30 years in the 20th century. Although this increase is often attributed to medical science and individual health care, advances in public health are responsible for 25 of the 30 years gained.² Because of public health, people can eat at restaurants and drink water without becoming ill, vaccinate their children to prevent debilitating diseases, and they know that wearing seatbelts, not smoking and maintaining a healthy weight will prevent premature death.

Public health has the responsibility for preparing for and responding to emerging issues that threaten the public's health. In recent history, the world has seen outbreaks of new illnesses such as AIDS, SARS and West Nile Virus and experienced the heightened threat of terrorist acts that may use biological agents such as anthrax and smallpox. The public is often fearful of these threats, and public health personnel lead our communities in prevention and response.

Public health plays a critical part in containing health care costs. According to the Centers for Disease Control and Prevention, cardiovascular disease, cancer and diabetes are the most costly, prevalent and preventable health problems in the United States.³ Chronic diseases account for 70 percent of all deaths in the United States and more than 75 percent of the \$1.4 trillion in medical care costs.⁴ In California, health care is the leading industry at \$150 billion per year, representing about 10 percent of the state's economy.⁵ By integrating public health prevention, the health care system can reduce disease, improve quality of life, prevent premature death and reduce health care costs.

Criticisms of public health

Despite all that public health has achieved and can accomplish, several reports have criticized the public health system and questioned whether its infrastructure and lack of coordination and preparedness impair its ability to protect the public's health. In 1988, the Institute of Medicine reported that the nation's public health system was in trouble, had lowered vigilance, and faced competing priorities from ongoing preventive efforts and emerging threats such as AIDS and environmental toxins, all of which ultimately threatened the public's health.⁶ The Institute followed up in 2002 with a report on public health in the 21st century and described how the real and perceived anthrax threats in 2001 revealed the vulnerabilities of the public health system due to political neglect, absence of science-based decision-making and outdated surveillance and communication systems.⁷

California's public health system has been criticized by internal participants and external reviewers. The California Conference of Local Health Officers asserts that public health has suffered from decades of neglect and cites examples of ill preparedness, such as California learning of an E. coli outbreak from Washington State; a widely criticized agreement with the U.S. Department of Agriculture about recalled meat products that prohibited sharing of certain information with local health departments; and problems with bioterrorism preparedness.⁸ The Little Hoover Commission issued a report in 2003 that identified the state's public health system "as the weakest link in California's homeland defense."⁹ At the Commission's request,



RAND Health conducted an assessment of gaps in California's public health system.¹⁰ The study results present a picture of uneven public health preparedness where a California resident's health and safety related to a major disease outbreak or act of bioterrorism will vary from county to county. The report also pointed to varying capabilities among counties to provide teen pregnancy prevention services and trace contacts of individuals with sexually transmitted diseases. The report also notes poor coordination between the state and counties.¹¹ The report states that there appears to be an absence of state leadership and local health departments must fend for themselves.¹²

These organizations provide multiple recommendations to address the identified problems, all of which highlight the need for clear public health leadership. Both Institute of Medicine reports and the California Conference of Local Health Officers state the need for public health-trained physician leadership, which California does not require.¹³ The RAND Health study identified leadership qualities of health officers as an important factor in public health's preparedness.¹⁴

California's public health system

In California, county boards of supervisors must appoint local health officers to lead and protect the health of their communities.¹⁵ Local health officers, unlike any other medical practitioners, have police powers they can exercise to protect the public health, and they can take any preventive measure necessary to protect the public from any public health hazard during declared emergencies.¹⁶ Commensurate with the level of responsibility it gives to local health officers, California law requires that they be physicians.¹⁷

Several state departments have public health functions, but the California Department of Health Services (DHS) is responsible for administering and enforcing most public health laws and programs. The department advises local health authorities and, when it determines that public health is threatened, can control and regulate their actions.¹⁸ Despite the department having these considerable powers, state law does not require the appointment of a state public health officer.¹⁹ Public health emergencies know no geopolitical boundaries, and one report revealed a troubling situation where understanding of public health legal authority varied greatly across local health jurisdictions; however, the state has no similarly credentialed counterpart to the local health officers to advise the Governor and ensure that the state appropriately exercises its emergency powers.²⁰

The Little Hoover Commission issued a report in April 2003 recommending that public health functions be led by a physician and practice science-based leadership.²¹ The California Conference of Local Health Officers supports the concept of physician leadership on public health issues, emphasizing that medical expertise is critical for "sound interpretation and rational enforcement" of public health laws, "lends the necessary authority and credibility to lead and guide" public health efforts and is "grounded in collegial and professional respect" in the relationship between public health officials and other physicians and medical

organizations.²² The Institute of Medicine's 1988 report on public health also recommended that public health functions be under the leadership of a person with public health training and doctoral level education as a physician (or in another health profession).²³ According to a national survey, 23 states and territories require the lead health official to be a physician.²⁴

The department has attempted to identify a state health officer in various ways. When the director has been a physician or other trained health professional, the department has designated that person as the state health officer. When the director has not been a trained health professional, the department designated a physician elsewhere in the department or has recruited and appointed an individual to serve in that capacity. The current health officer is an assignee from the Centers for Disease Control and Prevention. However the position has no statutory or regulatory existence or authority, which translates to an absence of authority and accountability for the exercise of police powers.²⁵

The salary California currently pays for top officials may be inadequate to attract and retain a qualified state public health officer. For purposes of comparison, the California Government Code sets the annual salary of the director of DHS, which is currently \$117,386.²⁶ According to a national survey, this puts California in the bottom 21 states and territories.²⁷ In contrast, several local health officers in California can earn salaries that exceed that of the CDHS director. The health officers in Stanislaus and Placer counties can earn salaries that approach \$200,000 and the health officer for the City and County of San Francisco can earn a salary in excess of \$216,000.²⁸

Recommendations

- A. The Governor should work with the Legislature to consolidate all core public health functions into one newly created organization under the direction of a state public health officer.**

The state public health officer should have necessary qualifications (education, credentials, experience and leadership) and a clear role, responsibility, authority and accountability solely focused on public health. By creating the position, the state avoids having to delegate this important function to someone borrowed from the ranks or another governmental entity. The position should have exempt status to permit recruitment from outside of the state's civil service system.

The state public health officer would provide professional and technical leadership to the medical and scientific professionals serving in DHS and local public health departments. The incumbent would work with local health officers, schools of public health, and health care systems on prioritizing and planning of public health services,



establishing public health policy and forging a strong public health network. Most importantly, the state public health officer would provide the medically-based rationale and responsibility in recommending and exercising considerable police powers in a public health emergency and work in close partnership with local health officers and the federal Centers for Disease Control and Prevention.

The state public health officer would be the chief communicator on public health issues to the general public and health professionals. Such a person would be more credible if he or she has medical training and public health expertise. The incumbent would strengthen public health's role in assuring the conditions for population health, working in partnership with employers and businesses, the media, academia, the health care delivery system, and communities.²⁹ California's public health officer would provide and advocate for science-based, public health decision-making with policy-makers, promote understanding of the multiple determinants of health and mobilize and support communities in developing and sustaining solutions to health problems. This person would be the key link in forging the relationships and providing the leadership necessary to make public health a priority equal to public safety.

B. The Department of Health Services, or its successor, should establish a competitive salary for the state public health officer.

The state will have difficulty recruiting a public health officer without establishing a salary commensurate with the desired qualifications. The state should conduct a salary survey of local health officers and key officials in California's schools of public health and compare them with the salaries of health officials across the nation to determine the appropriate salary to recruit a trained, experienced public health physician to serve in the capacity of state public health officer.

California has already set a precedent to establish a higher salary for a medically trained individual in a critical position. The Department of Mental Health has an assistant director of Clinical Services with a maximum salary range of \$178,608.³⁰ This position is a career executive assignment, and the incumbent serves as the department's highest level medical consultant and must be a board approved physician.

Fiscal impact

Although a salary survey is recommended, the costs below presume hiring a public health officer effective July 2005 at an annual salary of \$200,000 plus 30 percent for benefits and \$15,000 for annual operating expenses. Though a robust public health system will save health care costs and increase years of useful life, the savings cannot be quantified.

General Fund
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	0
2005–06	\$0	\$275	(\$275)	1
2006–07	\$0	\$275	(\$275)	1
2007–08	\$0	\$275	(\$275)	1
2008–09	\$0	\$275	(\$275)	1

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Endnotes

- ¹ Institute of Medicine of the National Academies, *“The Future of Public Health”* (Washington, D.C., National Academy Press, 1988), pp. 7–8, <http://books.nap.edu/books/0309038308/html/index.html> (last visited June 9, 2004).
- ² Centers for Disease Control and Prevention, *“Ten Great Public Health Achievements—United States, 1900–1999”* *“Morbidity and Mortality Weekly Report”* (April 2, 1999), <http://www.cdc.gov/mmwr/preview/mmwrhtml/00056796.htm> (last visited April 29, 2004).
- ³ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, *“Chronic Disease Overview,”* <http://www.cdc.gov/nccdphp/overview.htm> (last visited May 17, 2004).
- ⁴ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, *“Chronic Disease Overview.”*
- ⁵ Dan Walter, *“Medical Politics and Money, from HMOs to Dogs’ Teeth,”* *“Sacramento Bee”* (June 9, 2004) p. A-3.
- ⁶ Institute of Medicine of the National Academies, *“The Future of Public Health”* (Washington, D.C., National Academy Press, 1988), pp. 1–2.
- ⁷ Institute of Medicine of the National Academies, *“The Future of the Public’s Health in the 21st Century”* (Washington, D.C., National Academy Press, November 2002), p. 3, <http://www.nap.edu/catalog/10548.html> (last visited June 9, 2004).
- ⁸ Letter from Scott Morrow, M.D., M.P.H., president, California Conference of Local Health Officers, to California Performance Review (April 13, 2004).
- ⁹ Letter from Michael E. Alpert, chairman, Little Hoover Commission, to Governor Gray Davis and Members of the Legislature (April 10, 2003).
- ¹⁰ Little Hoover Commission, *“To Protect and Prevent: Rebuilding California’s Public Health System”* (Sacramento, California, April 2003), p. 3.
- ¹¹ Dorsey Griffith, *“Study: Counties’ Readiness Varies for Health Crisis,”* *“Sacramento Bee”* (June 2, 2004) p. A-5.



- ¹² *Testimony from Nicole Lurie, RAND Corporation, RAND Health, to the California Senate Committee on Health and Human Services, Sacramento, California, June 2, 2004, p. 5, <http://www.rand.org/publications/CT/CT227/CT227.pdf> (last visited June 10, 2004.)*
- ¹³ *Institute of Medicine of the National Academies, "The Future of Public Health" (Washington, D.C., National Academy Press, 1988), p. 11; Institute of Medicine of the National Academies, "The Future of the Public's Health in the 21st Century" (Washington, D.C., National Academy Press, November 2002), p. 415; letter from Scott Morrow, M.D., M.P.H., president, California Conference of Local Health Officers, to California Performance Review (April 13, 2004); and Little Hoover Commission, "To Protect and Prevent: Rebuilding California's Public Health System" Sacramento, California, April 2003), p. 30.*
- ¹⁴ *Nicole Lurie, Jeffrey Wasserman, Michael Soto, Sarah Myers, Poki Namkung, Jonathan Fielding and Robert Burciaga Valdez, "Local Variation in Public Health Preparedness: Lessons from California," "Health Affairs" (June 2, 2004), <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.341/DC1> (last visited June 10, 2004).*
- ¹⁵ *Health and S. C., Section 101000. Health and S. C., Sections 101025–101070 outline the major responsibilities and authority of the local health officers.*
- ¹⁶ *Health and S. C., Section 101040.*
- ¹⁷ *Health and S. C., Section 101005.*
- ¹⁸ *Health and S. C., Section 100180.*
- ¹⁹ *Association of State and Territorial Health Officials, "2002 Salary Survey of State and Territorial Health Officials" (Washington, D.C., 2002), Chart E. The 51 respondents represented 49 of the 50 states, the District of Columbia and Puerto Rico.*
- ²⁰ *RAND Corporation, RAND Health, "Public Health Preparedness in California, Lessons Learned from Seven Health Jurisdictions" (Santa Monica, California, 2004), p. 40 (pre-publication copy). <http://www.rand.org/publications/MG/MG247/MG247.pdf> (last visited June 9, 2004).*
- ²¹ *Little Hoover Commission, "To Protect and Prevent: Rebuilding California's Public Health System" (Sacramento, California, April 2003), p. iii.*
- ²² *Letter from Poki Stewart Namkung, M.D., M.P.H., President, California Conference of Local Health Officers, to Hattie Rees Hanley, Little Hoover Commission (February 6, 2003); and California Conference of Local Health Officers, "CCLHO Responds to the Recommendations from Little Hoover Commission Report," Sacramento, California, January 8, 2004, p. 1 (briefing document).*
- ²³ *Institute of Medicine of the National Academies, "The Future of Public Health" (Washington, D.C., National Academy Press, 1988), p. 11.*
- ²⁴ *Association of State and Territorial Health Officials, "2002 Salary Survey of State and Territorial Health Officials" (Washington, D.C., 2002) p. 1.*
- ²⁵ *Interview with Eileen Eastman, California Department of Health Services, Sacramento, California (March 15, 2004); and interview with Kevin Reilly, California Department of Health Services, Prevention Services (May 2004).*
- ²⁶ *Gov. C. Section 11552 sets the annual salary for the Director of the Department of Health Services and thirty-three other executive positions. The salary began at \$85,402 in January 1988, and the Government Code allows for increases comparable to but not exceeding the percentage of general salary increases provided for state employees during a fiscal year; and the immediate past director took a substantial pay cut to move from a local health department and serve as the Department of Health Services director.*
- ²⁷ *Association of State and Territorial Health Officials, "2002 Salary Survey of State and Territorial Health Officials" (Washington, D.C., 2002), Chart L.*

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- ²⁸ County of Stanislaus, "Job Classification and Salary report—As of 4/03/2004 ALPHA," <http://www.co.stanislaus.ca.us/hr/SalaryInfo/per902.pdf> (last visited May 18, 2004). Health officer salary is \$5,028–7,543 biweekly, which equates to \$130,728–196,118 annually; and Placer County, Health Officer, "2004 Basic Salary Schedule" County of Placer (A.O. 5:01 p.m. 12/26/03). <http://www.placer.ca.gov/personnel/2004-basic-salary-plan.htm> (last visited on May 18, 2004). Health officer salary range 69 is \$12,928–15,713, which equates to \$155,136–188,556 per year; longevity pay is \$16,499 per month and \$197,988 per year; and City and County of San Francisco, Department of Human Resources, "Compensation Manual Fiscal year 2003–2004," April 12, 2004, <http://www.sfgov.org/site/uploadedfiles/dhr/compmanl.pdf> (last visited May 18, 2004). The Health Director salary is \$6,320–8,312 biweekly (1/3/04 rate), which equates to \$164,320–216,112 per year.
- ²⁹ Institute of Medicine, "The Future of the Public's Health in the 21st Century," November 2002, p. 3. (report brief).
- ³⁰ California State Personnel Board, <http://spb.ca.gov/employment/spbpay2rd.cfm> (last visited May 12, 2004); and Department of Finance, "2004–2005 Salaries and Wages Supplement." The Fiscal Year 2004–2005 annual salary for the Department of Mental Health, assistant director of clinical services is \$168,660.



Make California's HIV Reporting System Consistent With its AIDS Reporting System, and Improve AIDS Reporting

Summary

California uses a code-based system for reporting Human Immunodeficiency Virus (HIV) cases and a name-based system for reporting cases of Acquired Immunodeficiency Syndrome (AIDS). The code-based system is labor intensive, less accurate and more complex than the name-based system and risks the loss of federal funding. California should make its HIV reporting system consistent with its name-based AIDS reporting system, and improve its AIDS reporting to identify additional unreported cases.

Background

Public health officials use disease reporting to monitor public health, develop prevention strategies, set priorities and evaluate programs, allocate resources and facilitate research.¹ California requires health care providers to confidentially report more than 80 diseases and conditions to local health officers.² All states require reporting of HIV and AIDS.³ All states use confidential name-based systems for reporting AIDS and all other reportable diseases and conditions, except HIV.

AIDS has been reportable in California for more than 20 years. Since AIDS cases represent later stages of the disease, AIDS data are less useful than HIV data for public health professionals to monitor the epidemic, and target and evaluate prevention programs.⁴ Public health professionals need accurate HIV case data in addition to AIDS data to assess the spread and impact of the HIV/AIDS epidemic. California responded to this need by implementing code-based HIV reporting in July 2002. Local health departments have already reported almost 31,000 cases of HIV, representing more than 35 percent of reported cases of individuals living with HIV/AIDS in California.⁵ California is one of only seven states that have an HIV reporting system that is solely code-based.

AIDS reporting system

Local health departments identify between 95 and 98 percent of California's AIDS cases through active surveillance.⁶ Local health departments actively seek case information from health care providers and other data sources, complete the case report form, assure the accuracy and completeness of the data, and forward the data to the state's HIV/AIDS Case Registry.⁷ State health staff verify data accuracy and forward the information to the Centers for

Disease Control (CDC) using a secure, electronic data system.⁸ The HIV / AIDS Case Registry and local health departments rely on patient names and other data elements for epidemiologic follow-up and to assure the accuracy and uniqueness of each case. The AIDS reporting system is confidential in that only authorized public health staff has access to patient names, which are protected with security systems at the federal, state and local levels.

Implementation of HIV reporting

California law prohibits name-based HIV reporting, and previous attempts to change this through legislation and ballot initiative have failed.⁹ California HIV / AIDS advocates have strongly opposed any form of name-based HIV reporting in the past due to confidentiality concerns, but supported a code-based system for HIV cases. Legislation that would have codified such a system failed to pass.¹⁰ In 1999, California began developing regulations to create a code-based HIV reporting system and implemented HIV reporting on July 1, 2002.

Thirty-six states have implemented name-based HIV reporting, five use name-to-code systems, two allow client choice of name or code and seven, including California, use a code-only system.¹¹ Texas, Puerto Rico and Kentucky, which used code-based HIV reporting systems, have changed to name-based systems.¹²

Threat to federal funding

California received more than \$223 million in Ryan White Comprehensive AIDS Resources and Emergency (CARE) Act funds in Federal Fiscal Year (FFY) 2004 for Titles I and II, of which approximately \$174 million is by formula that uses AIDS case data.¹³ Beginning as early as FFY 2005 and no later than FFY 2007, the federal government will include CDC-confirmed HIV case data in the Ryan White CARE Act funding formula.¹⁴ CDC considers HIV data from code-based systems to be unreliable and will not accept the data and is unlikely to confirm them for use in allocating Ryan White funds.¹⁵ If the federal government does not include California's HIV data and relies solely on its AIDS data, it could cost the state up to \$50 million annually in Ryan White CARE Act funds and cause reduced services to clients.¹⁶

California is the only state among the five largest that uses an HIV reporting system different than its AIDS reporting system.¹⁷ The other four, New York, Florida, Texas, and New Jersey, use name-based HIV reporting systems and will have an advantage over California when CDC confirms their HIV data for the Ryan White funding formula. By not changing to a name-based HIV reporting system, California risks losing its fair share of Ryan White CARE Act funds when the funding formula changes.

If California chooses to retain its code-based HIV reporting system and secure its fair share of federal funds, it must demonstrate that its system meets CDC criteria and negotiate acceptance of its data. The original budget for HIV reporting included \$235,000 for evaluation, and the



State Office of AIDS recently estimated that it could cost up to \$500,000 to formally evaluate the system and determine whether the system meets CDC's minimum performance standards for completeness, timeliness, accuracy and risk information.¹⁸ However, the Office of AIDS does not have funds available to evaluate its HIV reporting system.

Code-based HIV reporting is unnecessarily burdensome

Under the current system, laboratories must create partial codes and providers must complete them. Providers and laboratories find the code-based HIV reporting system confusing and more time intensive than the name-based AIDS reporting system. Furthermore, the code-based system is prone to error and makes it difficult for local health departments to follow up with providers and complete case reports in a timely manner.¹⁹

Local health departments must often provide technical assistance to providers on the correct method of reporting cases and completing forms. This means that local health department staff may see client names in the course of ensuring proper record matching and completion of case reports. If the local health department staff cannot see the records, they must rely on the providers. Providers are generally unwilling to do the matching because of workload concerns and complexity.

The State Office of AIDS staff must work with local health departments to ensure data accuracy prior to forwarding data to CDC, and the code-based HIV reporting system requires more work than a name-based system to resolve accuracy and duplicate reporting issues. The Office of AIDS has lost positions and funding to support code-based HIV reporting as well as AIDS reporting.²⁰

Concerns about name-based HIV reporting

Opponents of name-based HIV reporting express concerns about confidentiality, but the HIV reporting system has the same measures that protect the confidentiality of AIDS case reporting. California has statutory protections for public health records, which the state has enhanced for HIV and AIDS, and state and local health departments must adhere to federal security and confidentiality standards. California has had no documented or reported cases of illegal or inappropriate disclosure of case information from the state's AIDS Case Registry.

Advocates are also concerned that a name-based system will deter people from HIV testing. However, no states with name-based HIV reporting systems have seen sustained patterns of lower HIV testing after implementation. Advocates raised this concern about implementing a code-based system in California, but there has been no decline in HIV testing in the state since reporting began in July 2002.²¹ Finally, Californians still have access to anonymous testing sites in which healthcare providers do not know the name of the client and are also exempt from HIV reporting.²²

Implementing name-based HIV reporting and improving AIDS reporting

No additional resources are needed to make the HIV reporting system consistent with the AIDS reporting system. The name-based AIDS reporting system is already in place, and the HIV cases are reported in the same database. California can change the HIV reporting system and all providers, laboratories and the state and local health departments can fully convert to the name-based system within six months. State and local health staff would update the current code-based files as new data are received, which state staff estimated they could complete within 12 months.²³

California has not maximized opportunities to improve its reporting of AIDS (non-HIV) cases. Physicians currently monitor CD4+ cell counts, an element of the body's immune response system, to determine the impact of HIV on a person's immune system.²⁴ Lab reporting of low CD4+ counts is an excellent source of data for potential unreported AIDS cases, and California is one of only 13 states that do not require it.²⁵ Low CD4+ reporting will identify unreported AIDS cases and will help California qualify for additional federal funds.

Recommendations

- A. The Governor should work with the Legislature to expressly permit name-based HIV reporting.**
- B. Following passage of legislation to implement name-based HIV reporting, the Department of Health and Human Services should amend the California Code of Regulations for disease reporting to repeal the current HIV reporting regulations, which require a non-name code and add HIV to the regulation that allows confidential reporting of all other diseases, including AIDS, by name.**
- C. The Department of Health Services, or its successor, should amend the California Code of Regulations for disease reporting to add laboratory reporting of low CD4+ counts to local health departments no later than July 1, 2005.**

Fiscal Impact

Using the FFY 2004 formula appropriations as the funding base, the state risks a loss of up to \$50 million annually in Ryan White CARE Act funds if the CDC does not confirm California's (and other code-based states) reported HIV cases for FFY 2007.²⁶ Using the CDC's data estimates for June 2000, California's estimated living HIV cases represent a range of 39 to 49 percent of the state's combined HIV and AIDS cases. This represents a substantial contribution to a revised CARE Act funding formula.²⁷ California can prevent this loss if it conforms its HIV reporting system to its name-based AIDS reporting system.²⁸

California will avoid an approximate cost of \$235,000 to \$500,000 needed to evaluate its code-based HIV reporting system.²⁹ Without a demonstration that California's HIV reporting system



meets its criteria, CDC will not consider accepting data from any states with code-based systems.

California will improve the business climate for providers and laboratories that have experienced additional workload caused by a code-based system. State and local health department staff will realize workload efficiencies and can devote more time to ensuring accuracy of information and improving timeliness of HIV and AIDS reporting. The savings cannot be estimated at this time.

The state can implement these recommendations within existing resources.

Endnotes

- ¹ Centers for Disease Control and Prevention, "Overview of Public Health Surveillance," by Denise Koo, MD, MPH <http://www.pitt.edu/~super1/lecture/lec3011/005.htm> (last visited May 7, 2004) (slide presentation).
- ² California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 1, Article 1.
- ³ The Institute of Medicine of the National Academies, "Measuring What Matters: Allocation, Planning and Quality Assessment for the Ryan White CARE Act" (Washington, D.C. 2003), pp. 76–80. All states implemented AIDS reporting in the early 1980s. States implemented HIV reporting over an 18-year period with the first states beginning in 1985 and the last state beginning in 2003.
- ⁴ National Alliance of State and Territorial AIDS Directors, "HIV Prevention Fact Sheet, The AIDS Continuum," Washington, D.C., May 2002 (fact sheet); and National Alliance of State and Territorial AIDS Directors, "HIV Prevention Fact Sheet, HIV Surveillance," Washington, D.C., May 2002 (fact sheet). The time from HIV infection to AIDS can average 10 years and ranges from 5 to 20 years.
- ⁵ Department of Health Services, Office of AIDS, "California HIV Case Surveillance Report" (April 30, 2004), <http://dhs.ca.gov/ps/ooa/Statistics/pdf/Stats2004/apr04HIVmerged.pdf> (last visited June 7, 2004); and Department of Health Services, "AIDS Surveillance Report for California" (April 30, 2004), <http://dhs.ca.gov/ps/ooa/Statistics/pdf/Stats2004/apr04AIDSmerged.pdf> (last visited June 7, 2004).
- ⁶ E-mail from Juan Ruiz, acting chief, HIV/AIDS Epidemiology Branch, California Department of Health Services, Office of AIDS (April 15, 2004).
- ⁷ California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 1, Article 3.5, Section 2653.15.
- ⁸ Centers for Disease Control and Prevention, "CDC Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome, Morbidity and Mortality Weekly Report" (December 10, 1999), <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr4813a1.htm> (last visited June 15, 2004), pp. 10–11. Before sending the data to the CDC, state staff removes all personal identifiers. To help the CDC compare AIDS case data to what already exists in its databases, states and territories generate a 4-digit code from the patient's last name using the Soundex system. The CDC uses Soundex and date of birth to match and unduplicate cases to assure an accurate, unduplicated count for each state and territory. The CDC works with states to resolve potential duplicate cases since it does not have identifying information.

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- ⁹ Health & S. C. Section 120975. California statute permits disclosure under specified conditions but not for public health disease reporting.
- ¹⁰ State of California, Legislative Counsel, "Official California Legislative Information" (AB 1663 veto message) http://www.leginfo.ca.gov/pub/97-98/bill/asm/ab_1651-1700/ab_1663_vt_19980929.html (last visited June 15, 2004); and State of California, Legislative Counsel, "Official California Legislative Information," (AB 103 veto message) http://www.leginfo.ca.gov/pub/99-00/bill/asm/ab_0101-0150/ab_103_vt_19991010.html (last visited June 15, 2004). Governor Pete Wilson vetoed AB 1663 in 1998 stating that a code-based system was inadequate. Governor Gray Davis vetoed AB 103 in 1999 and recommended the department seek federal assistance to fully fund the costs of a code-based system. California did not receive federal funding for the code-based system and subsequently appropriated \$2.8 million from the General Fund to implement it.
- ¹¹ The Institute of Medicine of the National Academies, "Measuring What Matters: Allocation, Planning and Quality Assessment for the Ryan White CARE Act," pp. 76–80. Name-to-code systems collect and use the clients' names to match and unduplicate case reports, then convert to a code and destroy the names within a specified period of time. Besides California, the code-based states are Hawaii, Illinois, Maryland, Massachusetts, Rhode Island, and Vermont. Delaware, Maine, Montana, Oregon and Washington use name-to-code systems. Connecticut and New Hampshire allow use of name or code.
- ¹² Commonwealth of Kentucky, General Assembly, 2004 Regular Session, House Bill 82 (04 RS HB 82/EN), <http://www.lrc.ky.gov/record/04rs/hb82.htm> (last visited June 15, 2004). Kentucky will change its code-based HIV reporting system to a name-based system effective January 1, 2005; and the Institute of Medicine of the National Academies, "Measuring What Matters: Allocation, Planning and Quality Assessment for the Ryan White CARE Act," p. 80. Texas and Puerto Rico changed to a name-based HIV reporting system in January 1999 and January 2003 respectively.
- ¹³ Department of Health Services, Office of AIDS, "CARE Act Consolidated Funding--All Titles Sorted by Alpha Order" (Sacramento, California, April 27, 2004). California's nine Title I Eligible Metropolitan Areas received \$102 million in Ryan White funds for FY2004, and the State received \$121 million in Title II funds in FY2004.
- ¹⁴ Health Services and Resources Administration, HIV/AIDS Bureau, "A Compilation of the Ryan White CARE Act of 2000," Sections 2603(a)(3)(C)(i)–2603(a)(3)(D)(ii), <http://hab.hrsa.gov/law/compile.htm> (last visited May 10, 2004).
- ¹⁵ Interview with Dr. Robert Janssen and staff, Centers for Disease Control and Prevention, National Center for HIV, STD and TB Prevention, Division of HIV/AIDS Prevention—Surveillance and Epidemiology, Atlanta, Georgia, April 28, 2004. CDC staff says that it would take six years to develop standard mechanisms to evaluate code-based HIV reporting systems, conduct evaluations, conduct studies for unduplicating interstate data, and implement the findings. The CDC staff states that this process is necessary for confirming HIV cases from code-based systems, and they do not have the resources to do this.
- ¹⁶ Letter from Senator Dianne Feinstein, Senator Ted Kennedy and 13 other members of Congress to the Centers for Disease Control and Prevention, May 4, 2004. The members asked the CDC to accept HIV case data from code-based states.
- ¹⁷ The Centers for Disease Control and Prevention, "HIV/AIDS Surveillance Report 2002," Vol. 14, Table 14. <http://www.cdc.gov/hiv/stats/hasr1402/2002SurveillanceReport.pdf> (last visited May 11, 2004). The top five states (in descending order), New York, California, Florida, Texas, and New Jersey represented 57 percent of the nation's AIDS cases reported as of December 2002.
- ¹⁸ E-mail from Vince Torres-Gil, Department of Health Services, Office of AIDS (April 20, 2004); and e-mail from Barbara Bailey, Department of Health Services, Office of AIDS (May 12, 2004); and Centers for Disease Control and Prevention,



“CDC Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome, Morbidity and Mortality Weekly Report” (December 10, 1999), p. 13.

- ¹⁹ *Interview with Glennah Trochet, M.D., Sacramento County Department of Health and Human Services, Sacramento, California (March 23, 2004); interview with Maree Kay Parisi, San Francisco Department of Public Health, San Francisco, California (April 14, 2004); interview with Michael Bursaw, San Diego County Health and Human Services Agency, San Diego, California (April 15, 2004); interview with Alexander F. Taylor, San Bernardino County Department of Public Health, San Bernardino, California (April 15, 2004); and interview with Gordon Bunch and staff, Los Angeles County Department of Health Services, Los Angeles, California (May 3, 2004).*
- ²⁰ *E-mail from Vince Torres-Gil, Department of Health Services (April 20, 2004). California appropriated \$2,828 million in FY 2000–2001 for development, training, implementation and evaluation of HIV reporting, of which the Office of AIDS received \$1.369 million for positions and contracts and allocated \$1.431 million to local health departments for surveillance personnel.*
- ²¹ *E-mail from Deanna Sykes, Department of Health Services, Office of AIDS (April 12, 2004).*
- ²² *California Code of Regulations, Title 17, Division 1, Chapter 4, Subchapter 1, Article 3.5, Section 2643.10(g) and Section 2643.20. Once a client enters the health care system, all HIV testing is confidential (versus anonymous), and providers must report positive results.*
- ²³ *Interview with Jim Creeger, chief, HIV/AIDS Case Registry, Department of Health Services, Office of AIDS, April 26, 2004. The change would relieve laboratories from creating a partial code and relieve providers from completing the code and maintaining a cross reference of codes to case files.*
- ²⁴ *A CD4+ count of less than 200 per microliter (uL) or less than 14 percent of total T-lymphocytes in combination with a positive HIV test constitutes an AIDS case.*
- ²⁵ *The Institute of Medicine of the National Academies, “Measuring What Matters: Allocation, Planning and Quality Assessment for the Ryan White CARE Act,” pp. 117–118. As of April 2003, California, Alabama, Arizona, Florida, Georgia, Michigan, Minnesota, Montana, North Carolina, North Dakota, South Dakota, Vermont and Virginia do not have CD4+ reporting.*
- ²⁶ *Three factors will determine the amount of federal Title I and II formula funds received by California’s Ryan White CARE Act grantees: federal appropriations for Title I and Title II, the formula and California’s HIV and AIDS data. This estimate presumes no change in the funding formula or federal appropriations.*
- ²⁷ *Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, “Procedure Used to Estimate the Number of Adolescents and Adults Living with HIV Infection, but not AIDS, in Areas without Name-based HIV Reporting before 1994,” Atlanta, Georgia, August 2002 (internal report). The CDC states limitations to the modeled estimates, which are not substitutes for HIV case surveillance data.*
- ²⁸ *Congress could mitigate the funding loss for California and other coded states if it includes “hold harmless” provisions in the next reauthorization of the Ryan White CARE Act or increases the appropriations to the extent that they counteract losses due to the formula change. In past reauthorizations of the reauthorized CARE Act, Congress included “hold harmless” provisions to minimize losses resulting from formula changes at about 1 percent per year.*
- ²⁹ *E-mail from Barbara Bailey, Department of Health Services, Office of AIDS (May 12, 2004).*



Consolidate the State's Mental Health and Alcohol and Drug Programs to Better Serve Californians

Summary

California administers its alcohol, drug and mental health programs in two separate agencies. Consolidating the management of these behavioral health programs will improve coordination of county administered services to persons suffering from both mental illness and substance use disorders.

Background

California's alcohol and drug programs are administered by the Department of Alcohol and Drug Programs (ADP) with most services operated by or through counties. California's mental health programs are administered by the Department of Mental Health (DMH).

For Fiscal Year 2004–2005, ADP is budgeted for 356 positions to administer approximately \$591 million in total funds. DMH is budgeted for 9,183 positions to administer approximately \$2.5 billion to fund the state hospitals and community services. Within DMH are 318 headquarters positions not directly related to state hospital operations to administer approximately \$1.8 billion in total community services funds.¹ Virtually all community mental health services are delivered by or through counties in concert with more than \$650 million in mental health funds which go directly to counties rather than through the DMH budget.²

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) reports that more than half the people diagnosed with a mental disorder also have an alcohol or other drug-related disorder, and of those persons diagnosed with serious mental illness, 41 percent have alcohol or other drug disorders.³ Persons suffering from serious and persistent mental illness who are involved with the criminal justice system have been estimated to have co-occurring substance abuse disorders at rates as high as 82 percent.⁴ According to SAMHSA, "The most common cause of psychiatric relapse today is use of alcohol, marijuana, and cocaine. The most common cause of relapse of substance use/abuses today is untreated psychiatric disorder."⁵

Inadequate and ineffective treatment of substance abuse and mental illness not only destroys lives, but also manifests in costs and problems in virtually all government programs including health care, education, housing/homelessness and particularly adult and juvenile justice

systems. Experience with treating persons diagnosed with both mental illness and substance abuse disorders—known as co-occurring disorders—indicates that merging treatments produces better results.⁶

The Substance Abuse and Mental Health Services Administration recently completed the first in a series of policy reviews on co-occurring disorders. According to SAMHSA Chief of Staff Gail Hutchings, there was clear consensus from behavioral health officials representing ten states that integrated treatment is the preferred option for persons with co-occurring disorders.⁷ However, many people in the addiction field fear that merging addiction and mental health responsibilities will reduce the visibility of alcohol and drug treatment and prevention.⁸

Over the last twenty years, public mental health treatment in California has been moving from a “medical model” in which decisions were made exclusively by professional treatment staff—primarily psychiatrists and psychologists—to a “recovery model” in which the consumer participates fully in treatment planning and implementation. The mental health recovery approach is becoming increasingly like that employed by alcohol and drug treatment programs. At the same time, the alcohol and drug abuse treatment field is becoming more professional with greater certification of treatment providers and staff. The increasing similarities in the treatment approaches, however, are not fully understood or appreciated by the two disciplines.

While alcohol and drug programs include an effective focus on prevention, mental health has not developed a useful prevention strategy. Public mental health treatment programs have greatly increased involvement of consumers and family members in all aspects of program administration. Mental health treatment is generally regarded as employing a systems approach while alcohol and drug services have evolved more as a collection of services. Each system could benefit from association with the other. Robert Nikkel, Administrator of Oregon’s Office of Mental Health and Addiction Services, reports that placing both functions together in Oregon was disruptive at first, but has produced considerable benefit for both service systems over time.⁹

Twenty-five other states have merged their mental health and substance abuse program functions. The National Association of State Mental Health Program Directors (NASMHPD) reports that while the reorganization trend of the 1980s and early 1990s split mental health and substance abuse services, the trend now appears to be moving toward consolidating both functions into the same agency.¹⁰

Thirty-eight California counties have merged local departments dealing with mental health and substance abuse.¹¹ While most counties that have merged alcohol and other drug (AOD) and mental health (MH) responsibilities report improved services to persons dually diagnosed with mental illness and substance abuse disorders, counties struggle to employ expensive



“work arounds” in which a great deal of administrative work is done to ensure proper bookkeeping to integrate mental health and substance abuse services. Two counties—San Bernardino and Stanislaus—report keeping two sets of books to overcome some of the obstacles created by separate state operations.¹² San Francisco County reports its biggest administrative challenge may well be relating to two separate and unconnected departments at the state level.¹³

Monterey County is reportedly better able to serve Temporary Assistance for Needy Families (TANF) referrals since they merged their systems in 1996.¹⁴ Stanislaus County has integrated its service teams to include AOD and MH specialists without “homogenizing,” but instead, emphasizing the unique clinical strategies and values of each field. Clients enter the same door, and when receiving both AOD and MH services, are tracked in one chart.¹⁵ Alameda County reports significant benefit from having previously separated program management staff sitting at the same table helping each other solve problems while gaining better understanding and appreciation of each other’s professional culture.¹⁶ San Francisco reports developing a number of highly effective combined programs, such as multiple diagnosis medically supported detox, dual diagnosis residential programs, dual diagnosis outpatient care, and providing substance abuse medication protocols to mental health physicians.¹⁷ No county responding to the question of potential for loss of emphasis on AOD services reported any such loss.

Recommendation

The Health and Human Services Agency, or its successor, should consolidate the administration of the state’s substance abuse and mental health programs.

Fiscal Impact

Savings of approximately \$1.8 million annually should accrue from elimination of duplicate functions and staff. At a minimum, the following positions should be eliminated: one director, one chief deputy director, one chief counsel, one public information officer, one deputy director/chief of legislation, one deputy director for administration, one deputy director/chief of information technology.

In addition, 10 percent of the Department of Alcohol and Drug Program administrative services and 5 percent of the Department of Mental Health administrative services could be eliminated. The reason for reducing DMH administrative services by only 5 percent presumes that the Department of Behavioral Health would continue to operate the state hospital system.

TOTAL FUNDS
(dollars in thousands)

Fiscal Year	General Fund Savings	Federal Fund Savings	Other Fund Savings	Total Net Savings	Change in PYs
2004–05	\$0	\$0	\$0	\$0	0
2005–06	\$180	\$1,653	\$20	\$1,853	(10)
2006–07	\$180	\$1,653	\$20	\$1,853	(10)
2007–08	\$180	\$1,653	\$20	\$1,853	(10)
2008–09	\$180	\$1,653	\$20	\$1,853	(10)

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–2004 expenditures, revenues and PYs.

Endnotes

- ¹ California Department of Finance, "Governor's Budget 2004–2005," (Sacramento, California, January 2004). pp. HHS 21 and HHS 102.
- ² Interview with Stan Johnson, chief, County Financial Program Support, California Department of Mental Health, Sacramento, California (May 25, 2004).
- ³ Substance Abuse and Mental Health Services Administration, "Report to Congress on Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders" (Rockville, Maryland, 2002), p. 1.
- ⁴ California Board of Corrections, "Mentally Ill Offender Crime Reduction Grant Program Annual Legislative Report" (Sacramento, California, 2002), p. 2.
- ⁵ Substance Abuse and Mental Health Services Administration, "Improving Services for Individuals at Risk of, or with, Co-Occurring Substance-Related and Mental Health Disorders" (Rockville, Maryland, January, 1997), p. 1.
- ⁶ Substance Abuse and Mental Health Services Administration, "Report to Congress on Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorder" (Rockville, Maryland, 2002), p. 15.
- ⁷ E-mail from Gail P. Hutchings, M.P.A., chief of staff, Substance Abuse and Mental Health Services Administration, to California Performance Review (May 17, 2004).
- ⁸ Interview with Toni Moore, administrator, Sacramento County Alcohol and Drug Program Administration, and Patrick Ogawa, director, Los Angeles County Alcohol and Drug Program Administration, Sacramento, California (March 16, 2004).
- ⁹ E-mail from Robert Nikkel, administrator, Oregon Office of Mental Health and Addiction Services, to California Performance Review (May 10, 2004).
- ¹⁰ National Association of State Mental Health Program Directors Research Institute, Inc., "State Mental Health Agency Organization and Structure: 2003," No. 03-10 (Alexandria, Virginia, January 2004), pp. 1–2.
- ¹¹ Interview with Jim Featherstone, director, Napa County Mental Health, and Marvoin Southard, DSW, director, Los Angeles County Department of Mental Health, board members, California Mental Health Directors Association, Sacramento, California (March 10, 2004).



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- ¹² Interview with Larry Poaster, PhD, director, Stanislaus County Department of Behavioral Health, retired, Modesto, California (March 30, 2004); and interview with Rudy Lopez, director, San Bernardino County Behavioral Health, San Bernardino, California (April 9, 2004).
 - ¹³ E-mail from James Stillwell, program manager, San Francisco Behavioral Health, to California Performance Review (April 12, 2004).
 - ¹⁴ E-mail from Robert Egnew, director, Monterey County Department of Behavioral Health, retired, to California Performance Review (April 1, 2004).
 - ¹⁵ E-mail from Dan Souza, director, Stanislaus County Department of Behavioral Health, to California Performance Review (April 1, 2004).
 - ¹⁶ Interview with Marye Thomas, MD, director, Alameda County Behavioral Health, Oakland, California (April 8, 2004).
 - ¹⁷ E-mail from James Stillwell.



Protect California's Children by Implementing a Statewide Online Immunization Registry

Summary

California has an opportunity to prevent disease in children while saving money for taxpayers and the private sector. California should provide web-based accessibility to a centralized statewide immunization registry for children to prevent disease and save taxpayer and private sector money.

Background

California law requires children to be immunized before they begin school.¹ Most childhood immunizations are supposed to begin well before children reach school age. More than half a million children are born in the state each year, each one needing about 20 shots to fully immunize them. Many, however, come from under- or non-insured families and may not even see a doctor before their second birthday. As a result, more than one in five is behind in their immunizations.²

According to Stateline.com, in 1999–2001 there were approximately 1,051,000 uninsured children in California.³ If the children are seen, the records are often times incomplete or out of date. Even when children do receive their immunizations when they're supposed to, it's often difficult for health care providers to know for sure that they have. California has a highly mobile population and as children move from one location to another, their immunization records may not follow them.

California is also a tourist destination for millions of people who visit each year from around the world. It's also a stop-over for people traveling to, or coming from, the Pacific Rim. This brings with it the possibility of imported diseases.

In March 2004, 11 American families traveled to China to adopt 12 orphans. Six of the children had confirmed cases of measles, and three others had suspected cases. The children flew from Hong Kong to San Francisco and then to their respective homes in Washington, Arkansas, Florida, Maryland and New York. During that time, some of the sick children came into contact with an unimmunized student in Washington who was catching a flight to California. That student became ill, as well. Public health authorities are still trying to determine whether any other nonimmunized people were exposed and, if so, how many.⁴

A bigger outbreak occurred between 1988 and 1991, when California experienced 18,000 reported cases of measles, 3,000 hospital admissions and 75 deaths. About half the patients were under five years of age. The outbreak cost California about \$30 million during those three years.⁵

The federal government's Healthy People 2010 has established a goal of having the immunization records of 95 percent of children under the age of six in an immunization registry by 2010. The Centers for Disease Control and Prevention (CDC) estimates about 44 percent children in this age group have their immunization records in registries. California is lagging behind, with only 20 percent of children's records in this age group included in regional immunization registries.⁶

Existing law allows health care providers and other entities, including schools, child care facilities, and welfare agencies, to share a patient's immunization information and certain identifying information with county immunization authorities and the California Department of Health Services (DHS), unless the patient or patient's legal representative has refused to permit such sharing.⁷ Pending legislation, SB 1764, adds in all foster care agencies. The measure also addresses internet accessibility and notification. As of this writing, the measure has the support of the California Nurses Association and the California Medical Association. There is no known opposition.

Currently there are registries in each of nine regions covering 53 of 58 counties. Each has its own software package to accomplish the same task:

1. Contra Costa County (in-house development)
2. Kern County (QS)
3. Los Angeles (in-house development: ITS LA)
4. Marin County (in-house development: Cedar)
5. San Bernardino County (in-house development)
6. San Diego (in-house development)
7. San Francisco (CMMS)
8. San Joaquin County (in-house development)
9. Santa Clara County (ADIOS)

The nine regional immunization registries are coordinated by DHS. Each regional registry works with local public health officials and the medical community towards the goal of immunizing as many children as possible.⁸

One study indicates the State of California could realize an economy of scale with a statewide immunization registry application, resulting in savings in \$32,480,000 (nearly \$32.5 million) annually from decrease in workload for schools and the Women, Infants and Children aid program (\$6,900,000), reduction in paperwork for health care providers and DHS (\$4,600,000), and reduced disease and over-immunization (\$3,700,000).⁹



The way it works now, when children are immunized, their records are forwarded by medical providers to county officials, who then key the information into their particular system and forward records to DHS. With a statewide immunization registry software application, immunization information would be keyed into a statewide system by the health care provider and would then be instantly available across the state, with no county staff involved.¹⁰

Kaiser Permanente currently maintains immunization records for all their members, including more than 210,000 of its members who are under six years of age.¹¹ Kaiser has indicated a willingness to share their data with California, assuming some way is found to allow Kaiser members to either participate or opt out.¹²

Recommendation

The California Department of Health Services, or its successor, should develop a statewide web-based online immunization registry system by July 1, 2005.

- For the health and well-being of California's children and all other citizens, the Secretary of Health and Human Services, or its successor, should work with the Department of Finance, or its successor, to ensure funding for development and implementation of the registry;
- The California Department of Health Services, or its successor, should develop partnerships with interested support groups and the state for the California State Immunization Information System to develop and implement the registry; and
- The registry should address the federal Health Insurance Privacy and Portability Act, security, and data sharing with federal and local agencies, and health providers as appropriate.

Fiscal Impact

Implementing a statewide online immunization registry should lead to improved health immunization information and provide substantial savings to the state and local governments. The cost of developing the registry and savings to public health programs cannot be estimated at this time.

Endnotes

- ¹ *Health & Safety Code, Section 120375(c).*
- ² SB 1764 Language http://info.sen.ca.gov/pub/bill/sen/sb_1751-1800/sb_1764_cfa_20040428_124135_sen_comm.html (last visited April 28, 2004).
- ³ *Stateline.org, Low-Income Uninsured Children by State, 1999–2001, in thousands (three year average)* <http://www.stateline.org/stateline/?pa=fact&sa=showAllFactsForHeader&headerId=327391> (last visited June 11, 2004).
- ⁴ Dr. Robert Schechter, chief, Technical Assistance Section, California Department of Health Services, “California’s Immunization Registries: Milestones reached, miles to go” (Sacramento, California), April 20, 2004 (presentation).
- ⁵ Dr. Robert Schechter, chief, Technical Assistance Section, California Department of Health Services, “California’s Immunization Registries: Milestones reached, miles to go.”
- ⁶ California Coalition for Childhood Immunization, “California Immunization Registries: Projected Costs and Savings,” March 8, 2004 <http://www.ca-siis.org/docs/BenefitsCostsofIZ%20Registries%20REV3-8-04.pdf> (June 11, 2004).
- ⁷ *Health & S. C., Section 120335(b).*
- ⁸ Susan Salkowitz, Noam H. Arzt, Ruth Gubernick, Aileen Fisher-Isaksen, HLN Consulting LLC and Salkowitz Associates LLC, “California SSIS Registry Software Evaluation Summary,” September 25, 2003, pp. 1–2, <http://www.ca-siis.org/summary.html> (last visited June 14, 2004).
- ⁹ California Coalition for Childhood Immunization, “California Immunization Registries: Projected Costs and Savings,” March 8, 2004.
- ¹⁰ Interview with Vernetta Marsh, immunization coordinator, Yolo County Public Health Department (April 20, 2004).
- ¹¹ E-mail from Joahn Schwalbe, data consultant, Kaiser Permanente (June 10, 2004).
- ¹² E-mail from Dr. Steve Black, co-director, Vaccine Study Center, Kaiser Permanente (June 10, 2004).



City-Level Mental Health Programs Are Outdated, Inconsistent With Laws

Summary

State law makes counties responsible for delivery of mental health services to all persons residing within the county. Two city programs continue to receive direct state mental health funding. Services rendered by the city programs are technically outside the purview and oversight of the counties in which they are located. Eliminate the two remaining city-level mental health programs because they perpetuate an approach to mental health service delivery that is outdated and inconsistent with state law.

Background

The Community Mental Health Services Act, enacted in 1957, provided California counties and cities the option to establish mental health programs to serve local residents. That law required counties and cities that opted to set up such programs to pay 50 percent of the cost, with the state providing the remaining 50 percent. Three city programs elected to set up mental health programs under the new law. In 1969, with the passage of the Short-Doyle Act, county mental health programs became mandatory for counties with a population of 100,000 or more and the state match increased to 75 percent. In 1973, such programs became mandatory in all counties. However, two city programs—the City of Berkeley and the Tri-City Mental Health Center—remained in operation and continued to receive direct funding from the State Department of Mental Health (DMH). When the state enacted realignment legislation in 1991, the Welfare and Institutions Code provided that, if these programs elected to do so, they could continue to receive direct payments.^{1,2}

City program operations

The city of Berkeley and Tri-City Mental Health Center receive General Fund allocations to provide community mental health services to local residents. They receive funds from two sources. The first is the realignment allocation, which the State Controller distributes on a monthly basis, based on a percentage formula specified in law. The second is an AB 2034 allocation that DMH pays directly, for provision of integrated services to homeless adults with mental illness. The city programs offer only community-based mental health services, providing neither acute hospital services nor state hospital services, which are a county responsibility. The city programs do not receive federal Substance Abuse and Mental Health Services Administration (SAMHSA) funds from the state; these funds are allocated only to county mental health programs. Finally, while the city programs receive some funding for Medi-Cal mental health services under the auspices of the county-operated Local Mental

Health Plan, they do so in very different ways. The County of Alameda has chosen to treat the City of Berkeley as a county Medi-Cal provider in an arrangement under which the city makes the Medi-Cal match but the county bills DMH, with federal funds passing through the county to the city. The County of Los Angeles has chosen to permit Tri-City to bill DMH and receive federal funds directly, with no county involvement.

City of Berkeley

The two city programs have evolved in very different ways. The City of Berkeley originally established its mental health program, which also serves the City of Albany, based upon a conviction that its residents had unique needs that would not be met by Alameda County. Over time, this program has been working more closely with Alameda County. Although the city continues to receive direct allocations as described above, the Berkeley program actually functions as a contracted mental health provider. Alameda County submits claims for payment on the city's behalf and includes city cost information on the county cost report. The county also submits consolidated client data to DMH that includes both county and City of Berkeley data.

Tri-City Mental Health Center

The Tri-City Mental Health Center developed in a very different manner. It was established in the early 1960s by three Los Angeles County cities—Pomona, Claremont and La Verne—as a Municipal Joint Powers Authority. When they established Tri-City, the three cities were isolated geographically from the rest of Los Angeles, and the cities were concerned that the county would not provide an adequate level of mental health service to their residents. Today the Tri-City area is integral to, and contiguous with, the rest of greater Los Angeles. Nonetheless, the Tri-City Mental Health Center has continued to operate separately from the County of Los Angeles, submitting its own claims, cost reports and client data to DMH.

Recently, Tri-City Mental Health Center has had financial difficulties, and in February 2004, it filed for bankruptcy protection under Chapter 9. The case is now in federal court and Tri-City is developing a plan for continued operation. However, Tri-City owes DMH \$12 million in federal funds due to over-claiming for Medi-Cal services, and DMH is listed as its largest creditor. Tri-City continues to receive its full share of realignment funds but has reduced the level of services it provides, prompting the County of Los Angeles to express concern that it will become responsible for services formerly rendered by Tri-City without additional funding. In addition, Tri-City has recently cancelled several service contracts with the county.

Comparison

No other state has been identified that faces a comparable situation under which anomalous city programs continue to operate within a county-based mental health system. Further, the politics of each of the two affected counties are unique to those areas.



Recommendations

- A. The Governor should work with the Legislature to eliminate the two remaining city-level mental health programs.**

- B. The state mental health program should reallocate the mental health funds of the two city-level programs to the respective counties. Specifically, all city of Berkeley funds should be reallocated to Alameda County and all Tri-City Mental Health Center funds should be reallocated to Los Angeles County.**

The counties could then choose to contract back with the city programs for ongoing provision of mental health services. Alternatively, the county may choose to contract with another mental health provider, or it may decide to use county staff to provide services directly.

The following advantages would be realized if this recommendation were implemented:

- Brings local practice into full conformance with state statute, which holds counties accountable for provision of all mental health services to their residents;
- Enables clients to access a single level of government, the county, for all mental health services, rather than being required to utilize a city program for some services and the county for others;
- Simplifies state oversight of local mental health programs by reducing the number of local entities receiving funds directly from the state; and
- Resolves questions about Tri-City Mental Health Center's ability to provide an acceptable level of mental health services for the amount of funding the Center receives.

Potential disadvantages of this recommendation are as follows:

- There may be opposition to the recommendation by the cities and/or the counties involved. Past attempts to eliminate these programs have failed due primarily to opposition from legislators representing the Berkeley area; and
- The counties would have to decide how best to provide community-based mental health services in the areas formerly served by the city programs, and implement that decision. This could be problematic in Los Angeles County, where it may take considerable time to develop an infrastructure to serve the Tri-City area, particularly if Tri-City Mental Health Center does not become the service provider for that area.

Fiscal Impact

The purpose of this recommendation is to place full responsibility for provision of all local mental health services with the counties, in conformance with state law and state policy for the overall mental health system. The state would transfer realignment and AB 2034 funds currently allocated to the two city programs to their respective counties. As a result, this recommendation is budget neutral with no additional costs or savings anticipated.

Implementation would have to be phased in over a two-year period to allow for passage of required legislation and resolution of various local personnel and administrative issues associated with moving program responsibility from one local governmental entity to another.

Endnotes

- ¹ *Information included in this section was developed based upon interviews conducted with the following individuals: interview with Stan Umeda, retired state employee, Sacramento, California (May 3, 2004); interview with Carl Elder, chief legal counsel, Department of Mental Health, Sacramento, California (May 3, 2004); interview with Irene Tamura, deputy attorney general, Office of the Attorney General, Sacramento, California (May 3, 2004); interview with Kathy Styc, chief, Statistics and Data Analysis, Department of Mental Health, Sacramento, California (May 3, 2004); interview with Stan Johnson, chief, County Financial Program Support, Department of Mental Health, Sacramento, California (May 4, 2004); interview with Mel Voyles, chief, Program Policy and County Operations, Department of Mental Health, Sacramento, California (May 4, 2004); and interview with Tim Mullins, former director, Orange County Mental Health, Sacramento, California (May 5, 2004).*
- ² *Chapter 89, Statutes of 1991, Welf. & Inst. C. Sections 5615 and 5616.*



Relocate the Vocational Rehabilitation Program to Improve Employment Outcomes of Individuals with Disabilities

Summary

The goal of California's Vocational Rehabilitation Program is to obtain high-quality jobs for individuals with disabilities. The program, however, is not performing well compared to other states. Relocating the Vocational Rehabilitation Program together with other employment and training programs authorized by the federal Workforce Investment Act would increase the quality of employment services provided to individuals with disabilities.

Background

The Department of Rehabilitation (DOR), located in the Health and Human Services Agency, administers the Vocational Rehabilitation Program (VRP), and has a proposed budget of \$330 million for Fiscal Year 2004–2005.¹ The program receives funding from state resources (21.3 percent) and federal reimbursements (78.7 percent).

VRP provides services to more than 100,000 people a year through 16 district offices and about 100 branch offices throughout the state.² DOR is operating under an "Order of Selection" priority basis, which means that due to limited resources, it can serve only individuals who have the most severe disabilities. VRP provides employment services such as training, transportation, assistive technology and job placement to people with disabilities. A vocational rehabilitation counselor works with the disabled individual to prepare an employment plan and help the individual find a job that suits his or her unique strengths and abilities. Successful program outcomes include the number of clients who obtain a job at the end of plan services and the salary or wages received.³

Vocational Rehabilitation Program performance

California's VRP program is continuing to have trouble finding quality jobs for individuals with disabilities. According to a report by the State Auditor, performance outcomes declined between 1990 and 1998. During this period, the number of clients served decreased and the number of clients leaving the program with a job in 1998 was about half of what it was nine years earlier. In addition, the department's average annual cost to serve each consumer more than doubled from \$1,225 to \$2,521. Part of this decline in performance is due to the costs of complying with new federal requirements, but California still has lower success rates and higher costs than five other states operating their programs using comparable methods.⁴

Comparison to other states

California's VRP performance ranks near the bottom when compared to other states on a variety of measures. In 2001, California's VRP ranked 49th out of 56 comparable VRP agencies in percent of competitive employment outcomes. It ranked 50th out of 56 in number of employment outcomes per \$1 million spent. It ranked 42nd out of 56 for number of employment outcomes per counselor and 50th out of 56 agencies for expenditure per employment outcome.⁵ These rankings show that California VRP is not nearly as successful as most other states in getting jobs for people with disabilities and is not as efficient in using its limited resources.

Furthermore, a comparison made in 2002 of VRPs in Texas, New York, Illinois, and Pennsylvania shows similar results. California's program had the largest budget among all these states at \$309 million, but found jobs for only 13,035 people with disabilities. This equals an average cost of \$23,705 per person employed. Texas, with a budget of only \$227 million, found jobs for 25,867 people, for an average cost of \$8,776 per person employed. Illinois and Pennsylvania, both operating under the "Order of Selection" priority basis, are also able to obtain employment for individuals with disabilities at a much lower cost—\$12,296 for Illinois and \$12,778 for Pennsylvania, almost half the cost of California's program.⁶ Economic and demographic characteristics can affect program outcomes as well as operating the VRP under a policy to serve the most significantly disabled individuals first. Nevertheless, these factors cannot fully explain California's low VRP performance relative to the other states.

Lack of integration with other employment programs

As stated in a 2001 report by the federal Department of Labor, barriers to employment for individuals with disabilities include the fragmentation of employment services and the isolation of individuals with disabilities from mainstream employment programs and services.⁷ Eliminating these barriers was a major goal of the reauthorized federal Rehabilitation Act, which required that Workforce Investment Act One-Stop Centers partner with VRP programs and provide services to individuals with disabilities.⁸

Centralizing workforce development programs

In 2002, California realized the importance of an integrated approach to employment training by creating a new entity, the Labor and Workforce Development Agency.⁹ The goal was to increase accountability and accessibility, eliminate duplications, and allow for efficiencies by combining services from more than one department. The Little Hoover Commission praised the move.¹⁰

Under the authority of the Labor and Workforce Development Agency is the Employment Development Department (EDD). EDD is the state entity authorized to administer the federal Workforce Investment Act in California and EDD administers several employment-related training programs, including a program for people with disabilities called the Jobs for All program. This program enhances employment opportunities for Californians with disabilities



by providing coordinated, one-on-one employment-related services and job retention assistance. EDD and DOR jointly developed and closely cooperated in the implementation of this program, which is available in about 40 EDD field offices.¹¹

Relocating VRP into EDD would move the state toward the goal of integrating employment and training programs for individuals with disabilities into an integrated service offering and allowing EDD to take advantage of complementary programs. The VRP programs focus more on job preparation needed by individuals with disabilities, whereas other EDD programs generally specialize in job placement. Combining these would allow EDD to provide the best services in both areas to clients. There would also be opportunities for savings from eliminating unnecessary field offices. The DOR has over 100 field offices with facility leases and related costs of over \$17 million.¹² By locating VRP programs within existing EDD field offices and One-Stop Centers, DOR leased facilities would be reduced over time, resulting in significant savings.

The importance of vocational rehabilitation programs

Studies have generally found that vocational rehabilitation pays for itself many times over in taxes paid and human potential realized.¹³ Florida State University conducted a cost-benefit analysis of employment for individuals with disabilities in Florida and found that for every dollar spent on vocational rehabilitation services, \$16 are returned to society.¹⁴ Benefits to the public sector include increased tax contributions, increased consumer spending and economic stimulation. Consolidating the VRP under the Labor and Workforce Development Agency provides an opportunity to improve the services and employment outcomes for people with disabilities.

Recommendation

The Governor should work with the Legislature to move the Vocational Rehabilitation Program from the Department of Rehabilitation, or its successor, to the Employment Development Department, or its successor.

Fiscal Impact

As part of the change, 25 positions within the Department of Rehabilitation could be eliminated. These are executive management and administrative positions that duplicate functions within the Employment Development Department. A total estimated savings of \$2.8 million, \$600,000 of which would accrue to the General Fund, would be generated.¹⁵ There will also be unknown savings in facility costs as staff are relocated to One-Stop Centers and old leases are abandoned. There may also be savings from reduced use of public assistance if the new organization is successful in finding jobs for more individuals with disabilities.

Administrative costs for the change are not expected to exceed \$200,000 on a one-time basis.

General Fund
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	0
2005–06	\$594	\$100	\$494	(12.5)
2006–07	\$594	\$0	\$594	(12.5)
2007–08	\$594	\$0	\$594	(12.5)
2008–09	\$594	\$0	\$594	(12.5)

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Other Funds
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	0
2005–06	\$2,193	\$100	\$2,093	(12.5)
2006–07	\$2,193	\$0	\$2,193	(12.5)
2007–08	\$2,193	\$0	\$2,193	(12.5)
2008–09	\$2,193	\$0	\$2,193	(12.5)

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Endnotes

- ¹ California Department of Finance, "Governor's Budget 2004–2005" (Sacramento, California, January 2004); and interview with John Doyle, budget officer, Budget Section, California Department of Rehabilitation, Sacramento, California (May 5, 2004).
- ² California Department of Finance, "Governor's Budget 2004–2005;" interview with John Doyle; and California Department of Rehabilitation, "Vocational Rehabilitation Services," <http://www.rehab.cahwnet.gov/eps/vocrehab.htm>. (last visited June 19, 2004).
- ³ United States Department of Education, Office of Special Education and Rehabilitation Services, Rehabilitation Services Administration, "Evaluation Standards and Performance Indicators for the Vocational Rehabilitation Services Program," <http://www.ed.gov/rschstat/eval/rehab/standards.html> (last visited June 19, 2004).
- ⁴ California State Auditor Report, "Although Federal Requirements Have Contributed to Its Rising Costs, by More Effectively Managing the Program, the Department of Rehabilitation Can Better Serve More Californians With Disabilities" (Sacramento, California, February 2000), Report Number 99111, pp. 11–23.
- ⁵ United States Department of Education, Office of Special Education and Rehabilitation Services, Rehabilitation Services Administration, "California Department of Rehabilitation Spreadsheet of Performance Results," compiled by Joe Pepin,



financial specialist, Rehabilitation Services Administration, Washington, D.C. Office. Spreadsheet compiled from 2001 fiscal monitoring reports: Rehabilitation Services Administration-2, Annual Vocational Rehabilitation Program/Cost Report; Rehabilitation Services Administration-113 Quarterly Cumulative Caseload Report; and Rehabilitation Services Administration-911 Report Annual Standards and Indicators.

- ⁶ United States Department of Education, Office of Special Education and Rehabilitation Services, Rehabilitation Services Administration, "RSA-2: Report 33B: Sequential Agency Rates of Persons Rehabilitated," Fiscal Year 2002; United States Department of Education, "Fiscal Year 2001–2005 State Tables for the U.S. Department of Education, Vocational Rehabilitation Grants;" and Council of State Administrators of Vocational Rehabilitation (CSAVR), "Order of Selection Status for State Vocational Rehabilitation Agencies for 2004," received from Carl Suter, executive director, CSAVR, Bethesda, Maryland, revised February 2004.
- ⁷ United States Department of Health and Human Services, "Delivering on the Promise: Preliminary Report of Federal Agencies' Actions to Eliminate Barriers and Promote Community Integration," presented to the President of the United States, December 21, 2001.
- ⁸ Council of State Administrators of Vocational Rehabilitation (CSAVR), "Principles for CSAVR During the 2003 Reauthorization of the Workforce Investment Act," http://www.rehabnetwork.org/position_papers/csavcr_principles_wia03.htm (last visited June 11, 2004).
- ⁹ California Department of Finance, "Governor's Budget Summary 2002–2003, Improving California's Workforce Development System" (Sacramento, California, January 2003), pp. 55–60; and Office of the California Governor, Reorganization Plan Number One, "California Labor and Workforce Development Plan" (Sacramento, California, March 2002).
- ¹⁰ California Little Hoover Commission, "Only a Beginning: The Proposed Labor & Workforce Development Agency" (Sacramento, California, April 29, 2002).
- ¹¹ California Employment Development Department, "Job Seeker Services, Jobs for All," <http://www.edd.cahwnet.gov/jsrep/jshow.htm> (last visited June 19, 2004).
- ¹² Interview with John Doyle (May 20, 2004).
- ¹³ Council of State Administrators of Vocational Rehabilitation (CSAVR), "Fact Sheet," http://www.rehabnetwork.org/textonly/press_room/public_or_fact.htm (last visited on June 19, 2004).
- ¹⁴ The Able Trust, "A Cost-Benefit Analysis of the Employment of People with Disabilities in Florida," by Assessment and Evaluation, The Educational Services Program (Florida State University, December 1999), p. 5.
- ¹⁵ California Department of Finance, "Governor's Budget 2004–2005, Salaries and Wages Supplement" (Sacramento, California, January 2004).
- ¹⁴ The Able Trust, "A Cost-Benefit Analysis of the Employment of People with Disabilities in Florida," by Assessment and Evaluation, The Educational Services Program (Florida State University, December 1999), p. 5.
- ¹⁵ California Department of Finance, "Governor's Budget 2004–2005, Salaries and Wages Supplement" (Sacramento, California, January 2004).



Standardize Criminal Background Reviews in Health and Human Services Agency

Summary

The California Health and Human Services Agency (HHS) and its various departments employ inconsistent standards for conducting criminal background reviews on individuals applying for licenses or employment. Inconsistencies in both departmental policy and state law can fail to prevent a person with a history of dangerous criminal behavior from having contact with children or adults who are receiving care in a health or community service facility.

Background

Five departments in HHS conduct background checks on applicants for licenses, employment and other contact with clients including the California Department of Social Services (DSS), the Department of Health Services (DHS), the Department of Mental Health (DMH), the Department of Alcohol and Drug Programs (ADP) and the Emergency Medical Services Authority (EMSA).¹ The purpose of criminal background reviews is to identify individuals whose contact with clients may pose a risk to the clients' health and safety.² Even though the departments share the goal of protecting children and adults from dangerous individuals, the laws regarding criminal histories and outcomes of criminal history reviews are very different. As a result, there are different levels of protection afforded children and adults depending on the type of facility rather than the type of client.

Each of the departments within HHS is among several public agencies authorized to conduct background checks by obtaining a person's criminal history information from the Department of Justice (DOJ).³ The laws authorizing these checks range from requiring every person who has contact with a child or adult in a community care facility to be fingerprinted, to allowing employees of a nursing facility or an emergency medical technician to provide care to children or adults without any criminal background screening.

After a specified person is fingerprinted, DOJ informs the appropriate department that the person either has no criminal record, or provides the criminal record for the department's review and the ultimate decision of whether to approve or disapprove an application for a license, for employment or other contact that requires a clearance. If a person is approved, DOJ notifies some departments if the person is later arrested for a crime. Since the mere existence of an arrest record cannot be used to suspend a license or terminate their employment without a

full investigation, some departments choose to investigate arrests for serious offenses, and take action to prevent the person from having contact with a client.⁴

	Social Services	Health Services	Mental Health	Alcohol and Drug Programs	Emergency Medical Services Authority
Who must undergo background check?	All care-, providers, and residents any other person who has contact with child or adult in any facility.	All direct care-providers only in Intermediate Care Facilities but not clinics, nursing homes or other health facilities.	All care-providers in psychiatric health facilities and mental health rehabilitation centers.	Care-providers for juveniles, but not for adults, in residential treatment facilities.	Applicants for a paramedic license. But law does <i>not</i> require EMT I or II to undergo background check.
May employee work before check is completed?	No.	Yes.	No.	No.	No.
What types of crimes require denial and what types allow department to apply its own discretion?	Any one of about 50 crimes including a violent felony or crime that requires registration as a sex offender prevents licensure or employment. Other crimes are evaluated on a case-by-case basis as law requires "good character."	Any one of about 50 crimes (some the same and some different from DSS) prevents licensure, nurse or home health aide certification. Other crimes are evaluated on a case-by-case basis as law requires "good character."	A violent felony within the past 10 years bars a person from working only in a psychiatric health facility or mental health facility. Other crimes are evaluated on a case-by-case basis.	A crime against a child, or a conviction for an alcohol or drug-related crime in past 3 years is basis for disapproving care to minors but doesn't bar employment. Other crimes are evaluated on a case-by-case basis.	A specified violent and sexually-related crime; or a felony conviction within past 10 years; or a theft, drug or force-related misdemeanor in past 5 years; or currently on probation or parole; is basis for denied paramedic license although director may make exception if "extraordinary circumstances exist." Other crimes are evaluated on a case-by-case basis.
Does department investigate arrests that occur after a person is approved?	DSS peace officers investigate arrests DSS considers serious; may take action even if not convicted.	Does not investigate arrests.	Does not investigate arrests.	Does not investigate arrests.	EMSA non-peace officers investigate most felony arrests.

Source: California Performance Review



Inconsistent requirements

DSS has the largest criminal background review program within HHSA.⁵ In Fiscal Year 2002–2003, almost 192,000 people were fingerprinted for a DSS facility.⁶ Twenty percent of the persons who are fingerprinted have a criminal record.⁷ About 3 percent of the records that contain a crime include a crime that prohibits a person from having a license or being cleared to work in a state facility.⁸ About 30 percent of the persons with a criminal record include a single, non-violent misdemeanor conviction that's more than five years old, which usually results in approval to operate or work in a facility. The remaining 67 percent of persons with a criminal record have been convicted of more serious crimes that are reviewed by DSS on a case-by-case basis primarily based on the seriousness of the offense, and number of years since the conviction occurred. Over the years, DSS has been criticized for not being strict enough to ensure protections in applying discretion to these crimes.⁹ In addition to reviewing convictions, DSS also investigates arrests of persons operating, living in or working in a facility in any capacity.¹⁰ While the most heinous crimes—such as rape and child molestation—are among the arrests that DSS defines as serious, so are writing a check for insufficient funds and arrests for prostitution.¹¹ Most arrest investigations do not result in an administrative action to close a facility or remove an employee.¹²

DHS has the second-largest number of criminal background checks each year.¹³ The intermediate-care facility, only one of several inpatient care facilities, is the only type of facility in which all direct-care staff and residents (not patients) must undergo a criminal background check.¹⁴ Pursuant to federal regulations, most of DHS' criminal background reviews are for certifying nurse assistants.¹⁵ DOJ received 39,236 fingerprints from DHS applicants in FY 2002–2003.¹⁶

DHS has a category of crimes that require it to deny an application, employment or certification. Most of the crimes that prevent certification are the same as those which bar DSS-licensure or employment although there are some major differences: DHS is not required to bar an applicant for distributing child pornography or carjacking.¹⁷ However, DHS, but not DSS, must bar applicants for aggravated mayhem, false imprisonment, or administering stupefying drugs to assist in commission of a felony, as well as non-violent crimes including theft and possession of forged lottery tickets.¹⁸

DHS background checks need not be completed before a person works with children or adults in a medical facility; therefore, a certified nurse assistant or other employee required to undergo a background check could be convicted of a violent crime or be a sex offender, and could work with patients for weeks before the department became aware of the crimes. If a crime involves an offense that bars a license, employment or certification, DHS decides whether the person should be certified or licensed based upon whether the conduct was job-related and what activities have occurred since the conviction.¹⁹

Unlike DSS, which routinely bars employees, whether or not they provide direct-care, based upon a conviction for battery, DHS only denies employment or certification if the facts underlying the conviction are directly linked to the individual's position at the facility. For instance, if a certified nursing assistant was found guilty of spousal battery, the employee would likely not be denied certification because the abuse did not occur in a facility.²⁰ When DHS is notified of an arrest, it contacts the court to determine if the arrest has resulted in a criminal charge and conviction, in which case DHS may take action. However, DHS does not investigate an arrest for a serious crime as a complaint.²¹ Therefore, a person working in a skilled nursing facility could conceivably be arrested for rape, but without a conviction, DHS does not investigate to determine whether there is evidence that would establish if the person poses a threat to patients.

DMH was required, effective January 1, 2003, to conduct criminal background reviews of direct-care staff in psychiatric health facilities and mental health rehabilitation centers.²² DMH must deny a license or employment to any person who has been convicted of a violent felony within the past ten years. Other crimes may be evaluated on a case-by-case basis.

ADP licenses residential treatment facilities and certifies narcotic treatment and driving under the influence programs. ADP requires only those individuals providing care to a juvenile in a residential treatment facility to undergo a background check.²³ In FY 2002–2003, only two such individuals were checked.²⁴ ADP may not allow a person to work with a juvenile if the person has ever been convicted of any crime against a child or of an alcohol or drug offense within the previous three years.²⁵

EMSA, which licenses Emergency Medical Technician-Paramedics, reviews the criminal background of persons applying to be paramedics.²⁶ In FY 2002–2003, there were 1,357 applicants.²⁷ Entry level, and mid-level emergency medical technicians—EMT I and II—are regulated by local authorities that are not required to conduct criminal background checks even though EMTs, as paramedics, provide care to vulnerable children and adults.²⁸ The law prohibits a person from becoming a paramedic if the applicant was ever convicted of murder, attempted murder, a sexually-related offense requiring registration as a sexual offender, or two or more felonies. EMSA must also deny the license if ten years have not elapsed since a single felony conviction, five years have not passed since a theft, drug or force-related misdemeanor conviction, or if the applicant is on probation or parole.²⁹ EMSA evaluates arrest reports on a case-by-case basis, investigating most felonies or crimes that reflect a pattern of conduct.³⁰

Because of the differences in the laws that identify the types of positions which require a criminal background check, and the types of crimes that prohibit a person from operating a facility or providing care to a child or adult receiving services in HHS, a person could conceivably be denied the opportunity to work as a housekeeper in a day care facility, yet be approved to work directly with adults or children in a nursing home, a mental health institution, or an alcohol and drug residential treatment facility.



HHSa could improve client protection in facilities, create efficiencies and provide applicants and employers with a clear understanding of the types of crimes that will not be tolerated in any facility, by specifying crimes that bar employment or licensure for a specified period of time. The current process of evaluating most crimes on a case-by-case basis is inefficient and poses the risk that a potentially dangerous person could abuse a child or adult.

Modifying statutes in the Health and Safety Code to replace “good character” with a class of crimes for which a period of time must elapse before an individual could apply for a license or employment would result in cost savings to the state by reducing a department’s processing time in half.³¹ Hearings would be limited to the issue of whether the crime fell into a class for which the underlying facts and circumstances are of no relevance.³²

Without investigating serious arrests, particularly those for crimes that would absolutely bar an individual from working in a facility—such as murder or rape—there is a real risk that a dangerous individual could be working in, or operating, a health facility, mental health facility or alcohol and drug facility.

Recommendations

A. The Governor should work with the Legislature to:

- 1. Specifying crimes that uniformly bar licensure for, or specified employment in, any community care or health facility. These crimes should include those specified under laws in the Health and Safety Code that currently apply to DSS and to DHS, so that a person cannot provide care if they have been convicted of a violent felony or a crime that requires registration as a sexual offender; and**
- 2. Change the laws in the Health and Safety Code to require that the criminal background checks conducted by DHS be completed before allowing an employee required to undergo the check to be present in a health facility.**

B. Effective January 1, 2005, DHS, or its successor entity, should adopt regulations that clarify that an arrest for a serious crime may be investigated as a complaint and that administrative action may be taken for unprofessional conduct should the investigation establish evidence that the person has engaged in conduct that poses a threat to patients.³³ The department, or its successor entity, should attempt to administratively establish the positions in FY 2004–2005 or through the 2005–2006 budget process.

C. Effective January 1, 2005, EMSA or its successor entity, should investigate serious misdemeanor arrests, in addition to felony arrests which are currently being investigated, so that it investigates all crimes that would bar licensure if convicted including, but not limited to, misdemeanor child abuse. EMSA may need to seek additional staffing of peace officers in FY 2004–2005, if necessary, to investigate serious arrests.

D. By November 1, 2004, the Secretary of HHSA, or its successor, should convene a workgroup to:

- 1. Identify the types of crimes for which a clearance should not be granted to a care-provider in any health or social services facility within five years of last conviction, and would be evaluated on a case-by-case basis only if the conviction is more than five years old. The types of crimes suggested include crimes of violence that do not bar licensure or employment, drug-related crimes and theft. The recommendations should be proposed in legislation for the 2005 session; and**
- 2. Identify whether the class of persons currently required to undergo a background check should be expanded to other employees in a health facility and to emergency medical technicians.**

Fiscal Impact

Data does not exist to quantify anticipated savings that may result from adding crimes for which a conviction would bar a person from employment for an unspecified period, or crimes that bar employment for a period of five years. It is anticipated that by removing crimes from those which the department may approve on a case-by-case basis to crimes that will bar employment indefinitely or for five years, the amount of staff time necessary to evaluate the request for approval will be cut in half.³⁴ The workgroup should be done with existing staff.

The following fiscal implications assume that implementation will begin January 1, 2005. It is projected that DHS will need 85 PYs to perform the workload associated with investigating serious crimes committed by people working with children or adults in health facilities. These 85 PYs should consist of 40.5 special investigators, 40.5 investigator auditors, 2 supervisors-in-charge, 1 associate program analyst and 1 office technician.³⁵ This will cost about \$4.2 million in FY 2005–2006 and \$7.1 million in 2006–2007 and beyond. The General Fund will fund one-half of the costs and the remaining costs should be funded with federal funds.³⁶

All Funds
(dollars in thousands)

Fiscal Year	Savings	General Fund Costs	Other Funds Costs	Total Net Savings (Costs)	Change in PYs
2004–05	\$0	\$2,100	\$2,100	(\$4,200)	42.5
2005–06	\$0	\$3,528	\$3,528	(\$7,056)	85
2006–07	\$0	\$3,528	\$3,528	(\$7,056)	85
2007–08	\$0	\$3,528	\$3,528	(\$7,056)	85
2008–09	\$0	\$3,528	\$3,528	(\$7,056)	85

The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–2004 expenditures, revenues and PYs.



Endnotes

- ¹ *The Department of Aging oversees adult day health centers but the criminal background checks are conducted by the Department of Health Services.*
- ² *Health & S.C. Section 1522.*
- ³ *Pen. C. Section 11105(b)(10).*
- ⁴ *California Constitution, Article 1, Section 1; Central Valley Ch. 7th Step Foundation, Inc. v. Younger (1989) 214 Cal.App.3d 145; Loder v. Municipal Court (1976) 17 Cal.3d 859; and Health & S.C. Section 1596.871(e). The Department of Social Services may take action against a day care provider based solely on an arrest notwithstanding 1596.871(e) pursuant to regulation.*
- ⁵ *The Department of Social Services licenses and monitors approximately 92,000 community care facilities, including child care, children’s residential—foster, group homes—elderly and adult residential facilities and day support facilities. Governor’s Budget, 2003–2004, p 133. The law requires that any person who has contact with a child or adult client must be fingerprinted. Health & S.C. 1522, 1569.17 and 1596.871. The department also conducts criminal background checks of prospective adoptive parents pursuant to Family Code Sec. 8710 (public adoptions), 8811 (private adoptions) and 8908 (inter-country adoptions).*
- ⁶ *E-mail from Tina Medich, assistant bureau chief, Department of Justice, Criminal Identification and Information Bureau, to California Performance Review, Sacramento, California (May 18, 2004).*
- ⁷ *E-mail from Bill Jordan, Bureau Chief, Department of Social Services Criminal Background Check Bureau, to California Performance Review (May 19, 2004).*
- ⁸ *Health & S.C. Sections 1522(b), 1569.17, and 1596.871; E-mail from Bill Jordan.*
- ⁹ *California State Auditor, “Department of Social Services: Continuing Weaknesses in the Department’s Community Care Licensing Programs May Put the Health and Safety of Vulnerable Clients at Risk,” (Sacramento, California, August 2003); California State Auditor, “Department of Social Services: To Ensure Safe, Licensed Child Care Facilities, It Needs to More Diligently Assess Criminal Histories, Monitor Facilities, and Enforce Disciplinary Decisions,” (Sacramento, California, August 2002).*
- ¹⁰ *Interview, Sophie Cabrera, investigations chief, Department of Social Services, Sacramento, California, (June 9, 2004). The Department of Social Services administratively established limited term positions to investigate conduct that resulted in an arrest of any person who is required to have a criminal background check. As of June 9, 2004, the department is only investigating crimes that would bar licensure if convicted, and crimes classified as “serious crimes against persons.”*
- ¹¹ *Department of Social Services, “Serious Non-Exemptible Crimes, Serious Crimes against Persons and Serious Crimes,” by Sophie Cabrera (Sacramento, California, June 10, 2004).*
- ¹² *Department of Social Services, “Report of administrative actions,” Leann Bratlien (Sacramento, California, June 3, 2004).*
- ¹³ *Interview with Brenda Klutz, deputy director, Department of Health Services, Sacramento, California (April 20, 2004). The Department of Health Services has approximately 6,000 licensed facilities.*
- ¹⁴ *Health & S.C. Section 1265.5. Doctors, registered nurses and dentists who work in a health facility undergo background checks through the respective professional boards within the Department of Consumer Affairs but other care-providers and employees who have contact with patients are not required to undergo a criminal background check.*
- ¹⁵ *Interview with Brenda Klutz; Title 42, CFR, Sec. 483.156; and Health & S.C. Sections 1337.8 and 1338.5.*

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- ¹⁶ E-mail from Tina Medich, assistant bureau chief, Department of Justice, Criminal Identification and Information Bureau (May 17, 2004).
- ¹⁷ The Department of Social Services bars crimes including the following crimes that do not bar operation or employment in a Department of Health Services facility: any kind of robbery under Pen.C. Sections 212.5, 213 and 214; using a child to distribute lewd material; gang-related intimidation of witnesses under Pen. C. Sections 136.1; Department of Health Services, Disqualifying Penal Code Sections. Department of Social Services, "Non-Exemptible Crimes."
- ¹⁸ Pen. C. Sections 205, 210.5, 222, 262, 484, 484b, 484d-j, 487 and 488.
- ¹⁹ Health & S.C. Section 1337.9.
- ²⁰ Interview with Linda Heisler, analyst, Professional Licensing and Certification Unit, Department of Health Services, Sacramento, California (April 6, 2004).
- ²¹ Interview with Linda Heisler; and interview with Patricia Morrison, chief, Professional Licensing and Certification Unit, Department of Health Services, Sacramento, California (April 8, 2004).
- ²² Health & S.C. Section 1250.2, California Code of Regulations Title 22, Div. 5, Section 77001 and Title 9, Div. 1, Section 781.00; Welf. & Inst. C. 5405(b)(1)(B); CCR Title 9, Division 4, Article 4, Section 10624; and interview with Al Nichols and Carol Salazar of Department of Mental Health, Sacramento, California (June 4, 2004). Nichols and Salazar indicated that as of June 4, 2004, the department had not yet implemented the background clearance process.
- ²³ Health & S.C. 11834.01; and CCR Title 9, Division 4, Article 4, Section 10624.
- ²⁴ E-mail from Tina Medich.
- ²⁵ Health & S.C. Sections 11834.01; and CCR Title 9, Division 4, Article 4, Section 10624.
- ²⁶ Health & S.C. Sections 1797.172(d)(3) and 1798.200.
- ²⁷ Interview with Tina Medich, assistant bureau chief, Department of Justice, Criminal Identification and Information Bureau, Sacramento, California (May 20, 2004).
- ²⁸ CCR Title 22, Division 5, Section 100079 (for EMT-Is) and 100123 (for EMT-IIs). Some local authorities conduct background checks of EMT applicants although it is not required.
- ²⁹ Health & S.C. Sections 1797.172 and 1798.200; CCR Title 22, Division 5, Section 100178.1.
- ³⁰ Interview with Richard McSherry, chief of investigations, Emergency Medical Services Authority, Sacramento, California (June 4, 2004).
- ³¹ E-mail from Bill Jordan.
- ³² Interview with Jaime Rene Roman, administrative law judge, Office of Administrative Hearings, Sacramento, California (May 27, 2004).
- ³³ Health & S.C. Sections 1337.8 and 1338.5.
- ³⁴ E-mail from Bill Jordan.
- ³⁵ Interview with Mitchell Miller, chief of investigations, Department of Health Services, Sacramento, California (June 18, 2004); and interview with Sophie Cabera.
- ³⁶ Assumption is implementation date of 1-1-05 for positions. Positions costed with statewide averages. Facility costs were not projected.



Maximize Revenue Collections in the Department of Health Services

Summary

The current Department of Health Services (DHS) fee and fine collection systems are disaggregated, inefficient and fail to collect all fees due to the state. The absence of a standard set of policies, procedures and controls for these disparate systems, results in critical audit findings. DHS should move all fee and fine related revenue receipt transactions to the Accounting Section at DHS to improve efficiency and ensure the use of proper accounting procedures. DHS should also develop and implement a web-based system for licensing and certification requirements and processing related fee and fine payments.

Background

As part of its mission to protect and improve the health of all California residents, the Department of Health Services (DHS) is responsible for a variety of programs that promote a preventive, coordinated, accountable and high-quality health care system. Unfortunately, the business processes utilized to collect fees and fines to support these programs are not designed to take advantage of available economies of scale and new technology.

The current processes are costly, paper-based, uncoordinated, time consuming, and inconvenient to citizens. Furthermore, numerous interviews have shown a failure to comply with established cash procedures as required within Chapter 8 of the State Administrative Manual.¹

Currently, DHS collects 92 separate fees and fines related to licensure, certification and enforcement activities. The DHS records nearly 350,000 separate transactions and collects more than \$150 million annually as part of these activities. Fees and fines are collected for activities as diverse as certification of radiological devices and pet food manufacturers. Consistently, there is a failure to use approved policies and procedures in the processing of revenue transactions for each of these fees and fines, and a failure to use available technologies to reduce costs and improve service. Of the 350,000 annual fee and fine revenue transactions completed at DHS, only 93,000 are processed by the DHS Accounting Section. Of the \$150 million collected via these transactions, only \$37 million is collected directly by the DHS Accounting Section. The remaining transactions are processed either by outsourced program staff, the State Board of Equalization (BOE) or private firms under contract.²

DHS devotes excessive resources to fee collections

The resources devoted to the receipt of licensing and certification materials and the accompanying fees currently include 67.5 staff at a cost of \$4.6 million annually, outsourced contracting at a cost of \$524,000 and costs of \$1.1 million to the BOE. Total costs are about \$6.2 million annually.³

DHS has utilized a decentralized model in response to a loss of staff in the Accounting Section.⁴ In addition, instead of maintaining critical oversight over financial transactions within the department, DHS chose to allow fee-based and Special Funded programs to hire staff to create individual accounting functions within individual programs. This decision has led to criticism from the Bureau of State Audits, which found some improper handling of DHS revenues by the Genetic Disease Branch.⁵ There is additional interview-based evidence that DHS programs have failed to properly record and deposit revenues for periods of up to six months. In addition, as a result of deficiencies in automated tools, DHS has failed to send past due notices to applicants, a failure that has cost the Radiological Health Branch an estimated \$3.7 million in fees.⁶

Through more than 20 direct interviews, numerous problems directly related to the decentralization of DHS revenue collection processes were discovered.⁷ The following chart details the problems:

1. Procedures for the receipt, collection and deposit of fees and fines vary widely and are determined by program staff with limited oversight or direction by DHS Accounting Section.
2. The decentralization of revenue collections has resulted in an increasing aging schedule of overdue fees and fines and for collection of returned financial instruments.
3. DHS public health programs are diverting health program staff from performing program related functions to fee and fine collections.
4. Fee and fine collection systems have high error rates and are technologically outdated.
5. Fee and fine collections are predominately check-based which increases administrative burdens and is unresponsive to private business needs for ease of payment.
6. Fee and fine collections include the payment instrument along with other non-monetary documentation.
7. Programs are not diligent in collecting the fines fully owed to DHS.
8. Certain types of licenses, such as laboratory licenses for provider physician offices, are not supported by fees.
9. Formal Accounts Receivable are not set-up for overdue fees and fines, resulting in increased risk of non-collection and the under reporting of Accounts Receivable in financial reports.
10. Deposits are not made in a timely manner, resulting in lost interest earnings to the state and the likelihood of dishonored checks and processing errors.



A review of other state agencies in California and agencies in other states shows a lack of consistent accounting practices for revenue collections by state governments. In California, in addition to the DHS, the California Environmental Protection Agency uses an informal decentralized collection process, whereas the California Department of Consumer Affairs and other states have made significant progress in centralizing collections and in moving towards web-enabled payment processes.⁸ Arizona, Florida, Georgia, Maryland and Texas have implemented online systems for the renewal of various business licenses.⁹ Although each of these systems are relatively new and the types of applications vary, it is important to note that the implementation of each system resulted in cost savings over time.

Recommendations

A. The Department of Health Services, or its successor, should pursue the following actions to maximize revenues gained through fee and fine collection:

- a. The DHS should pursue a strategic redirection of program staff and/or funding to allow for the centralization of all revenue transactions.
- b. The DHS should convene an e-business task force to initiate planning for implementation of an Internet-based process for licensing and certification responsibilities and the related fee and fine payments.
 - i. The task force should include members of the various entities that have licensing and certification requirements, members of the technical community, both public and private, representatives from other states that have implemented e-government solutions and DHS program and administrative staff.
 - ii. The key deliverable for the task force should be a comprehensive requirements document that will serve as the source document for a competitive bidding process.
 - iii. As part of that process DHS should invite bids from private business, the DHS Information Technology Services Division and other state agencies.

B. To facilitate competitive bidding, the Governor should work with the Legislature to amend Health and Safety Code Sections 105190 and 105250, which require the State Board of Equalization to serve as the collection agent for DHS for the Occupational Lead Poisoning Fee and Childhood Lead Poisoning Prevention Fee, respectively.

The amendments should allow DHS to choose the most appropriate collections agent for these fees.

Fiscal Impact

Consolidation of fee and fine collection efforts, and progression to an Internet-based process for licensing and certification and related fee and fine payments will generate efficiencies that will reduce the number of staff and resources required for this function. These savings cannot be estimated at this time. However, preliminary estimates suggest that a \$3.7 million annual net savings may be achieved if an automated system is implemented.

The implementation of an Internet-based application process for licensing and certification requirements and the related fee and fine payments will require development and maintenance costs. As mentioned previously, each licensing and certification application has unique business process needs, and therefore, comparison to other government entities start-up costs is difficult. Projections indicate that, the 92 DHS applications would require \$2.3 million in start-up costs.¹⁰

Endnotes

- ¹ *Interview with Victor Biancini, chief, Accounting Section, Department of Health Services, Sacramento, California (April 15, 2004); interview with Janey Butner, Department of Health Services, Sacramento, California (April 13, 2004); interview with George Cunningham, M.D., M.P.H., chief, Genetic Disease Branch, Department of Health Services, Sacramento, California (May 11, 2004); interview with Placido Dinsay, Department of Health Services, Sacramento, California (April 16, 2004); interview with Deborah Dubroff, Department of Health Services, Sacramento, California (April 12, 2004); interview with Sharon Ernst, Department of Health Services, Sacramento, California (April 19, 2004); interview with Larry Lance, Department of Health Services, Sacramento, California (April 20, 2004); interview with Clay Larson, Department of Health Services, Sacramento, California (April 20, 2004); interview with Barbara Materna, chief, Occupational Lead Poisoning Prevention Program, Department of Health Services, Sacramento, California (April 15, 2004); interview with Janet McKee, chief, Office of Health Information and Research, Office of Vital Records, Department of Health Services, Sacramento, California (April 21, 2004); interview with Doreen Miller, Department of Health Services, Sacramento, California (April 20, 2004); interview with Donnata Moreland, chief, Financial Operations and Analysis Section, Department of Health Services, Sacramento, California (April 16, 2004); interview with Patricia Morrison, chief, Professional Certification Branch, Licensing and Certification Division, Department of Health Services, Sacramento, California (May 7, 2004); interview with Karen Nickel, chief, Laboratory Field Services, Department of Health Services, Sacramento, California (April 15, 2004); interview with Anne Novak, Department of Health Services, Sacramento, California (April 19, 2004); interview with Jacki Partain, Department of Health Services, Sacramento, California (April 19 and 20, 2004); interview with Ron Piluron, chief, Medical Waste Program, Department of Health Services, Sacramento, California (April 20, 2004); interview with Michael Quinn, chief, Information Technology Services Section, Office of Vital Records, Department of Health Services, Sacramento, California (April 21, 2004); interview with Steven Rawiszzer, Department of Health Services, Sacramento, California (April 26, 2004); interview with MaryRose Repine, acting chief, Policy and Administration Branch, Licensing and Certification Division, Department of Health Services, Sacramento, California (May 6, 2004); interview with Susan Royo, Department of Health Services, Sacramento, California (April 20, 2004); interview with Philip Scott, senior health*



- physicist, Radiological Health Branch, Department of Health Services, Sacramento, California (April 26, 2004); interview with Richard Spinner, Department of Health Services, Sacramento, California (April 15, 2004); interview with Glenn Takeoka, chief, Environmental Health Services Section, Department of Health Services, Sacramento, California (April 28, 2004); interview with Norma Tucker, Department of Health Services, Sacramento, California (April 15, 2004); interview with Melissa Walk, manager, Administration and Financial, Newborn Screening Program, Department of Health Services, Sacramento, California (April 27, 2004); and interview with Kathleen Zelazquez, chief, Newborn Screening Program, Department of Health Services, Sacramento, California (April 27, 2004).
- ² Department of Health Services, "DHS Fee and Fine Collections by Program," Sacramento, California, April 12, 2004 (computer printout).
- ³ Interview with Victor Biancini; interview with Janey Butner; interview with George Cunningham; interview with Placido Dinsay; interview with Deborah Dubroff; interview with Sharon Ernst; interview with Larry Lance; interview with Clay Larson; interview with Barbara Materna; interview with Janet McKee; interview with Doreen Miller; interview with Donnata Moreland; interview with Patricia Morrison; interview with Karen Nickel; interview with Anne Novak; interview with Jacki Partain; interview with Ron Piluron; interview with Michael Quinn; interview with Steven Rawiszzer; interview with MaryRose Repine; interview with Susan Royo; interview with Philip Scott; interview with Richard Spinner; interview with Glenn Takeoka; interview with Norma Tucker; interview with Melissa Walk; and interview with Kathleen Zelazquez.
- ⁴ Interview with Victor Biancini.
- ⁵ California Bureau of State Audits, "The Genetic Disease Branch's Fee Settings, Billing, and Collection Processes Need Improvement, and Its Regulations Do Not Warrant Emergency Status," Report No. 97105 (Sacramento, California, September 1997).
- ⁶ Interview with Tara Good, acting assistant branch chief, Radiological Health Branch, Department of Health Services, Berkeley, California (April 20, 2004).
- ⁷ Interview with Victor Biancini; interview with Janey Butner; interview with George Cunningham; interview with Placido Dinsay; interview with Deborah Dubroff; interview with Sharon Ernst; interview with Larry Lance; interview with Clay Larson; interview with Barbara Materna; interview with Janet McKee; interview with Doreen Miller; interview with Donnata Moreland; interview with Patricia Morrison; interview with Karen Nickel; interview with Anne Novak; interview with Jacki Partain; interview with Ron Piluron; interview with Michael Quinn; interview with Steven Rawiszzer; interview with MaryRose Repine; interview with Susan Royo; interview with Philip Scott; interview with Richard Spinner; interview with Glenn Takeoka; interview with Norma Tucker; interview with Melissa Walk; and interview with Kathleen Zelazquez.
- ⁸ Interview with Donald Owen, assistant secretary, Fiscal and Administrative Programs, California Environmental Protection Agency, Sacramento, California (April 22, 2004); interview with Gary Weitman, chief, Administrative Services, Department of Consumer Affairs, Sacramento, California (April 22, 2004); and interview with Karen Calamia, manager, Cashiering/Payroll, Accounting Section, Department of Consumer Affairs, Sacramento, California (April 22, 2004).
- ⁹ Texas Comptroller of Public Accounts, "Move Certain Occupational and Professional Licensing Processes Online" (December 2000), <http://window.state.tx.us/etexas2001/recommend/ch01/eg04.html> (last visited June 20, 2004).
- ¹⁰ Interview with Gary Miglico, managing director, National eGovernment Solutions, Bearing Point, California (April 15, 2004).



Consolidate Licensing and Certification Functions

Summary

Many different state departments, agencies and boards are in the business of licensing and certifying health care professionals and facilities and programs both within and outside the Health and Human Services Agency. This results in inconsistent requirements, locations and oversight for licensing and certification requirements. Merging licensing and certification functions under a single authority would make services more consistent, cost-effective and responsive.

Background

State agencies perform a variety of licensing and certification functions relating to health and human services. They license facilities and professional staff as providing safe and quality services. They certify to the federal government that health care facilities and professionals are eligible for payments under the Medicare and Medicaid (Medi-Cal) programs. They also certify that certain categories of health and human services staff can provide specific services.

Most, but not all, of these agencies and boards are housed either within the Health and Human Services Agency (HHS) or the Department of Consumer Affairs (DCA). The following HHS departments license or certify facilities, programs or individuals providing services to children or adults:

- Department of Health Services (DHS);
- Department of Social Services (DSS);
- Department of Mental Health (DMH);
- Department of Aging (DOA);
- Department of Alcohol and Drug Programs (DADP); and
- Emergency Medical Services Authority (EMSA).¹

Of these departments, DHS and DSS have the largest licensing and certification programs. DHS regulates the quality of care in public and private health facilities, clinics and agencies throughout the state through licensure and certification of facilities, direct care staff and laboratory personnel.² DSS licenses and regulates facilities and personnel providing social services in a residential setting, child care and adult day social services.³ In addition, some 16 DCA boards and at least one independent board are responsible for licensure or certification of 35 categories of health care professionals.⁴ While some of these boards license or certify multiple categories of health care providers, many are responsible for licensure of only one category of health care professional.

Many state licensing and certification activities require knowledge of both state and federal law. For example, DHS is under contract with the federal Center for Medicare and Medicaid Services to certify skilled nursing facilities and hospitals for participation in the Medicare and Medicaid programs.⁵ On the other hand, DSS licensing requirements are governed only by state law.⁶ In total, the departments, agencies and boards oversee approximately 58 different types of facilities and programs, as well as more than 50 categories of health and human services professionals.⁷ For some departments and boards, the workload is enormous. For example, DSS is currently responsible for licensure of approximately 92,000 community care facilities, while DHS licenses and monitors nearly 1,400 skilled nursing facilities.⁸ The Medical Board of California is responsible for licensure of more than 115,000 physicians, and the Board of Registered Nursing is responsible for licensure of nearly 300,000 registered nurses.⁹ Other departments and boards have somewhat less daunting workloads.

All of these licensing and certification entities perform similar functions. They all review applications, develop regulations, license or certify facilities and/or professional staff, respond to complaints, and mete out appropriate penalties for violations. All are required to conduct criminal background checks on certain categories of licensees and/or their staff. In addition, generally, those entities responsible for licensure or certification of facilities must monitor those facilities on a periodic basis, which includes on-site visits.¹⁰ For example, by statute, DHS must visit home health agencies once each year unless the agency is certified to receive Medicare or Medicaid (Medi-Cal) reimbursement.¹¹ Further, entities that license or certify professional staff are usually responsible for overseeing requirements for continuing education. Finally, some, but not all, of these entities administer a license/certification renewal process. DSS does not require facilities to renew their licenses, although an annual fee must be submitted.¹² However, DHS requires both facilities and professional staff to renew their licenses.¹³

Potential efficiencies

Merging several entities or portions thereof create the possibility for streamlining the entry of qualified professionals and businesses into the health and human services system through combined screening, licensing and tracking processes. A consolidated structure makes it possible to create a more agile, business-responsive system, aid in workforce growth and increase the availability of health and human services options to consumers.¹⁴

Common professional skill sets. Efficiencies can be attained through the use of a knowledgeable cadre of staff from the consolidated agencies that possess the transferable skills sets necessary to run a uniform licensure and certification program at the lowest possible cost.¹⁵ Most licensing staff are either generalists or nurses. Specialized staff are fewer in number and perform specific functions. Potential efficiencies would result from using staff in inspection and enforcement functions in a broader manner, crossing into other facility types as needed. For example, it is currently possible to have two types of facilities operating within the same building that must be separately licensed by DHS and DSS, including separate applications, monitoring visits and fees. If a Skilled Nursing Facility, which is licensed by DHS, is on the



same premises as a Residential Care Facility for the Elderly, which is licensed by DSS, current protocols would involve separate inspections from the two departments, on separate schedules, to conduct the required licensing visits.¹⁶ The proposed consolidation of licensing functions would facilitate training of licensing staff to review more than one level of care, which could result in fewer site visits and greater operational efficiency.

Resolution of policies and practices that result in barriers to care. There are longstanding inconsistencies between state licensing boards and state departments involving policies related to scope and site of practice of health professionals. These inconsistencies have a direct impact on both the quality and cost of care. For example, dental hygienists cannot provide care in nursing homes independent of dentists and very few dentists wish to practice in nursing homes. Many residents cannot travel to dental offices and are not able to maintain good dental hygiene. This can result in tooth extractions, modified diets and nutritional deficiencies, all of which may lead to more costly health care. In a consolidated environment, policies and practices that result in barriers to care can be reconciled.¹⁷

Databases. Centralized databases would help to protect consumers from providers that have been banned from delivering services in any consumer setting.¹⁸ For example, DHS and DSS both maintain statewide tracking systems to identify prior licensees who have run afoul of the law. Shared databases could reduce or eliminate duplication and improve the ability of each licensing entity to identify providers with a prior history of significant problems that may be known to another licensing entity. A centralized database would also benefit the professional staff that provides health and human services to clients. For example, if a Certified Nurse Assistant working part-time in a Residential Care Facility for the Elderly also wishes to work part-time in a Skilled Nursing Facility, that individual currently must undergo a separate background check because the departments do not share a database.¹⁹ A single functional area with a centralized database could reduce the number of duplicate background checks.

Administrative functions. Administrative support functions, such as issuing licenses, collecting fees, and conducting criminal record clearances could be consolidated, streamlined and automated. This could reduce or eliminate backlogs, making it faster and easier for professionals and businesses to obtain and maintain ongoing licensure.

Enforcement functions. A single enforcement unit will be able to partner with the Department of Justice and other law enforcement entities on initial clearances of applications and uniform enforcement of disciplinary actions and sanctions.

Previous recommendation to consolidate

In its May 2004 report entitled *Real Lives, Real Reform: Improving Health and Human Services*, the Little Hoover Commission described the licensing and certification function as “a regulatory tool the State uses to prevent and respond to threats to the health and well-being of Californians.”²⁰ In that report, the commission recommended that facility and personnel

licensing and certification activities be consolidated.²¹ Specifically, the report proposes a Licensing and Certification Service Center that would report to the Health and Human Services Agency Secretary and respond to the needs of the departments within the Agency.²²

Comparison with other states

None of the states contacted regarding the structure of their health and human services licensing and certification functions has fully consolidated those functions. Some states are either in the process or have successfully consolidated some licensing functions. For example, Texas's most recent proposal would place child care licensing under the control of the state's Children and Families Department rather than the Department of Protective and Regulatory Services.²³ Connecticut, Delaware, Florida, Illinois, Kentucky, New Mexico, Rhode Island and Tennessee and the District of Columbia have consolidated licensing of children's programs under a separate state agency.²⁴ However, in Ohio, Pennsylvania, New York, Texas and Florida, such licensure and/or certification, whether for Medicaid- or non-Medicaid-covered services, is currently conducted by the single state authority for substance abuse services, rather than by a consolidated licensing authority.²⁵

Recommendation

The Health and Human Services Agency, or its successor, should sponsor legislation consolidating licensing and certification functions affecting delivery of health care services.

This would include all health and human services licensing and certification functions currently housed in the Health and Human Services Agency, Department of Consumer Affairs and any independent agencies or boards.

Fiscal Impact

Consolidating all licensing and certification activities in one place should create opportunities for significant cost savings as duplicative functions are eliminated. In its most recent report, the Little Hoover Commission estimated that consolidating certain health and human services licensing agencies could result in savings equal to 10 percent of personnel costs.²⁶ Based on this figure, we estimate that total annual savings will be \$16 million, with General Fund savings of \$4.6 million. These would be realized on an ongoing basis after a one-year implementation period.



General Fund
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	0
2005–06	\$4,652	\$0	\$4,652	(91)
2006–07	\$4,652	\$0	\$4,652	(91)
2007–08	\$4,652	\$0	\$4,652	(91)
2008–09	\$4,652	\$0	\$4,652	(91)

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Other Funds
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	0
2005–06	\$11,961	\$0	\$11,961	(162)
2006–07	\$11,961	\$0	\$11,961	(162)
2007–08	\$11,961	\$0	\$11,961	(162)
2008–09	\$11,961	\$0	\$11,961	(162)

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Endnotes

- ¹ Department of Finance, "Governor's Budget Summary 2004-05" (Sacramento, California, January 9, 2004), p. 105.
- ² Department of Finance, "Governor's Budget 2004-05, Salaries and Wages Supplement" (Sacramento, California, March 4, 2004), p. HHS 51.
- ³ Department of Finance, "Governor's Budget Summary 2004-05" (Sacramento, California, January 9, 2004), p. 133.
- ⁴ Department of Health Services, "Types of Facilities Licensed and Certified by the Program;" Health and Welfare Agency, "California Competes" (Sacramento, California, 1996), Attachment B; Department of Finance, "Governor's Budget 2004-05, Salaries and Wages Supplement," pp. SCS 8 and GG 31; survey of website search on the Board of Chiropractic Examiners, conducted in May 2004; and survey of website search on the Department of Consumer Affairs, various boards/committees, conducted in May 2004.

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- ⁵ E-mail from Brenda Klutz, deputy director, Licensing and Certification Program, Department of Health Services, to California Performance Review (June 17, 2004).
- ⁶ Interview with Bill Jordan, chief, Caregiver Background Check Bureau, and Gary Palmer, chief, Administrative Support Bureau, California Department of Social Services, Sacramento, California (June 17, 2004).
- ⁷ Department of Health Services, "Types of Facilities Licensed and Certified by the Program;" Health and Welfare Agency report; Department of Finance, "Governor's Budget 2004–05, Salaries and Wages Supplement;" survey of website search on Board of Chiropractic Examiners; and survey of website search on Department of Consumer Affairs.
- ⁸ Department of Finance, "Governor's Budget Summary 2004–05," p. 133; and California Department of Health Services, "FFY 2003 Workload Allocation and PY Count" (Sacramento, California, September 15, 2003).
- ⁹ Medical Board of California, "2002–2003 Annual Report," http://www.medbd.ca.gov/02_03annualreport.pdf (last visited June 20, 2004); and Board of Registered Nursing, "The BRN Report," Fall 2003, www.rn.ca.gov/policies/pdf/brnfall2003.pdf (last visited June 20, 2004).
- ¹⁰ Interview with Bill Jordan and Gary Palmer; e-mail from Brenda Klutz, deputy director, Licensing and Certification Program, Department of Health Services (June 17, 2004); and e-mail from Alfred Nicholls, chief, Licensing and Certification, Program Compliance, Department of Mental Health, to California Performance Review (June 18, 2004).
- ¹¹ Health & S. C. 1733.
- ¹² Interview with Bill Jordan and Gary Palmer.
- ¹³ E-mail from Brenda Klutz.
- ¹⁴ Issue memo, provided during interview with Brenda Klutz, deputy director, Licensing and Certification Program, Department of Health Services (March 15, 2004).
- ¹⁵ Issue memo provided by Brenda Klutz.
- ¹⁶ Interview with Bill Jordan and Gary Palmer.
- ¹⁷ Issue/Problem memo, provided by Brenda Klutz, deputy director, Licensing and Certification Program, Department of Health Services, sent to California Performance Review, March 15, 2004.
- ¹⁸ Issue/Problem memo provided to California Performance Review.
- ¹⁹ Interview with Bill Jordan, and Gary Palmer.
- ²⁰ Little Hoover Commission, "Real Lives, Real Reforms: Improving Health and Human Services" (Sacramento, California, May 2004), p. 38.
- ²¹ Little Hoover Commission, "Real Lives, Real Reforms: Improving Health and Human Services," p. 44.
- ²² Little Hoover Commission, "Real Lives, Real Reforms: Improving Health and Human Services," p. 42.
- ²³ E-Texas, "GG3: Consolidate Health and Human Services Agencies to Reduce Cost and Improve Service Delivery," January 2003, <http://www.window.state.tx.us/etexas2003/gg03.html> (last visited June 20, 2004).
- ²⁴ American Public Human Services Association, 2001–2002 Public Human Services Directory (Washington, D.C., June 15, 2002).
- ²⁵ Interview with Doug Day, Medicaid administrator, Ohio Department of Drug Addiction Services, Columbus, Ohio (May 17, 2004); interview with Jean Rush, program specialist, Office of Mental Health and Substance Abuse Services, Pennsylvania Department of Public Welfare, Harrisburg, Pennsylvania (May 13, 2004); interview with Marie Spada, addiction program specialist, New York Office of Alcoholism and Substance Abuse Services, Albany, New York (May 11, 2004); interview with Brad Bergeson, manager, Services Coordination Division, Texas Commission on Alcohol and Drug Abuse, Austin, Texas (May 10, 2004); Florida Department of Children and Families, "Substance Abuse," <http://www.dcf.state.fl.us/mentalhealth/sa/> (last visited June 20, 2004).
- ²⁶ Little Hoover Commission, "Real Lives, Real Reforms: Improving Health and Human Services," p. 41.



HHS 22

Issue Fee-Supported Licenses Without Delay

Summary

A variety of professionals and facilities involved in the delivery of health and human services are not able to enter the workforce because of a backlog in processing licenses and certifications required by the state. Hiring additional staff to process applications, supported by a loan from the General Fund, would address the backlog. Creating a special fund for license fee revenues would also help restore accountability to this area.

Background

California licenses and certifies a wide range of facilities and individuals, from clinics to nurse aides, laboratory scientists to medical device manufacturers. Much of this is done by the Department of Health Services (DHS), although many other state boards and departments also have licensing responsibility. Recently there has been a backlog in applications for many licenses, even though users pay fees that are supposed to cover the costs of processing applications on time.

For example, there are 18 regulatory programs that are adequately supported by fees paid by applicants and have a significant backlog. These applicants experience delays of up to 15 months in obtaining necessary approvals. This can be particularly burdensome when organizations or professionals cannot do business without a state license or certification. More than 1,700 facilities and more than 21,000 individuals are waiting for their licenses. Exhibit 1 provides additional details and references.

Exhibit 1
Backlogs in Licensing Functions at the Department of Health Services¹

DHS Division	License Category	Backlog* No. Facilities	Backlog No. Persons	Backlog Time
Licensing & Certification	Individuals: Cert. Nurse Asst., Cert. Home Health Aide		14,797	4–10 months
Licensing & Certification	Facilities: Ambulatory Surgical Clinic, Home Health Agency, Hospice, Skilled Nursing Facility, Clinics, Adult Day Health Care Center	260		9–12 months
Prevention Services	Individuals: Phlebotomist, Clinical Lab Scientist		6,841	2–12 months

Exhibit 1 (continued)
Backlogs in Licensing Functions at the Department of Health Services¹

DHS Division	License Category	Backlog* No. Facilities	Backlog No. Persons	Backlog time
Prevention Services	Facilities: Environmental Lab, Tissue Bank, Medical Device Manufacturer, Drug Manufacturer, Home Medical Device Retailer, Retail Water Facility, Food Processor	1,479		7–15 months

*Note: This table only reflects licensing or certification categories where the department identified a backlog of applications and where the licensing activity is considered by the department to be adequately fee-supported.

The lack of sufficient staff to process applications is causing these backlogs. During the past two years, DHS has cut approximately 150 positions and left an additional 50 positions vacant to accommodate budget cuts.²

The delays in processing license applications and certifications are having a serious impact on service providers and the quality of California’s health care system. For instance, one hospice company leased office space, hired key employees, and entered into contracts with suppliers to show DHS it was qualified for licensing. But DHS was behind schedule, delaying completion of its approval, resulting in additional costs to the hospice company of \$40–50,000.³

Impact on nurse aides

Nurse aides are critical to providing high quality health care, but more than 5,000 individuals are still waiting for certification as Certified Nurse Assistants or Home Health Aides.⁴ Processing these applications now takes four months or longer, during which time most of the individuals cannot work because they are not yet certified.⁵ Nearly 10,000 additional people are waiting to have their certification renewed.⁶

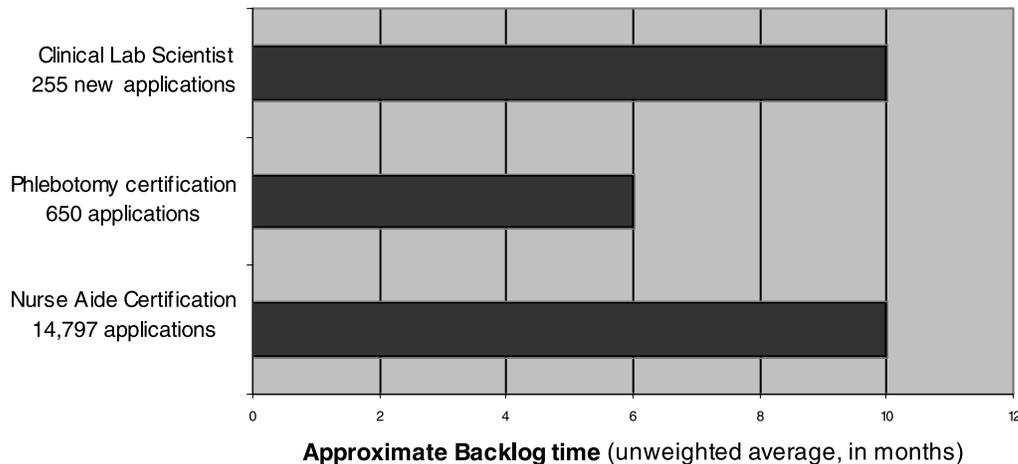
In addition to keeping qualified nurse aides out of hospital rooms and other settings, the backlog can jeopardize patient care. Almost 23,000 arrest and conviction records are waiting to be reviewed.⁷ The people named in these records could be working in patient care. DHS estimates that at least 2,800 people with pending background checks are currently certified and presumed to be actually working in patient care. Up to 60 percent of these people—almost 1,700 persons now working in patient care and more than 13,000 who could be working with patients—could have their certification revoked based on criminal violations.⁸

As a result of these backlogs, qualified individuals who want to work can’t, and individuals who should not work with patients do.



How long until I can work?

Exhibit 2: Backlogs in Individual Licensing Categories



Impact on health care facilities

The backlog in licensing and certification for health care facilities also has had profound negative effects on the health care system. DHS has identified a backlog of new license applicants in the following categories:

- Adult Day Health Care Center;
- Clinic;
- Home Health Agency;
- Hospice;
- Intermediate Care Facility/Developmentally Disabled; and
- Skilled Nursing Facility.

In some cases, applications pending since July and August 2003 are ready and waiting for an on-site survey. Ninety-three new facilities are awaiting inspection.⁹ Almost 170 more applications for new facilities are in process, but not yet ready for inspection.

The delay in licensing for health care facilities is exacerbated by priorities mandated by state and federal law. The federal government requires that DHS give priority to complaints, compliance visits to health care facilities, and other federal quality initiatives.¹⁰ California law requires DHS to process license applications for clinics within 100 days, but not other applications.¹¹ The result is that licenses get processed in priority areas but backlogs grow even longer for everything else.

Increasing staffing is an important part of eliminating the backlog in licensing and certification for facilities, but staffing will not solve the problem immediately. It takes time to become trained to review applications for facilities under applicable federal regulation. The training requires a four-week orientation, a three-month academy and federally-mandated examination.¹² Nurses, doctors and dieticians may be needed to review the proposed facility for compliance. Nevertheless, additional staffing is the first step towards prompt licensure and maximum protection of patient safety.

Impact on laboratories and other specialties

In addition to delays for professional licensing and certification of health care facilities, there are backlogs in certification of laboratories and other specialty areas. Backlogs have been identified in the following areas supported by fees:

- Environmental Laboratory accreditation;
- Phlebotomy Technician certification;
- Clinical Laboratory Scientist;
- Tissue Bank;
- Medical Device Manufacturer;
- Drug Manufacturer;
- Home Medical Device Retailer;
- Retail Water Facility; and
- Food Processor.

Each of these areas is fee-supported, but backlogs have resulted due to hiring freezes and budget cuts.¹³ License applicants who have paid for review of their applications should receive the determinations to which they are entitled, and the public should be confident that only qualified persons and organizations become licensed.

Setting fees to support adequate staff for licensing activities

The first step in eliminating the backlog of licensing applications is to increase staffing for license processing. Where possible, that should be done through the temporary redirection of staff or short-term hires. However, providing adequate staffing in the long term will also require a more rational fee policy.

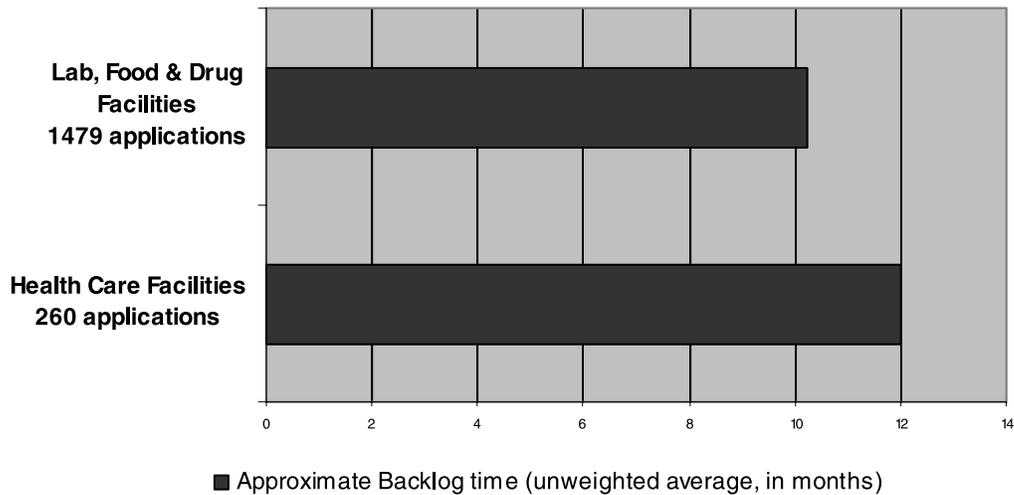
Fees for licensing and certification must be based on forecasts of future needs, not merely replaying past trends. Under the current system, variable fees (some fee amounts are fixed by statute) are set in the budget each year based on a report prepared by the Department of Health Services.¹⁴ Health Services calculates the fee it will recommend based on what fee would have balanced the *previous year's budget*.¹⁵ Thus, if there are more licensing applications in the next year, not enough money will be available to hire needed personnel and backlogs will result.



Instead of this dysfunctional system, fees should be based on a projection of what level of fees would be necessary to pay for adequate staffing in the coming year. A loan from the General Fund to the Department of Health Services could give the department the flexibility to hire personnel before a backlog develops.¹⁶

How Long Until I Can Start My Business?

Exhibit 3: Average Backlogs for Facility Licenses



Creating a special fund for license and certification fee revenue

A special fund also could help increase accountability and service quality within license and certification programs. All money paid to the Department of Health Services in license fees would go into the special fund rather than being siphoned into the General Fund. Surplus funds in a given year could then be carried over to future years when costs were higher. The special fund would maintain a cushion of surplus funds, initially established by a loan from the General Fund, to give it flexibility to hire personnel as needed to respond to licensing applications.

The existence of a special fund also would help establish accountability for DHS. Because all money paid by license applicants would be retained in the special fund for processing of applications, program administrators could be held accountable for the efficient and fair processing of licensing and certification applications.

Special funds have been established for DHS license activities in the past, but they have been limited to narrow licensing areas.¹⁷ A special fund for a broader range of licensing and certification functions was recommended more than a decade ago by the State Auditor.¹⁸ It is time to create a special fund along those lines to bring service and accountability to the health and human services licensing process. Unlike some other funds that are defined with great specificity, this one would be used for all licensing performed by DHS's Licensing and Certification Division.

Other areas for consideration

In addition to the priority areas identified above, DHS should review cross-subsidies in the department's licensing activities. Cross-subsidies occur when the surplus from one fee-supported licensing program is used to support another licensing program whose costs exceed the fees generated. Cross-subsidies can reflect rational priorities, but they can also conceal fee policies that don't make sense from needed scrutiny. DHS should evaluate whether subsidies between licensing programs accurately reflect government priorities and identify those fees that should be modified.

Recommendations

- A. The Department of Health Services (DHS), or its successor, should fill vacant positions that can be funded from fee-supported licensing and certification activities.**
- B. The Governor should work with the Legislature to establish a special fund for the license fees of DHS's Licensing and Certification Division.**
- C. Where possible, DHS, or its successor, should address licensing backlogs by temporary redirection of staff or temporary hires.**
- D. DHS, or its successor, should develop proposals to reduce licensing and certification backlogs to 30 days for applications that are ready for determination or on-site survey, as applicable.**
- E. The special fund license and certification efforts should be initiated with a loan from the General Fund.**
- F. DHS and other departments in the Health and Human Services Agency, or its successor, should evaluate raising license fees in categories that do not currently support the licensing work so license applicants who pay for their license can receive them and get to work in a timely manner.**



Fiscal Impact

The only immediate impact is to fill authorized but vacant positions, so no budget impact is expected. A short-term loan from the General Fund to the Special Fund will be required. Because the business units covered by these recommendations are almost completely fee-supported, future impacts are also expected to be minimal.

Endnotes

- ¹ Susan Diedrich, assistant secretary, Health and Human Services Agency, fax message (May 5, 2004); Brenda Klutz, deputy director, Licensing and Certification, Department of Health Services, interview (May 10, 2004); Patricia Morrison, Licensing and Certification, Department of Health Services, interview (May 19, 2004); Richard Rodriguez, Prevention Services, Department of Health Services (May 10–12, 2004); and Debbie Prinzo, Prevention Services Division, Department of Health Services, e-mail message (June 1, 2004).
- ² Interview with Brenda Klutz, deputy director, Licensing and Certification Division, Department of Health Services, Sacramento, California (April 29, 2004). Interviews with Richard Rodriguez, assistant deputy director, Prevention Services, Department of Health Services, Sacramento, California (May 10–12, 2004).
- ³ E-mail message from Curt Smith, Skilled Healthcare (April 13, 2004). Interview with Curt Smith, Skilled Healthcare, Foothill Ranch, California (June 7, 2004).
- ⁴ Certification of nurse assistants is required by Health & S.C. Sections 1337, 1337.1 and 1337.2. Certification of home health aides is required by Sections 1727(d) and 1736.1. Backlog as of March 2004. Department of Health Services, "Licensing and Certification Program, Professional Certification Branch, 4-30-04 staffing.doc," received from Brenda Klutz, deputy director, Licensing and Certification Division, Department of Health Services (May 12, 2004) (Unpublished report).
- ⁵ Letter from Susan Diedrich, assistant secretary, Health & Human Services Agency (May 5, 2004); interview with Patricia Morrison, chief of Professional Certification Branch, Licensing and Certification Division, Department of Health Services, Sacramento, California (May 19, 2004).
- ⁶ As of March 2004. Department of Health Services, "Licensing and Certification Program, Professional Certification Branch, 4-30-04 staffing.doc," received from Brenda Klutz, deputy director, Licensing and Certification Division, Department of Health Services (May 12, 2004) (unpublished report).
- ⁷ Letter from Susan Diedrich, assistant secretary, Health and Human Services Agency, May 5, 2004; interview with Patricia Morrison, chief of Professional Certification Branch, Licensing and Certification Division, Department of Health Services, Sacramento, California (May 19, 2004).
- ⁸ Interview with Patricia Morrison, chief of Professional Certification Branch, Licensing and Certification Division, Department of Health Services, Sacramento, California (May 19, 2004). Ms. Morrison advised that of the arrest records processed in Fiscal Year 2003–2004 through April 30, 2004, approximately 2700 resulted in revocation or denial of certification, while 1700 were cleared to work or continue work.
- ⁹ As of April 26, 2004. Department of Health Services, "Background: Licensing and Certification Workload/Backlog," received from Brenda Klutz, deputy director, Licensing and Certification Division, Department of Health Services, May 12, 2004 (unpublished report).

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- ¹⁰ Interview with Denise Arend, chief of Field Operations Branch, Licensing and Certification Division, Department of Health Services, Sacramento, California (May 19, 2004).
- ¹¹ Health & S.C. Section 1218.
- ¹² Interview with Brenda Klutz, deputy director, Licensing and Certification Division, Department of Health Services, Sacramento, California (April 29, 2004).
- ¹³ Interviews with Richard Rodriguez, assistant deputy director, Prevention Services, Department of Health Services, Sacramento, California (May 10–12, 2004).
- ¹⁴ Health & S.C. Section 1266.
- ¹⁵ Health & S.C. Section 1266; Department of Health Services, “Health Facility License Fee Report Fiscal Year 2004/05” (Sacramento, California, undated) (report to Legislature).
- ¹⁶ Department of Health Services, “Department of Health Services’ Licensing and Certification Program’s Plan to Revise California Health Facilities’ Licensure Fees” (Sacramento, California, September 1995) (report to the Legislature).
- ¹⁷ Tissue Bank License Fund, Nursing Home Administrator’s State License Examining Fund and others. Governor’s Budget 2004–2005, pp. HHS 48–49.
- ¹⁸ State Auditor Report #93020, December 1993, as quoted by Department of Health Services, “Department of Health Services’ Licensing and Certification Program’s Plan to Revise California Health Facilities’ Licensure Fees” (Sacramento, California, September 1995) (report to Legislature).



Streamline Oversight Requirements for Conducting Medical Survey/Audits of Health Plans

Summary

Conducting medical surveys and audits of managed health care plans in California is important to help ensure that persons enrolled in health plans receive high quality, necessary medical care. Some health plans in California, however, undergo costly and duplicative routine medical surveys and audits conducted by state and private entities. This results in a duplication of work for and significant costs to some health plans, and is an inefficient use of state government resources.

Background

California has 63 percent of its population enrolled in managed health care plans, also called health maintenance organizations or HMOs, more than any other state in the country.¹ A total of 45 full-service health plans provide coverage that includes basic health care services, such as emergency and hospital care, to more than 23 million Californians.²

People obtain coverage from health plans in two ways. First, many individuals and employers purchase coverage through “commercial” health plans using their own funds.³ Second, the state pays for coverage of low-income individuals through the Medi-Cal program, using a nearly equal mix of state and federal funds.⁴ Medi-Cal provides health coverage to more than 6.5 million eligible persons.⁵

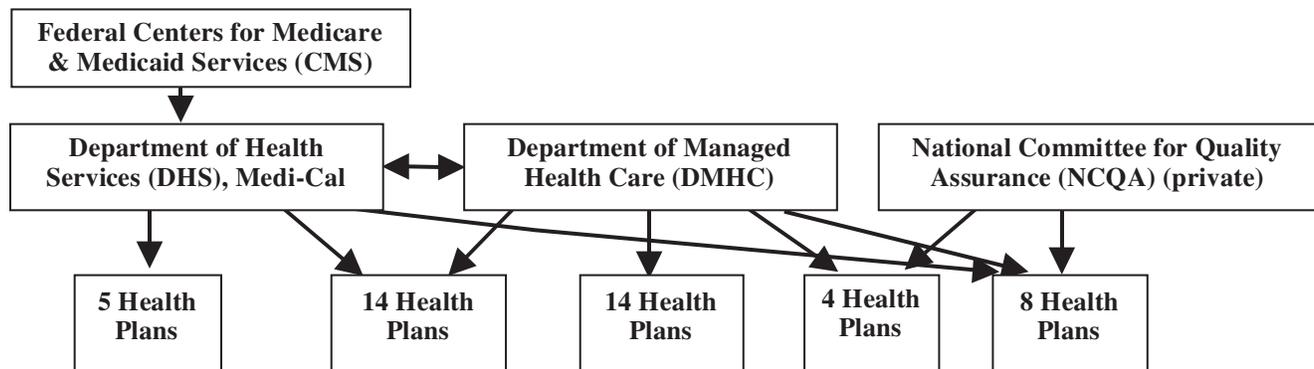
Federal law requires the state to perform routine medical audits of health plans participating in the Medi-Cal program to ensure that the plans provide quality services and follow federal regulations.⁶ The Department of Health Services (DHS) is responsible for auditing a health plan before approving or renewing a contract to provide services to people enrolled in Medi-Cal.⁷

The state also requires routine medical surveys be conducted of commercial health plans.⁸ The Department of Managed Health Care (DMHC) conducts medical surveys, similar to those conducted by DHS, of full-service commercial health plans which are required to have a license issued by DMHC to do business in California.⁹

This regulatory scheme promotes substantial duplication. Of the 45 health plans in the state, 22 of them provide coverage both to persons enrolled in Medi-Cal and to individuals and businesses enrolled in a commercial health plan; these plans are subject to both DHS audits

and DMHC surveys.¹⁰ In addition, 12 of the plans are currently accredited by the National Committee for Quality Assurance (NCQA), a private organization whose standards are generally more demanding than either state or federal law.¹¹ Exhibit 1 summarizes the current situation in more detail.

Exhibit 1: Routine Medical Surveys/Audits of Full-Service Health Plans in California as of June 2004



The need for streamlining

Streamlining of the auditing process for health plans in California is necessary to reduce state government inefficiency and the regulatory burden on health plans, both of which increase costs.

Eliminating the duplication of medical surveys and audits is likely to result in some savings to state government, though it is not possible to quantify the expected savings at this time. Savings would flow to the General Fund because roughly half of the costs of audits for the Medi-Cal program are paid out of the state's General Fund.¹² The rest of the costs to the Medi-Cal program and the costs to DMHC are paid for by the federal government and fees from health plans, respectively.¹³ Recent efforts to partially streamline medical surveys and audits have resulted in only minor savings to DMHC and DHS, according to staff at each department.¹⁴

Meanwhile, the annual costs to a full-service health plan for participating in a medical survey or audit are estimated to range from \$50,000 to over \$250,000, depending on the size of the health plan and which entity conducts the survey or audit.¹⁵

Federal and state laws recognize eliminating duplicative medical surveys and audits of health plans and health care providers, such as doctors, who provide services for persons enrolled in a health plan as an important state goal.¹⁶

Past efforts at reform

Existing laws promote or require DHS and DMHC staff to coordinate medical surveys and audits of health plans within the jurisdiction of both departments.¹⁷ Working together, DHS



and DMHC have created a joint medical survey/audit that is used by both departments, and staff members collaborate in conducting the surveys and audits.¹⁸

Despite these efforts, there is still a great deal of room for improvement. Simply put, it is easier to have just one organization perform a function than to have two organizations coordinate together to do the same job. Despite the existence of the joint survey, the four largest health plans in California—Kaiser Permanente, Blue Cross, Health Net and Universal Care—are still subject to surveys and audits conducted separately by both DHS and DMHC because of differences in the scope of the two reviews, and logistical and other issues.¹⁹ In addition, neither department is taking full advantage of existing information available from the accreditation performed by NCQA to potentially reduce the work of conducting medical surveys and audits.²⁰

Using information from accreditation reviews to reduce the number of audits

Twelve of the state's health plans, including its ten largest ones, volunteer to undergo medical surveys conducted by NCQA, a private accrediting organization.²¹ Health plans participate because accreditation helps them market themselves to consumers; the accreditation is supported by federal law, based on best practices, and accepted nationwide.²² Many employees prefer or are required by their employers to purchase health care coverage from accredited health plans.²³

Accreditation by NCQA lasts for three years unless there are significant changes within a health plan during that period. Renewal requires a new medical survey.²⁴ NCQA will also review health plans for compliance with requirements of particular states if the health plans pay a nominal fee.²⁵ Accreditation often requires more information than is requested in surveys or audits by either DHS or DMHC.²⁶

Because of the quality of review performed by NCQA, the state could save or redirect valuable resources by accepting NCQA accreditation in lieu of regular surveys or audits when the NCQA accreditation criteria meet or exceed state or federal requirements. This is allowed in some situations by state and federal laws which permit DHS to accept the results of an accrediting organization in place of conducting its own audit in six areas.²⁷ It would also advance the important goal recognized in state law of avoiding duplication of surveys and audits of health plans and other health care providers.²⁸ It is, however, not explicitly allowed for DMHC under current state law.²⁹

However, neither DHS nor DMHC has ever used results from NCQA instead of its own surveys and audits.³⁰ Conducting a separate review sometimes makes sense when the state has requirements that are not addressed by the accrediting organization.³¹ But a 2001 NCQA report found that 63 percent of survey/audit requirements used by DHS and DMHC were "highly consistent" with NCQA's accreditation standards, indicating that there is great opportunity to use information from NCQA reviews to streamline state audits.³²

Comparison with other states

Twenty-seven states, including 6 of the largest 10 states, recognize NCQA accreditation as satisfying some or all of their state’s regulatory requirements.³³ Nine states require NCQA to conduct reviews to monitor compliance with some of their state’s regulatory requirements.³⁴ Two states—Florida and Hawaii—even go so far as to require NCQA accreditation for all HMOs operating in the state.³⁵

In discussions with representatives from three states that partially rely on NCQA reviews—Pennsylvania, Michigan and Florida—all reported that using NCQA results saved staff time.³⁶ Each of these states continues to conduct surveys in non-routine areas not covered by NCQA, and each retains the authority and discretion to enforce their health plan licensing laws.³⁷

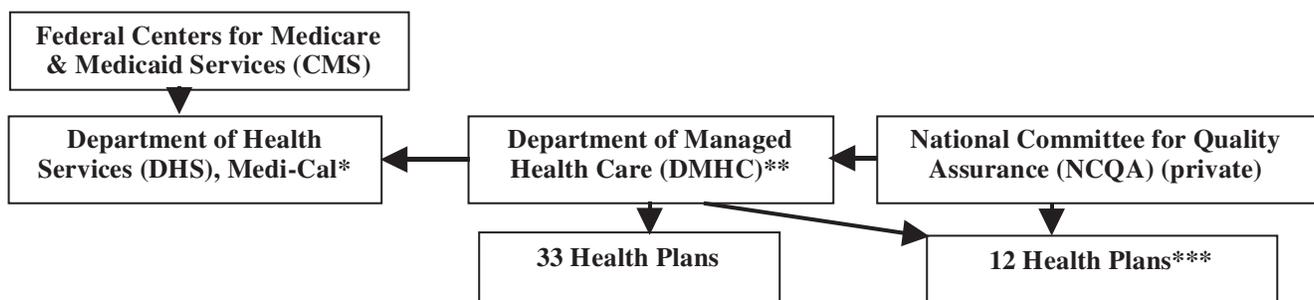
Recommendations

- A. The Governor should work with the Legislature to require the state to use the results from accrediting organizations where they are equivalent to or exceed the state’s standards regarding medical surveys/audits of health plans.**

This legislation should permit health plans voluntarily accredited by approved organizations to be exempted from routine surveys and audits by DHS and DMHC; authorize the state to monitor the procedures of the accrediting organization; and require approval of state officials before accepting the accrediting organization’s review in lieu of the state’s own review.

Exhibit 2 below illustrates the results of implementing the recommendations.

Exhibit 2—Proposed Routine Medical Surveys/Audits of Health Plans in California



* DHS would be authorized to approve results from audits submitted by DMHC prior to submission to CMS.

** DMHC would be authorized to approve results from surveys and audits conducted by NCQA.

*** These health plans would either undergo a shorter routine survey/audit conducted by DMHC or may elect to have a complete survey by DMHC in addition to NCQA accreditation.



This would provide an incentive for, but not require, health plans to become nationally accredited. It would also enable DHS and DMHC to shift resources away from conducting duplicative audits and surveys and towards higher value activities.

B. The Governor should issue an Executive Order requiring DMHC and DHS, or their successor, to eliminate duplicative functions related to conducting medical surveys/ audits of health plans.

Under state law, DHS is permitted to contract with DMHC or any other organization to conduct audits for DHS.³⁸ DHS should be instructed to use this authority to enter into a Memorandum of Understanding with DMHC where all medical plan audit and survey responsibilities allowable under the law would be transferred to DMHC. This would result in a single organization conducting medical surveys and audits of health plans in California.

Fiscal Impact

It is not possible to accurately estimate expected savings because the extent of cost reductions will depend on how many health plans choose to participate in national accreditation programs and how many plans choose to use their accreditation in lieu of either DHS or DMHC conducting medical surveys or audits. DHS and DMHC, or their successor, should be instructed to report back with more detailed savings assessments as part of the Fiscal Year 2006–2007 budget.

In addition, there will be substantial savings to accredited health plans if they choose to use their accreditation in lieu of having routine medical surveys and audits conducted by DHS or DHMC.

Endnotes

- ¹ California Healthcare Foundation, “California Health Care Market Report 2004,” by Allan Baumgarten, (Oakland, California, 2004), p. 10; and Aventis Pharmaceuticals, “HMO-PPO/Medicare-Medicaid Digest, Managed Care Digest Series, 2001” (Bridgewater, New Jersey, 2002), pp. 18–20.
- ² California Department of Managed Health Care, “DMHC 2003 Annual Assessment Report” (Sacramento, California, April 2, 2004); and e-mail from Mary Cosmides, Department of Health Services, to California Performance Review (June 4, 2004). Does not include three health plans that have surrendered their licenses issued by DMHC.
- ³ “Commercial” health plan examples: Kaiser Permanente, Blue Shield, and Health Net. “Non-commercial” or publicly funded health plan examples: Medi-Cal/Medicaid, Medicare, Healthy Families, Aid to Infants and Women and the Managed Risk Medical Insurance Program.
- ⁴ Office of the Governor, “California State Budget Summary 2004–2005” (Sacramento, California, January 9, 2004), p. 97.

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- ⁵ Legislative Analyst's Office, "Health and Social Services Analysis of the 2004–2005 California Budget" (Sacramento, California), p. C-27.
- ⁶ Federal Social Security Act Section 1932 (C) [42 U.S.C. 1396u-2].
- ⁷ Welf. & Inst. C. Sections 14450, 14459.5.
- ⁸ Health & S. C. Section 1380.
- ⁹ Health & S. C. Sections 1342, 1380, 1349, 1343, 1349.1 and 1349.2.
- ¹⁰ Federal Social Security Act Section 1932(C) [42 U.S.C. 1396u-2]; Welf. & Inst. C. Sections 14450, 14456, 14456.5, 14457, and 14459.5; Health & S. C. Section 1380; California Department of Managed Health Care, "DMHC 2003 Annual Assessment Report;" e-mail from Mary Cosmides; e-mail from Saralea Altman, senior health care service analyst, Department of Managed Health Care (May 27, 2004).
- ¹¹ California Healthcare Foundation, Medi-Cal Policy Institute, "Medi-Cal Audit Crosswalk: A comparison of the NCQA Accreditation Standards and Medi-Cal Regulatory Oversight Requirements for Managed Care Organizations," by Kristine Thurston, Meshell Hicks, Lana Cotner, and Steve Friedman (Oakland, California, January 2001), pp. 5–107; interview with Leanne Gassaway, California Association of Health Plans, Sacramento, California (June 10, 2004); and National Committee for Quality Assurance, "Health Plan Report," <http://hprc.ncqa.org/frameset.asp> (last visited June 10, 2004).
- ¹² Office of the Governor, California State Budget Summary 2004–2005.
- ¹³ Health & S. C. Section 1431.4; California Department of Managed Health Care, "DMHC 2003 Annual Assessment Report."
- ¹⁴ E-mail from Kip Gilbert, assistant deputy director, Office of Administrative Services, Department of Managed Health Care, to California Performance Review (March 26, 2004); e-mail from Winston Mesaku, chief, Medical Review North, Audits and Investigations, Department of Health Services, to California Performance Review (June 8, 2004); and e-mail from Saralea Altman (June 8, 2004).
- ¹⁵ E-mail from Leanne Gassaway, vice president, Legal and Regulatory Affairs, California Association of Health Plans, to California Performance Review (May 4, 11, and 13, 2004, and June 1, 2004).
- ¹⁶ Federal Social Security Act Sections 1932(C) (2) (B) [1396u-2] and 1852(e) (4) [42 U.S.C. 1395w-22]; Health & S. C. Sections 1380(c), 1342.8 and 1342.4; Welf. & Inst. C. Sections 14460, 14456, and 14457.
- ¹⁷ Welf. & Inst. C. Sections 14456 and 14457; Health & S. C. Sections 1380(c), 1342.8, and 1342.4.
- ¹⁸ E-mail from Winston Mesaku (May 27, 2004); and e-mail from Saralea Altman (June 8, 2004).
- ¹⁹ E-mail from Winston Mesaku (May 26, 2004); e-mail from Luis Rico, acting chief, Medi-Cal Managed Care Division, to California Performance Review (May 24, 2004); and e-mail from Saralea Altman (April 19, 2004).
- ²⁰ E-mail, Winston Mesaku (May 26, 2004); Interview, Saralea Altman, senior health care service analyst, Department of Managed Health Care, Sacramento, California (March 10, 2004).
- ²¹ NCQA-accredited health plans in California: Kaiser Permanente, Blue Cross, Health Net, Universal Care, Inland Empire Health Plans, Molina, LA Care, Orange County Health Authority, Blue Shield/California Physician's Service, PacifiCare, Cigna HealthCare, Aetna Health, Heritage Provider Network.
- ²² Interview with Leanne Gassaway, vice president, Legal and Regulatory Affairs, California Association of Health Plans, Sacramento, California; Mark L. Andrews, executive vice president, General Counsel; Joe Parra, director, Governmental Affairs, Molina Healthcare, Sacramento, California; Leticia Mendez, legislative affairs manager, Michael Turrell, director, Compliance; Chad Westover, director, Accounts Executive/Field Operations, Wellpoint, Inc., Thousand Oaks, California; and Dave Meadows, vice president, State Health Programs, Health Net of California, Rancho Cordova, California (April 29, 2004); "CMS Approves NCQA's 2004 Medicare+Choice Deeming Standards," NCQA website



press release, January 9, 2003, <http://www.ncqa.org/communications/news/2004M+Cdeemingstandards.htm> (last visited June 9, 2004).

- ²³ E-mail from Peter Lee, president, Pacific Business Group on Health, San Francisco, California, to California Performance Review (May 19, 2004); and e-mail from Richard Krolak, chief, Office of Long Term Care and acting chief, Self-Funded Health Plans, CalPERS, to California Performance Review (June 19, 2004).
- ²⁴ National Committee for Quality Assurance, "Standards and Guidelines for the Accreditation of MCOs," Item No.10352-100-04 (Washington, DC, 2003), p. 44.
- ²⁵ Interview with Patricia Pergal, National Committee for Quality Assurance (Washington, DC) (June 15, 2004).
- ²⁶ Interview with Leanne Gassaway (June 10, 2004).
- ²⁷ Federal Social Security Act Section 1932 [42 U.S.C. 1396u-2(c)(2)(B)] and 1852 [42 U.S.C. 1395w-22(e)(4)]; Welf. & Inst. C. Sections 14456 and 14459.5.
- ²⁸ Health & S. C. Sections 1342.8, 1380 and 1380.1; Welf. & Inst. C. Sections 14460, 14457 and 14456.
- ²⁹ E-mail from James Tucker, attorney, Department of Managed Health Care, to California Performance Review (June 9, 2004).
- ³⁰ E-mail from Winston Mesaku (May 26, 2004); and interview with Saralea Altman (May 10, 2004).
- ³¹ E-mail from Luis Rico (May 24, 2004); e-mail from Winston Mesaku (May 26, 2004); and e-mail from Saralea Altman (April 19, 2004).
- ³² California Healthcare Foundation, "Medi-Cal Policy Institute. Medi-Cal Audit Crosswalk: A comparison of the NCQA Accreditation Standards and Medi-Cal Regulatory Oversight Requirements for Managed Care Organizations." An analysis of this report found 63 percent of the performance measurements were "highly consistent" and 36 percent were "consistent with variation" between NCQA and those of both DHS and DMHC.
- ³³ National Committee for Quality Assurance, "State Recognition of NCQA Accreditation" (Washington, DC). Arizona, Colorado, Delaware, Florida, Georgia, Hawaii, Iowa, Kansas, Kentucky, Maryland, Massachusetts, Maine, Michigan, Missouri, Montana, Nebraska, Nevada, New Mexico, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, Washington, Wisconsin, and West Virginia.
- ³⁴ National Committee for Quality Assurance, "State Recognition of NCQA Accreditation" (Washington, DC). Delaware, Georgia, Kansas, New Jersey, Oklahoma, Pennsylvania, Rhode Island, Virginia, and West Virginia.
- ³⁵ National Committee for Quality Assurance, "State Recognition of NCQA Accreditation" (Washington, DC).
- ³⁶ Interview with David Henry, director, Division of Quality Review, Pennsylvania Bureau of Managed Care, Harrisburg, PA (June 3, 2004); interview with Sheila Embry, section manager, Quality Improvement & Program Development, Michigan Medicaid Program, Lansing, Michigan (June 4, 2004); interview with Tom Warring, bureau chief, Florida Bureau of Managed Health Care, and Ann Bratton, administrator, Network Services, Florida Agency for Health Care Administration, Tallahassee, Florida (June 4, 2004).
- ³⁷ Interview with David Henry, director, Division of Quality Review, Pennsylvania Bureau of Managed Care, Harrisburg, PA (June 3, 2004); interview with Sheila Embry, section manager, Quality Improvement & Program Development, Michigan Medicaid Program, Lansing, Michigan (June 4, 2004); Interview with Tom Warring, bureau chief, Florida Bureau of Managed Health Care, and Ann Bratton, administrator, Network Services, Florida Agency for Health Care Administration, Tallahassee, Florida (June 4, 2004).
- ³⁸ Welf. & Inst. C. Sections 14456 and 14457.



Intermediate Care Facilities for Individuals with Developmental Disabilities not Benefiting from Full Federal Participation

Summary

Consistent with other states, California should increase federal financial participation under Medi-Cal by changing the definition of services provided by Intermediate Care Facilities for people with developmental disabilities (ICFs/DD) to include day program services and transportation. This change would allow these services to be Medi-Cal funded and would save \$43.5 million state General Funds annually.

Background

About 7,000 people with developmental disabilities live in community-based health facilities called Intermediate Care Facilities, a Medicaid benefit.¹ Medicaid is a federal program, administered by the states, providing health care for low-income and people with disabilities. In California, the Medicaid program is called Medi-Cal.

Medi-Cal funds ICF/DD residential services for people with developmental disabilities who require 24-hour treatment and supervision in a structured setting. The California Department of Health Services (DHS) licenses and sets daily payment rates for the ICFs/DD providers.² California receives federal financial participation for the per diem costs of Medi-Cal eligible people in the ICFs/DD at a specified reimbursement rate, 50 percent effective July 1, 2004.³

California's definition differs from federal and other states

Federal Medicaid regulations allow broad definitions of the services provided in an ICF/DD.⁴ Other states, including New York, Texas, Florida and Illinois have defined their ICF/DD programs broadly to cover other services such as day programs and transportation, thereby increasing federal funding under Medicaid.⁵ However, California continues to have a narrow definition that only includes the residential portion of costs in the rate for the ICF/DD program. The state General Fund pays 100 percent of any other services, including day programs and transportation. The California Department of Developmental Services (DDS) contracts with 21 nonprofit corporations known as regional centers located throughout the state to purchase community-based services, including day programs and transportation.⁶ Day programs provide other services needed by people living in ICFs/DD such as programs to develop skills in self-care, behavior, social and recreation and employment.⁷

The California Legislative Analyst's Office (LAO) reported on this issue in previous budget analyses and most recently in its analysis of the 2004–2005 Governor's budget. The LAO estimates that modifying the ICF/DD rate setting procedure and implementing other related changes could generate as much as \$50 million annually in additional federal funds.⁸

Options to obtain federal Medicaid funding

The supporting analysis for the LAO recommendation is from a January 2003 report issued by an independent consultant, under contract with DDS, to identify ways to increase the amount of federal Medicaid funding.⁹ The report provides three options the state could use to obtain federal Medicaid funding for day programs and transportation services for people living in ICFs/DD. These options are as follows:

- Option 1 Redefine the ICF/DD program as an “all-inclusive” service and restructure the payment methodology to allow ICF/DD vendors to bill Medi-Cal for services purchased through subcontract from day service and transportation providers selected by the people living in the ICF/DD.
- Option 2 Create new Medi-Cal stand-alone services in the Medicaid State Plan that include those day services now provided by regional centers to people living in ICFs/DD.
- Option 3 Re-certify all qualifying ICFs/DD as Community Care Facilities, enabling the residential care and associated day services and transportation services to be billed as Home and Community-Based Services under an existing federal waiver—assuming that the vendors, people living in the ICFs/DD and services provided meet appropriate eligibility and documentation requirements.

The LAO report states that each of the options creates programmatic and administrative problems that would affect both implementation and the amount of new federal Medicaid funding. Thus, implementation of any of the options would require a very focused and determined commitment and effort.

DDS staff believe the third option in the consultant report, recertifying all qualifying ICFs/DD as Community Care Facilities, is the easiest option to implement because there would be the least impact on the ICF/DD day program and transportation providers.¹⁰ Under this approach, clients in ICF/DD programs would be covered under the Home and Community-Based Services waiver, and all services currently purchased by regional centers would become eligible for federal financial participation. However, a bill currently pending before the Legislature mandates implementation of the first option, which would redefine the ICF/DD program as an “all-inclusive” service.

The bill, California Assembly Bill 2775 (AB 2775), does two primary things. First, it identifies the services now purchased by regional centers for ICF/DD residents that could qualify for federal Medicaid reimbursement. Second, it redefines the ICF/DD benefit as an all-inclusive



service package with a single rate. Thus, under the provisions of this bill, services now purchased by the regional centers with no federal reimbursements would be included as a part of the ICF/DD benefit and be reimbursed by Medi-Cal under a single all-inclusive rate. AB 2775 would require the DHS to adopt regulations implementing the bill's provisions by January 1, 2006.¹¹

DDS staff states that DHS will need to initiate and complete a significant amount of the work required to implement this change. At the date of this writing, DHS, in collaboration with DDS, is drafting a request for consultation and advice to the federal Region IX Center for Medicare and Medicaid Services (CMS) on expanding the definition of ICF/DD services to include community-based day program and transportation services.¹²

Redefining the ICF/DD rate as all-inclusive would also provide California with additional federal financial participation due to the recently enacted Quality Assurance Fee.¹³ Under the Quality Assurance Fee, the DHS requires each ICF/DD to pay a fee of 6 percent of its entire gross receipts. In return, the ICF/DD providers receive a rate increase as part of their Medi-Cal reimbursement to cover the Quality Assurance Fee. For the 2003–2004 rate year, the daily rates were raised for all ICFs/DD by 9.57 percent, a net increase of 3.57 percent.¹⁴ If the proposed all-inclusive rate is established, the 6 percent Quality Assurance Fee paid by the ICFs/DD would be included in that rate and would increase the amount of federal financial reimbursement.¹⁵

Opposition to the proposed all-inclusive ICF/DD rates probably will come from the California Association of Health Facilities, Developmental Services Network and California Rehabilitation Association due to concerns about changing the ICF/DD rate-setting process.¹⁶ Currently, ICF/DD providers have no administrative responsibilities for day program and transportation services used by their resident clients because day program and transportation providers contract directly with regional centers to provide services to these clients.

The concerns could be addressed by using a portion of the additional federal funds to compensate the ICF/DD, day program and transportation providers for any increased administrative responsibilities. One approach to minimizing the impact on ICF/DD, day program and transportation providers would be to have the regional center, under contract to the ICF/DD provider, be the conduit to pass through the purchase of service amounts to the day program and transportation providers. Under this approach, the day program and transportation providers would see few changes in the current regional center billing and reporting process. The ICFs/DD could be allowed to keep a higher percentage of the Quality Assurance Fee to offset the costs of their expanded responsibilities in administering the new contracted program.¹⁷

Personnel reduction inhibits implementation

The LAO reported in its analysis of the 2004–2005 Governor’s Budget that DDS would find it difficult to implement this change in the ICF/DD rate structure without additional positions and resources.¹⁸ DDS reported to the Legislature in the *Regional Centers Estimate for the 2004–2005 Governor’s Budget* that the department cannot absorb new projects or workload due to the personnel reductions it has had over the past two years, even if such projects or workload increase federal financial participation.¹⁹

CMS’s response to the request may not be favorable, according to DHS and DDS staff, as CMS in recent years has been more hesitant to expand the states’ reimbursable Medicaid services. In addition, DHS and DDS staff have concerns about the timing of this request because CMS five-year review is expected later this year.²⁰ DDS reported to the Legislature in its *Regional Centers Estimate for the 2004–2005 Budget* that the state is expecting a CMS review of its Home and Community-Based Services waiver program prior to September 30, 2005, or during Fiscal Year 2004–2005.²¹ The state experienced a significant loss of federal funding during the last CMS review in 1997. Further, CMS has raised the bar in terms of expectations since 1997, in response to a critical federal General Accounting Office report of CMS’s oversight of states’ waiver programs.²² CMS’s response to the General Accounting Office audit suggests that future reviews may be more aggressive.²³

Recommendations

- A. The Health and Human Services Agency, or its successor, should redefine the Intermediate Care Facilities for people with developmental disabilities (ICF/DD) program to increase federal financial participation. In addition, the agency should work with staff to address their concerns on adequately preparing for the Center for Medicare and Medicaid Services (CMS) review in the Fiscal Year (FY) 2004–2005.**
- B. The Department of Health Services, or its successor, should request consultation with CMS Region IX on developing all-inclusive ICF/DD rates and obtaining approval of a State Medicaid Plan Amendment. Pending approval of the amendment, DHS and DDS should draft regulatory changes with measures to compensate ICFs/DD, day programs, transportation providers and/or regional centers for any increased administrative responsibilities that may result from the recommended changes.**
- C. If CMS does not approve the all-inclusive rate option, the Health and Human Services Agency, or its successor, should review and evaluate the other options suggested by the consultant to obtain additional federal fund participation for day program and transportation costs for clients in ICF/DD programs.**



Fiscal Impact

If pending Assembly Bill (AB) 2775 is signed into law, it will require that the Health and Human Services Agency, or its successor, adopt regulations by January 1, 2006. These regulations will allow for an all-inclusive rate that will allow the state to recover all costs expended on day care and transportation costs for children and adults in ICF/DD facilities. In FY 2002–2003, 5,399 ICF/DD clients were in day programs at a total purchase of service cost of \$69 million while 6,517 ICF/DD clients received transportation services at a total purchase of service cost of \$15 million.²⁴ These costs under AB 2775 will be shared 50/50 with the federal government.

This implementation of an all-inclusive ICF/DD rate is estimated to generate an additional \$43.5 million in federal revenues and offset an equal amount of state General Fund on an annual basis. This estimate is based on actual day program and transportation costs for ICF/DD clients in FY 2002–2003 and the Medicaid reimbursement rate for FY 2004–2005. The total day program and transportation costs for ICF/DD clients, based on actual costs for FY 2002–2003, are \$84 million, which would bring in additional federal reimbursements of \$42 million based on the 2004–2005 federal participation rate of 50 percent. In addition, a 9.57 percent per diem rate increase that should be paid by the federal government to provide reimbursement for the Quality Assurance Fee will generate another \$4 million in federal financial participation (\$84 million x 9.57 percent x 50 percent) for a total increase in federal financial participation of \$46 million.

Implementation of an all-inclusive rate may result in five additional staff and service costs of about \$2.5 million General Fund for DHS, DDS, and regional centers. This estimate is from the independent consultant's January 2003 report, as adjusted to reflect updated information.²⁵

General Fund
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	0
2005–06	\$23,000	\$1,250	\$21,750	2.5
2006–07	\$46,000	\$2,500	\$43,500	2.5
2007–08	\$46,000	\$2,500	\$43,500	2.5
2008–09	\$46,000	\$2,500	\$43,500	2.5

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Endnotes

- ¹ Interview with Paul Choate, Data Extraction, Department of Developmental Services, Sacramento, California (May 6, 2004).
- ² Department of Developmental Services, "Intermediate Care Facilities and Program Types," <http://www.dds.cahwnet.gov/LivingArrang/icf.cfm> (last visited June 11, 2004).
- ³ Interview with Grant Gassmon, Long-Term Care Reimbursement Unit, Department of Health Services, Sacramento, California (May 7, 2004).
- ⁴ Code of Federal Regulations 42-435.1009.
- ⁵ Interview with Richard Nussbaum and Linda Kelly, New York State Department of Health Bureau, Albany, New York (May 5, 2004); interview with Carolyn Pratt, Texas Long-Term Care Rate Analysis Unit, State of Texas, Austin, Texas (May 4, 2004); interview with Kim Smoak, ICF/DD specialist, Florida Agency for Health Care Administration, State of Florida, Tallahassee, Florida (May 4, 2004); and interview with Steve Rudolph, Division of Medical Programs, State of Illinois, Springfield, Illinois (April 28, 2004).
- ⁶ Legislative Analyst's Office, "Budget Analysis 2004–2005" (Sacramento, California, February 2004).
- ⁷ Department of Developmental Services, "Day Program and Vocational Services," http://www.dds.cahwnet.gov/DayProgram/day_main.cfm (last visited June 11, 2004).
- ⁸ Legislative Analyst's Office, "Budget Analysis 2004–2005."
- ⁹ Department of Developmental Services, "Developmental Disabilities in California: An Analysis of Federal Revenue Opportunities," by PNP Associates (Loudonville, New York, January 10, 2003) pp. 35–42. (Consultant's report.)
- ¹⁰ Interview with Dale Sorbello, deputy director, Community Operations Division, Department of Developmental Services, Sacramento, California (April 20, 2004 and May 4, 2004); and interview with Julie Jackson, deputy director, Community Services and Support Division, Department of Developmental Services, Sacramento, California (April 29, 2004).
- ¹¹ California Assembly Bill 2775, 2003–2004 Session, Sacramento, California.
- ¹² Interview with Mary Lamar-Wiley, chief, Medi-Cal Benefits Branch, Department of Health Services, Sacramento, California (May 7, 2004).
- ¹³ Interview with Gary Macomber, Ramey, Macomber and Associates LLC, Sacramento, California (May 6, 2004).
- ¹⁴ Department of Health Services, Medi-Cal Publications, "Medi-Cal Update Part 2 Billing and Policy, April 2004, Bulletin 325, New Quality Assurance Fee Program" (Sacramento, California, April 2004).
- ¹⁵ Interview with Gary Macomber.
- ¹⁶ Interview with Dale Sorbello; and interview with Julie Jackson.
- ¹⁷ Interview with Gary Macomber.
- ¹⁸ California Legislative Analyst's Office, "Budget Analysis 2004–2005."
- ¹⁹ Department of Developmental Services, "For Legislative Review-Regional Centers Local Assistance Estimate for the 2004–2005 Governor's Budget" (Sacramento, California, January 9, 2004).
- ²⁰ Interview with Dale Sorbello; interview with Julie Jackson; and interview with Mary Lamar-Wiley, chief, Medi-Cal Benefits Branch, Department of Health Services, Sacramento, California (May 7, 2004).
- ²¹ Department of Developmental Services, "For Legislative Review-Regional Centers Local Assistance Estimate for the 2004–2005 Governor's Budget."



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- ²² U.S. General Accounting Office, “Long-Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should be Strengthened,” Report 03-576, (Washington, D.C., June 20, 2003).
- ²³ Department of Developmental Services, “For Legislative Review-Regional Centers Local Assistance Estimate for the 2004–2005 Governor’s Budget.”
- ²⁴ Interview with Paul Choate.
- ²⁵ Department of Developmental Services, “Developmental Disabilities in California: An Analysis of Federal Revenue Opportunities,” pp. 35–42; and interview with Daniel McCarroll, Legislative Unit, Department of Health Services, Sacramento, California (May 14, 2004).



Obtain Best Prices for Durable Medical Equipment

Summary

The Department of Health Services (DHS), or its successor, should implement a competitive bid process to purchase all durable medical equipment for the Medi-Cal program at reduced rates through a limited number of providers.

Background

Medi-Cal is California's Medicaid health care program. This program pays for a variety of medical services for children and adults with limited income and resources. Medi-Cal is supported by federal and state taxes.

The Medi-Cal program currently pays for a broad range of durable medical equipment (DME). Item costs vary from a few dollars per item to items that cost thousands of dollars. DME includes items such as canes, crutches, walkers, oxygen equipment, wheelchairs, patient monitoring devices, infusion equipment, breast pumps, inhalation therapy equipment and nerve, muscle and bone stimulators. Total Medi-Cal costs for DME have escalated in recent years with total expenditures for DME rising from \$63 million in Fiscal Year 1994–1995¹ to \$230 million in FY 2002–2003.² This represents an increase of 265 percent during an eight year period.

Success of interim bid process and negotiations

The Department of Health Services (DHS) has pursued cost savings for other high-cost benefits through negotiating substantial rebates and discounts from providers such as drug manufacturers and infant formula manufacturers. Welfare and Institutions Code Section 14105.3 (b) allows DHS to enter into exclusive contracts with manufacturers for DME products.

Based upon the previous successes of competitive bidding and given the existing legal authority, DHS was approved for a budget change proposal in FY 2002–2003 which established positions and funding to implement and oversee the DME Contracting Program. In justifying the additional resources needed to implement the contracting program, DHS estimated annual savings to the Medi-Cal program of \$19 million (\$9.5 million General Fund). The full year savings for this effort were included in the original Medi-Cal Estimate for FY 2004–2005.³

To date, DHS has yet to implement a DME contract due to conflicting program priorities and a perception that recent reductions to DME reimbursement rates will minimize potential

savings.⁴ Due to this failure, the May revision to the 2004–2005 Governor’s Budget now estimates \$7.4 million in savings in FY 2004–2005, assuming a November 1, 2004 initiation, and \$11.2 million on an ongoing basis.⁵ The reduction to the annual savings figure in the Medi-Cal estimate reflects DHS estimates of a reduced number of DME items that will be competitively bid, and represents a projected 15 percent savings for those items that will be competitively bid.⁶ Greater savings can be generated by implementing a competitive bid process that stipulates that the winning bids must include a weighted average rate reduction in the products offered of 10 percent, and no product shall be offered at a price that is above the rate established within Title 22, California Code of Regulations.

Other states have initiated processes to competitively bid

The states of Florida, New York and Texas have taken steps towards initiating competitive bidding for the provision of DME products or medical supplies. Florida has implemented a competitive contract for hospital beds and respiratory equipment and supplies.⁷ New York has issued competitive bids for incontinent supplies and diabetic supplies. Texas has yet to implement a competitive contract pending ongoing discussions with the provider community. Although, due to the recent implementation of these competitive bid processes, there exists no confirming data, the State of Texas 2001/02 biennium budget reflected anticipated savings of \$18.3 million total funds (\$7.3 million General Fund) for planned contracting.⁸ It is important to note that all three states have received concerted opposition from the DME and medical supply community, including filing of litigation. To date, no litigation has expressly forbidden competitive bidding.⁹

At the federal level, the federal Centers for Medicare and Medicaid Services has conducted demonstration projects on the feasibility and effectiveness of establishing competitively bid Medicare fees for DME with great success. The demonstration projects were conducted in Polk County, Florida and in Bexar, Comal and Guadalupe counties in Texas. The results of the projects showed overall savings to Medicare of 17 percent to 22 percent and no significant adverse effects on beneficiaries.¹⁰ Most important to California, given recent trends in usage, the projects showed significant declines in usage and the associated costs of oxygen-related items and services, which is shown by Electronic Data Systems, the California fiscal intermediary for Medi-Cal claim payments, as one of the areas of most dramatic DME reimbursement increases for California.¹¹

Strategic purchasing can improve the fight against fraud

Fraud is prevalent in the area of DME due to the potential for quick profits, the relative ease that providers have in obtaining beneficiaries’ eligibility numbers and there being no licensing requirements for providers of DME products. A Florida Statewide Grand Jury Report reported that the Florida Agency Health Care Administration was incurring DME fraud of \$3.5 million annually.¹²



The California Bureau of State Audits, in 1999 suggested that DHS initiate reenrollment of all existing Medi-Cal providers as part of an effort to curtail suspected fraud in Medi-Cal. As DME was considered the highest area of fraud risk, DHS completed reenrollment of all DME providers by the end of FY 2000-2001 and placed a moratorium to suspend further enrollment of DME providers into the Medi-Cal program. There are 848 DME providers enrolled to participate in the Medi-Cal program, which is approximately 500 less than existed prior to the reenrollment exercise and initiation of the moratorium. The contracting via competitive bid for DME services would further dramatically reduce the number of DME providers, thereby consolidating the auditing of providers and allowing for fewer, more in-depth audits to address fraud, and the implementation of activities such as unannounced visits to DME providers to ensure that the providers are a viable business.

Recommendations

- A. The Department of Health Services (DHS), or its successor, should contract for the purchase of all durable medical equipment by competitive bid, with a limited number of providers.**

This strategy will allow for significant savings, known standard costs for durable medical equipment (DME) devices, potential minimization of fraudulent billings and fraudulent providers, and increased ability to audit the universe of Medi-Cal DME providers.

- B. The competitive bid process should stipulate that the winning bids must include a weighted average rate reduction in the products offered of 10 percent, and no product should be offered at a price that is above the rate established within Title 22, California Code of Regulations relating to reimbursement rates for DME.**
- C. The competitive bid process should include all durable medical equipment devices and supplies, including prosthesis and orthotic devices.**
- D. It is imperative that the competitive bid process ensure that Medi-Cal beneficiaries have adequate reasonable access to providers of DME.**

In assuring access, DHS, or its successor, should be directed to specifically address geographical barriers, public transit barriers and hours of service barriers.

- E. DHS, or its successor, should issue a Request For Proposals by September 1, 2004 and award individual contracts by January 1, 2005.**

Staff has already been approved for this task, so the proposed timelines are viable.

Fiscal Impact

The May revision to the FY 2004–2005 Governor’s Budget includes General Fund savings for FY 2004–2005 and an additional savings thereafter for DME contracting. The annual savings figure in the Medi-Cal estimate reflects DHS estimates of a reduced number of DME items that will be competitively bid, and represents a projected 15 percent savings for those items that will be competitively bid. The Governor’s Budget also reflects \$354 thousand in ongoing staffing costs to implement DME contracting.

A greater level of Medi-Cal savings can be generated by implementing a competitive bid process that stipulates that the winning bids must include a weighted average rate reduction in the products offered of 10 percent, and no product shall be offered at a price that is above the rate established within Title 22, California Code of Regulations. The projected savings shown are based on a 10 percent reduction in the pricing of all DME products, using calendar year 2003 total payments of about \$244 million for all DME products as provided by the DHS Fee-For-Service Claim Data Warehouse.¹³

General Fund (dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$3,300	\$0	\$3,300	0
2005–06	\$6,600	\$0	\$6,600	0
2006–07	\$6,600	\$0	\$6,600	0
2007–08	\$6,600	\$0	\$6,600	0
2008–09	\$6,600	\$0	\$6,600	0

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Federal Fund (dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$3,300	\$0	\$3,300	0
2005–06	\$6,600	\$0	\$6,600	0
2006–07	\$6,600	\$0	\$6,600	0
2007–08	\$6,600	\$0	\$6,600	0
2008–09	\$6,600	\$0	\$6,600	0

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.



Endnotes

- ¹ Department of Health Services, "Fiscal Year 2002-03 Budget Change Proposal FLMC-08" (Sacramento, California), p. 2.
- ² Department of Health Services, "Fee-For-Service Claim Data Warehouse: Medi-Cal Fee-For-Service Payments by Provider Type," (Sacramento, California, April 13, 2004).
- ³ Department of Health Services "Fiscal Year 2002/03 DHS Budget Change Proposal FLMC-08," p. 3.
- ⁴ Interview with Paula Patterson, Department of Health Services, Sacramento, California (April 15, 2004).
- ⁵ Interview with Michael Alexander, Fiscal Forecasting Branch, Department of Health Services, Sacramento, California (May 5 and 6, 2004).
- ⁶ Department of Health Services, "Fiscal Year 2002/03 DHS Budget Change Proposal FLMC-08," p. 3.
- ⁷ Florida Agency for Health Care Administration: "Durable Medical Equipment and Supplies Services Request for Proposals AHCA 0203" (Tallahassee, Florida), p. 1.
- ⁸ Texas Performance Review: "Disturbing the Peace, Chapter 6 Fraud, FR2: Ensure Appropriate Use of Medicaid-Funded Services and Equipment" (Austin, Texas, 1996).
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- ¹² Florida Statewide Grand Jury Report, "Medicaid Fraud in the Area of DME" (Tallahassee, Florida, May 6, 1996).
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Maximize Federal Funding by Shifting Medi-Cal Costs to Medicare

Summary

The Medi-Cal program pays for health care for low-income individuals. The Medicare program pays for health care for the elderly and disabled. The federal government pays for a portion of both programs, but pays a larger portion of the costs of health care for people enrolled in both programs. An outreach program should be implemented to more aggressively encourage Medi-Cal beneficiaries to enroll in the Medicare program.

Background

The Medicaid program (called Medi-Cal in California) is a joint federal and state program that pays for health care for low-income people. The federal and state governments each pay about 50 percent of the program costs. The Department of Health Services (DHS) administers the Medi-Cal program. Under state and federal law, Medi-Cal is the “payor of last resort” when a beneficiary has third-party health coverage or insurance.¹ That is, Medi-Cal is only required to pay for the costs that remain after all other insurance carriers have been billed.

Medicare is a federal program providing health insurance to qualified aged, blind and disabled individuals. Medicare eligibility is restricted to those individuals or their family members who have paid taxes into the social security system. Medi-Cal beneficiaries who also are eligible for Medicare are called dual eligibles. Because Medi-Cal is the payor of last resort, Medicare pays for most of the costs of the health care provided to beneficiaries with dual eligibility.

The Social Security Administration (SSA) Retirement, Survivors, and Disability Insurance program, also known as Title II, provides benefits to disabled people, where the individual (or family members) has paid taxes into the social security system.

Benefits of enrolling more Medi-Cal beneficiaries in Medicare

As discussed above, state and federal law require Medicare to pay for health care services provided to beneficiaries with dual eligibility before Medi-Cal is required to pay. Medicare currently pays for about 65 percent of the health care costs for dual eligibles. In January 2006, when Medicare begins paying for prescription drugs, the federal share of health care costs for dual eligibles will increase slightly each year until it reaches approximately 72 percent in 2015. By Fiscal Year 2008–2009, the federal share will be almost 67 percent. Thus, by enrolling a Medi-Cal beneficiary into Medicare, an estimated 15 to 17 percent of the health care costs will be shifted from the state to the federal government.²

Medi-Cal beneficiaries who could be eligible for Medicare

Most Medi-Cal beneficiaries who reach age 65 or those who have been receiving Title II SSA disability benefits for a period of time (depending upon their medical condition) will automatically be eligible for Medicare. Other Medi-Cal beneficiaries under age 65 can get Medicare or SSA Title II disability benefits, if they meet certain criteria. These beneficiaries must have a chronic, permanent disabling disease, be in the country legally, and have paid social security taxes for a certain length of time.³

For example, Medi-Cal beneficiaries diagnosed with End Stage Renal Disease (kidney disease) can qualify immediately for Medicare after the third month of dialysis treatment. Beneficiaries diagnosed with Amyotrophic Lateral Sclerosis (ALS) can qualify for Medicare as soon as they are found eligible for SSA Title II disability benefits.⁴

Medi-Cal beneficiaries diagnosed with other chronic diseases, such as Muscular Dystrophy or Multiple Sclerosis (MS), can qualify for Medicare after receiving SSA Title II disability benefits for two years. Individuals can qualify for up to 12 months of retroactive benefits, so some Medi-Cal beneficiaries potentially could become eligible for Medicare within one year of approval for SSA Title II disability benefits.⁵

Medi-Cal beneficiaries with chronic disabling diseases typically have extremely high health care costs. For example, beneficiaries with End Stage Renal Disease require dialysis treatment, or may require organ transplants, which are very costly. Providing services to beneficiaries with ALS is also a very costly because the only federally approved drug, Rilutek, costs about \$700 a month. Adaptive equipment can be expensive as well. A power wheelchair with tilt and recline features can cost as much as \$17,000. A home health aid for 10 hours a day can cost more than \$30,000 a year.⁶ The table below shows average costs for a number of chronic, permanent disabling diseases.

Diagnosis	Number of Medi-Cal beneficiaries not covered by Medicare	Average monthly cost of health care
End Stage Renal	6,966	\$2,105
ALS	21	\$1,168
Muscular Dystrophy	2,006	\$978
Multiple Sclerosis	2,342	\$688

Source: June 2004 EDS study of Medi-Cal clients diagnosed with ALS, Muscular Dystrophy or MS who are not currently covered by Medicare.

Many Medi-Cal beneficiaries who could qualify for SSA Title II disability or the Medicare program fail to apply for these programs.⁷ They often do not know about these programs or are reluctant to enter into a complex application process. Many of them are not aware that



Medicare reimbursement rates are higher and, therefore, would allow them to see a greater variety of service providers.⁸

The Medi-Cal Reform workgroup findings included a statement that almost 50 percent of those clients who qualify for Medi-Cal on the basis of disability also qualify for Medicare.⁹ In another study, the Lewin Group found that between 20 and 40 percent of Medicaid clients with chronic diseases would become Medicare eligible, if they were to apply.¹⁰

Current program for encouraging Medicare enrollment

The DHS has a competitively-bid contract with Electronic Data Systems (EDS) to process Medi-Cal claims. Each month EDS sends DHS a file of beneficiaries who have received renal services and are not enrolled in Medicare. These beneficiaries are sent a notice explaining that they may be eligible for Medicare. While this is a good start, the program is limited to only one chronic disease and there is no follow up to ensure beneficiaries enroll in Medicare. The DHS conducted one follow-up study and found that about four percent of the beneficiaries who were contacted had become eligible for Medicare.

Public-private partnership proposal

The contract between DHS and EDS allows EDS to propose opportunities for cost savings and receive a share of those savings. EDS has proposed to take the lead in managing a public-private partnership to enroll more Medi-Cal beneficiaries with dual eligibility in Medicare.

The public-private partnership program would be focused on aggressive outreach and follow-up and would include the following elements:

- Contacting all beneficiaries who did not call a toll-free assistance phone number within 30 days of receipt of a notice informing the beneficiary of potential Medicare eligibility.
- Offering to fill out the Medicare application for beneficiaries with information obtained over the telephone.
- Offering to send field representatives to meet with beneficiaries.
- Sending staff to dialysis centers to work with beneficiaries and the nurses assigned to these beneficiaries, since there is a concentration of potential Medicare eligibles at these locations.
- Mailing letters to providers informing them of the benefits of having patients transition to Medicare so providers would encourage their patients to apply.

The DHS is authorized to perform work history data matches with SSA to identify the number of qualifying quarters for a Medi-Cal beneficiary or spouse. The DHS could request work history data matches for the beneficiaries identified by EDS as potential Medicare eligibles. The DHS could then forward that information to EDS to allow them to focus enrollment efforts on those beneficiaries who have the highest probability of becoming Medicare eligible.

Comparison with other states

Other states are beginning to adopt similar strategies to the one suggested above. For example, Washington has implemented a pilot program using state staff to enroll beneficiaries with renal failure and severe developmental disabilities into the Medicare program. Savings estimates are not available at this time but the program seems to be a very promising first step.¹¹

Recommendations

- A. The Department of Health Services, or its successor, should authorize EDS to develop an outreach program to enroll Medi-Cal beneficiaries with a diagnosis of End Stage Renal Disease or ALS into the Medicare program and beneficiaries with Muscular Dystrophy or MS into the SSA Title II disability program. This should be authorized by September 2004.**
- B. The Department of Health Services, or its successor, should discontinue the current program notifying Medi-Cal beneficiaries of the benefits of applying for Medicare, and redirect staff performing this function to other activities within the department.**
- C. The Department of Health Services, or its successor, should submit the file of potential Medicare eligibles to SSA to identify the number of qualified work quarters and provide this information to EDS. If a beneficiary is married and the spouse's Social Security Number is on file, DHS should also send a request to SSA for the spouse's work history. This procedure should be implemented by December 2004.**
- D. The Department of Health Services, or its successor, should establish metrics to evaluate the effectiveness of this outreach program. The data should be used to determine whether to extend the period in which EDS can share the savings beyond the two-year time frame specified in the contract, whether to staff the outreach program with state staff, or whether to discontinue the outreach program. These metrics should be established by April 2005.**
- E. The Department of Health Services, or its successor, should determine, by August 2005, whether the Medicare outreach program should be expanded to include other high-cost Medi-Cal beneficiaries.**

Fiscal Impact

The state can avoid paying more than \$3 million in Medi-Cal program costs for beneficiaries with high-cost chronic diseases by working with EDS to enroll eligible clients in the federal Medicare program. The fiscal estimate is based on actual paid claims for persons with either of four chronic diseases for the years 2002 and 2003. Adjustments have been made to reflect the fact that a small number of these clients already apply for Medicare benefits. To be



conservative, the lowest estimated rate for the percentage of these clients who would be eligible for Medicare was used.

The federal government pays 50 percent of the health care costs for clients who are eligible for Medi-Cal. Based on actual paid claim figures dollars, the federal government pays 65 percent of the health costs for clients who are eligible for both Medi-Cal and Medicare. When prescription drugs are covered by Medicare, beginning in January 2006, the percentage of health care costs covered by the federal government will increase slightly each year (until the federal share reaches approximately 72 percent in 2015).

There will be costs to the state associated with enrolling these clients in Medicare. EDS will receive 10 percent of any program savings. The state will pay for the monthly Medicare premiums (currently about \$53.60 per month from the General Fund) so that Medicare will pay for all inpatient and outpatient services. There will also be costs for advertising, travel, and other administrative support costs.

This recommendation would not require legislation and no benefits will be realized until after the planning has been completed, clients have been contacted, and the federal government has processed the applications.

General Fund
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004-05	\$0	\$0	\$0	0
2005-06	\$5,303	\$1,826	\$3,477	0
2006-07	\$6,681	\$2,857	\$3,824	0
2007-08	\$8,171	\$3,334	\$4,837	0
2008-09	\$10,405	\$4,015	\$6,390	0

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003-04 expenditures, revenues and PYs.

Endnotes

- ¹ Welf. & Inst. C. Section 14124.90; and the Social Security Act, Section 1902(a)(25).
- ² EDS, "Medicare Transition Program" (Plano, Texas, March 2001), p. 1; and interview with Kevin Gorospe, chief, Pharmacy Benefits, Department of Health Services, Sacramento, California (June 14, 2004).
- ³ Medicare: The Official U.S. Government Site for People With Medicare, "Medicare Eligibility Tool," <http://www.medicare.gov/MedicareEligibility/home.asp?dest=NAV%7CHome%7CGeneralEnrollment&version=alternate&browser=IE%7C6%7CWin2000&language=English> (last visited June 11, 2004); and interview with April Williams, Center for Medicaid and Medicare Region IX, San Francisco, California (May 26, 2004).
- ⁴ Social Security Online, "Answers To Your Questions," http://ssa-custhelp.ssa.gov/cgi-bin/ssa.cfg/php/enduser/std_adp.php?p_faqid=164 (last visited June 11, 2004).
- ⁵ E-mail from Rosalyn Echols, Social Security Administration to California Performance Review (May 25, 2004). Rosalyn Echols of SSA stated in an e-mail that many claims for disability benefits have some retroactivity because people file after they become disabled and many file after other public and private disability benefits have been exhausted. In addition, retroactivity is typically granted back to the date of application. Ms. Echols stated that statistical information on the amount of retroactive benefits is available through Freedom of Information requests, but not readily available in the SSA Regional office.
- ⁶ ALS Survival Guide, "Is ALS an Expensive Disease?" http://www.lougehrigsdisease.net/als_what_is_als.htm (last visited June 11, 2004).
- ⁷ Henry J. Kaiser Foundation, "State Health Facts Online," <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicare&subcategory=Beneficiaries&topic=As+Percent+of+State+Population> (last visited June 11, 2004). There are only three states (Alaska, Tennessee and Utah) that have a lower percentage of Medicare recipients than California.
- ⁸ EDS, "White Paper on the Medicare Transition Program" (Plano, Texas), p. 1.
- ⁹ Department of Health Services, "Medi-Cal Redesign: Improvement and Cost Saving Suggestions," http://www.medi-calredesign.org/pdf/elig_Improvement_and_Cost_Savings_Sugg.doc (last visited June 18, 2004), p. 3.
- ¹⁰ The Lewin Group, "Medicaid Cost Containment in Washington State," http://www.lewin.com/Lewin_Publications/Medicaid_and_S-CHIP/WashMedicaidCostContainment.htm (last visited June 11, 2004).
- ¹¹ E-mail from Carol McCrae, program manager, Medicare Savings Program, Washington Department of Social and Health Services to California Performance Review (June 2, 2004).



Automate Identification of Other Health Coverage for Medi-Cal Beneficiaries

Summary

The process used to identify Other Health Coverage (OHC) for Medi-Cal beneficiaries is manual and paper intensive, causing huge backlogs and lost opportunities to avoid expenditures by the Medi-Cal program. In addition, the current process does not capture all OHC information for Medi-Cal beneficiaries. The state should automate this process to improve its accuracy and capture savings.

Background

The Medi-Cal program is California's version of the federal Medicaid program that provides health coverage to more than 6.5 million public assistance and low income beneficiaries. State law requires Medi-Cal applicants to provide information about their entitlement to OHC when they apply for Medi-Cal. Federal law requires Medi-Cal to be the payer of last resort; however, eligibility for OHC does not disqualify an individual for Medi-Cal. Providers must bill OHC or Medicare for services rendered before billing Medi-Cal. Medicare is the federal health insurance program offered to anyone over age 65 and individuals who are blind or disabled that meet certain federal rules. Medicare provides coverage for hospital inpatient services, some nursing home services and limited coverage of drugs. Medicare coverage of drugs will be expanded significantly beginning in 2004–2005.¹

When a Medi-Cal beneficiary has OHC, typically they have medical coverage from commercial health plans, private health insurance, or other types of medical insurance. Some OHC covers all medical services or excludes certain services, such as drugs or obstetrics. Medi-Cal can only be billed for services that the OHC or Medicare will not pay for. Approximately 5 percent of the Medi-Cal population is eligible for commercial or private health plan coverage.² An additional 14 percent is eligible for Medicare. The average amount saved by Medi-Cal for every beneficiary identified with OHC is \$117 per month.³ With almost 20 percent of the Medi-Cal population having either Medicare or commercial health plan coverage, it is very important that the Department of Health Services (DHS) be accurate and timely in tracking this information to avoid Medi-Cal expenditures. However, the existing method used to identify OHC is slow and untimely, resulting in erroneously paid health service claims or premium payments to Medi-Cal managed care plans.

Manual process to report OHC

DHS records OHC information for Medi-Cal beneficiaries in the Medi-Cal Eligibility Data System (MEDS) via a manual process that was set up decades ago before the advent of current computer technology. MEDS is the database of Medi-Cal eligibility records maintained by DHS. County welfare departments process Medi-Cal applications and are required to complete a form that identifies any OHC. The form is sent to DHS and manually keyed into MEDS. When MEDS has an OHC indicator on the beneficiary record, claims from providers are rejected, thus avoiding significant expenditures for the Medi-Cal program. Providers are also able to access MEDS prior to rendering services, so they can identify beneficiary eligibility for OHC or Medicare to bill accordingly.

Automated reporting of OHC

In addition to people who apply for Medi-Cal in county welfare offices, other individuals eligible for federal supplemental security income or Medicare programs are also eligible for Medi-Cal. Medicare and OHC for these recipients are recorded in a database maintained by the federal Center for Medicare and Medicaid Services, which sends a monthly tape that reports recipient Medicare and OHC. DHS runs the monthly tape against MEDS to update eligibility records. DHS uses this electronic process to identify supplemental security income and Medicare beneficiaries whose claims should be billed to Medicare or OHC. Medi-Cal avoids expenditures of more than \$4 billion annually due to Medicare eligibility. Only \$80 million of the \$4 billion in avoided expenditures is due to OHC. Currently, the bulk of cost avoidance savings is Medicare eligibility.⁴

A good comparison for automated reporting of OHC is the State of New York, which has a large Medicaid population of more than 4 million. New York's 58 counties record OHC when eligibility is processed at application. The state also contracts with Public Consulting Group to initiate billings and perform monthly data matches with over 100 carriers and Medicare.⁵ This electronic updating of their Medicaid eligibility database results in a higher volume of eligibility file updates for OHC on a timelier basis. The state reports annual cost avoidance of \$4 billion and recoveries of \$60 to \$70 million.⁶

Problems caused by the manual operation to report OHC

DHS' manual operation to record OHC or changes to OHC (loss of eligibility for commercial/private health coverage) is staffed by 23 employees who input data on the OHC forms received from the county welfare departments. DHS receives from 2,000 to 5,000 forms in the mail per week. There is a constant backlog of unrecorded forms, typically from four to six months. This four to six month gap in keying OHC updates to MEDS results in significant expenditures for the Medi-Cal program.⁷ In addition, newly acquired OHC is often never reported by existing Medi-Cal beneficiaries and there is no automated process in place to capture this information.



When the MEDS record has not been updated with an OHC indicator, DHS will erroneously pay provider claims for beneficiaries with OHC. Conversely, beneficiaries who have lost OHC can experience access-to-care problems if the OHC indicator has not been removed from MEDS. Nine employees staff a toll-free line to take calls on access-to-care problems caused by OHC changes not reflected on MEDS. Some of these calls also relate to unreported Medicare eligibility.

Dual enrollment in Medi-Cal managed care

Medi-Cal applicants who reside in counties with Medi-Cal managed care plans must enroll in one of the contracted health plans. The Medi-Cal program contracts with MAXIMUS to perform the enrollment function for Medi-Cal managed care. Per regulations, if an applicant has OHC, the enrollment contractor may not enroll that applicant into a Medi-Cal managed care plan.⁸ If MEDS does not reflect OHC because of the backlog of unrecorded forms, however, MAXIMUS initiates enrollment into a Medi-Cal managed care plan. DHS has not implemented a process to disenroll a managed care enrollee who has OHC. Dual enrollment of Medi-Cal applicants with OHC into Medi-Cal managed care plans causes significant expenditures by Medi-Cal for monthly premiums to managed care plans.

An edit was designed in MEDS to automatically initiate disenrollment from a Medi-Cal managed care plan whenever the beneficiary record indicated OHC; however, it was never turned on.⁹ DHS expends substantial sums in monthly premiums to Medi-Cal managed care plans for beneficiaries who already have OHC. In Fiscal Year 2002–2003, almost 1 million member months were paid in premiums to Medi-Cal managed care plans for beneficiaries with OHC.¹⁰ Based on current monthly premium rates, this costs the state more than \$90 million annually.¹¹

Efforts to recover claims paid

DHS contracts with Health Management Systems (HMS), on a contingency fee basis, to initiate data matches and billings to commercial health plans. The billings are initiated to recover claims erroneously paid by Medi-Cal because of the backlog for recording OHC on MEDS. HMS is allowed to keep up to 15 percent of any amount recovered. For a claim that was erroneously paid, HMS initiates a billing and data match with the carrier to provide updated OHC information to MEDS. The level of recovery for erroneously paid claims is very low. Less than \$8 million per year is recovered or only 4 percent of the billings.¹² Commercial health plans reject the billings primarily due to untimely filing of the claim, unauthorized services by the health plan or absence of electronic billing. Currently, HMS has not been requested by DHS to initiate monthly data matches for all carriers or Medicare.

DHS' Third Party Liability Branch has been meeting with a county consortium for more than five years to try to automate the OHC identification process. There has been very minimal success in receiving OHC data electronically from counties. Files received from two of the existing county systems have had poor data quality. There are four different platforms and up

to 19 different eligibility systems in the 58 counties.¹³ The numerous county systems have made it difficult to secure cooperation and recognition of this data exchange as a priority. In addition, DHS' Information Technology Division has had no resources to devote to development of an electronic process for OHC identification.

Recommendations

A. The Department of Health Services, or its successor, should develop a process to record OHC electronically.

To fast-track this recommendation, the Health and Human Services Agency should expand the scope of work for the contingency fee contractor, HMS, to require initiation of data matches on a monthly basis with all carrier files as well as with the Medicare eligibility file. Timelier recording of OHC would eliminate the four to six month backlog of unrecorded OHC forms, decrease erroneously paid health service claims and reduce phone calls from beneficiaries experiencing access-to-care problems.

B. The Department of Health Services, or its successor, should initiate a process to disenroll Medi-Cal managed care beneficiaries who have OHC.

Significant savings will result from discontinuance of payment of monthly premiums for approximately 76,000 beneficiaries with OHC currently enrolled in Medi-Cal managed care plans.

Fiscal Impact

Directing the HMS contractor to initiate monthly data matching to identify OHC will record OHC electronically and eliminate the six month backlog of unrecorded OHC forms. Timelier reporting of OHC and reduction of erroneously paid claims should reduce Medi-Cal beneficiary costs by an estimated \$10 million per year.¹⁴ The HMS contractor will be paid a 15 percent contingency fee, resulting in an estimated cost of \$1.5 million per year. Funds are 50 percent federal and 50 percent general fund.

The immediate disenrollment of managed care beneficiaries who have OHC results in the disenrollment of approximately 76,000 beneficiaries with OHC.¹⁵ The estimated reduction in Medi-Cal beneficiary costs is \$45 million per year. Funds are 50 percent federal and 50 percent general fund.

Additional savings of \$200,000 result from a reduction of nine staff that process the OHC forms and respond to phone calls to the WATS line. With implementation of monthly data matching to identify OHC, the volume of forms and phone calls is anticipated to be reduced by one-third. OHC staffing is funded at 75 percent federal and 25 percent general fund.



General Fund
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	0
2005–06	\$27,550	\$750	\$26,800	(4.5)
2006–07	\$27,550	\$750	\$26,800	(4.5)
2007–08	\$27,550	\$750	\$26,800	(4.5)
2008–09	\$27,550	\$750	\$26,800	(4.5)

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Other Fund
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	0
2005–06	\$27,650	\$750	\$26,900	(4.5)
2006–07	\$27,650	\$750	\$26,900	(4.5)
2007–08	\$27,650	\$750	\$26,900	(4.5)
2008–09	\$27,650	\$750	\$26,900	(4.5)

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Endnotes

- ¹ Interview with Bud Lee, chief, Pharmacy Section, Medi-Cal Policy, California Department of Health Services, Sacramento, California (April 2, 2004).
- ² Interview with Loretta Wallis, chief, Fiscal Analysis and Estimates Section, California Department of Health Services, Sacramento, California (March 8, 2004).
- ³ Interview with Alan Muck, chief, Other Health Coverage, California Department of Health Services, Sacramento, California (May 20, 2004).
- ⁴ Interview with Jeff Kemp, chief, Health Insurance Section, California Department of Health Services, Sacramento, California (March 25, 2004).
- ⁵ Interview with Robin Johnson, health program administrator, New York Department of Health, New York (May 3, 2004).
- ⁶ Interview with Jeff Flora, deputy director, New York State Bureau of Revenue Initiatives and Fraud, New York (May 11, 2004).
- ⁷ Interview with Alan Muck, Sacramento, California (March 10, 2004).
- ⁸ California Code of Regulations, Title 22, Section 53891(a)10.
- ⁹ Interview with Pete Olsen, senior information systems analyst, Information Technology Division, California Department of Health Services; and interview with Mary Menz, policy section chief, Medi-Cal Managed Care Division, California Department of Health Services, Sacramento, California (May 20, 2004).

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- ¹⁰ *E-mail from Jim Klein, research specialist, Medical Care Statistics Section, California Department of Health Services to the California Performance Review, Sacramento, California (May 20, 2004).*
- ¹¹ *California Department of Health Services, Medi-Cal Managed Care Division, "Monthly Report of Current Capitation Rates" (Sacramento, California, April 2004).*
- ¹² *Interview with Alan Muck.*
- ¹³ *Interview with Christine Dunham, assistant director, System Integrations Division, California Health and Human Services Agency Data Center, Sacramento, California (April 12, 2004).*
- ¹⁴ *Interview with Alan Muck.*
- ¹⁵ *Interview with Jim Klein.*



Improve Integrity in Medi-Cal Through the Use of Smart Cards

Summary

The annual cost of fraud and abuse in the Medi-Cal program is in the billions of dollars. Smart cards can validate the identity of a Medi-Cal beneficiary, ensure a service is authorized and prove that both the provider and the beneficiary were actually present for a claimed Medi-Cal service. This technology could greatly reduce fraud and abuse in the Medi-Cal program by identifying potential fraud and abuse before a claim is paid.

Background

Medicaid is a joint federal and state program that pays for health care for low-income people. In California, the Medicaid program is called Medi-Cal. The Department of Health Services (DHS) has primary responsibility for administering the Medi-Cal program. Most providers of health care services to Medi-Cal beneficiaries are fee-for-service providers who receive payment for each authorized service provided. The total budget for Medi-Cal in Fiscal Year 2003–2004 is \$28.7 billion; of this amount, Medi-Cal fee-for-service costs are projected to be \$18.3 billion.¹

Several recent reports estimate the annual amount of fraud and abuse in the Medi-Cal program is between \$1.8 and \$3 billion.² In response to a 2003 report by the Bureau of State Audits, DHS plans to complete an error rate study by late 2004 that will measure the amount of major types of Medi-Cal fraud and abuse. The State of Texas has completed a similar study; error rates for certain categories of fraud from the Texas study were used for estimating certain subsets of fraud and abuse in the Medi-Cal program.³

California has taken steps to detect potential fraud before paying claims, but most of the antifraud effort is focused on paid claims. The Center for Medicaid and Medicare Services (CMS), the federal agency that oversees the Medi-Cal program, has estimated denying claims prior to payment yields from five to 15 times more savings than attempting to recover overpayments based on a post-payment review.⁴ CMS has authorized a 75 percent federal match for many Medi-Cal antifraud activities. Implementation of smart cards to detect fraud prior to paying claims is expected to qualify for the 75 percent federal match.

Smart cards are identification cards with an embedded computer chip that can be an effective tool to identify Medi-Cal fraud and abuse prior to paying claims from fee-for-service providers. Smart card technology is more than 30 years old.⁵ Similar to many technologies, the

cost has decreased over time and smart cards have become a cost effective solution for a variety of applications. In 2001, the Datacard Group stated, "Smart cards have progressed so much in the past five years that they are now small versions of our desktop computers."⁶ In 2003, smart card manufacturers shipped over 1 billion cards to be used for many purposes including health care, mobile phones, satellite television, financial, physical access, electronic tolls and drivers' licenses.⁷

Commercially available computer chips range in size and cost. A card costing about \$3 can store beneficiary demographic information, biometric information (such as one or more fingerprints), health information (emergency information, prescriptions, referrals, lab results, immunizations, appointments, etc.), security information and stored cash value amounts to facilitate beneficiary co-payments.⁸

The State of Texas recently implemented a pilot project with vendors implementing smart card solutions to detect potential fraud and abuse.⁹ California would need to use a similar approach. When a beneficiary is determined eligible for assistance, the state issues a smart card with information about the beneficiary, such as the name and birth date. When the beneficiary goes to a provider participating in the pilot, finger image information is added on the card. Because fingerprints are not reliable indicators for either children or very elderly persons, a fingerprint from one or both parents or guardians is used. When the beneficiary goes to a provider for service, a smart card reader validates the beneficiary's (or the parent's or guardian's) identity and records the check-in time. After the service has been provided, the beneficiary's check-out time is recorded. The provider also must use a smart card check-in/check-out to authenticate his or her identity and to validate that he or she is a valid Medicaid provider.¹⁰

Potential fraud prevention

The use of smart cards could have a significant effect on certain types of Medi-Cal fraud and abuse by identifying potential fraud and abuse prior to the payment of a claim.



Type of fraud	Estimated Annual Cost	Description
False claims	More than \$400 million ¹¹	Billing for services that were not actually provided (referred to as “phantom claims” in Texas reports.)
Claims for services to deceased beneficiaries	\$3 million ¹²	Billing for alleged services for deceased persons.
Card swapping	Unknown	Loaning cards to ineligible persons; selling ID to fabricate claims; using stolen card to obtain services.
Misrepresenting service dates	Unknown	Fraudulent reporting of service dates to allow a Medi-Cal beneficiary who was not eligible on the date that the service was actually provided.
Provider number stolen	Unknown	Stolen provider numbers are used to bill for services for which the authorized provider is unaware.

Other benefits of smart cards

The additional functionality available on smart cards is determined by the size and cost of the embedded chip.

- Smart cards can give authorized providers immediate access to certain beneficiary health information. This would be especially helpful for certain vulnerable groups served by the Medi-Cal program, particularly children in foster care, who may move from location to location and thus doctor to doctor. Similarly, there could be a significant benefit for emergency care or other instances when a beneficiary is seeing a new provider and is not able to provide or communicate pertinent medical information.
- Smart cards can be programmed to detect whether a proposed medication is either not on the Medi-Cal list of approved medications, not consistent with the diagnosis, not age-appropriate or contraindicated based on the beneficiary’s other medications, food allergies or other chronic conditions.
- Smart card technology could enable the state to offer a single card for both Medi-Cal and electronic benefit transfer services, such as the Women, Infants, and Children (WIC) Supplemental Nutrition program, Food Stamps, or CalWORKs/TANF, since smart cards can be programmed to be ATM-enabled.¹³
- Smart cards could allow beneficiaries to review their benefits, health information and appointment schedules or to print an immunization certificate as done in the Western Governors Association Health Passport project.¹⁴
- Smart cards can be programmed to serve as a source for data transmission between providers, pharmacies and labs. This would speed up service to the beneficiary and reduce the number of incorrect prescriptions and lab tests. It has been estimated that 98,000 Americans die each year as a result of preventable errors. The most common error is incorrect dosages or types of medication given to patients.¹⁵

Potential concerns about smart cards

Fingerprinting has become more commonplace and is now required for a driver's license and for various professions, including teachers, doctors, lawyers, coaches and certified public accountants. Despite the prevalence of fingerprinting, beneficiary advocacy groups may still object to the fingerprinting component of the smart card process because Medi-Cal beneficiaries would have their prints validated on every provider visit.

Medi-Cal providers also may have concerns about fingerprinting. It will take extra time for office staff to collect fingerprint information at the beneficiary's initial visit (estimated at two to three minutes) and to validate the fingerprint information at subsequent visits (estimated at one minute).¹⁶ Some providers may be concerned about loading additional software onto their office computers. Others may be concerned about the space requirements for the additional associated devices.¹⁷

Recent experiences with smart cards by other government organizations

- Texas is currently piloting a smart card/biometric match for the Medicaid program. The Front End Authentication and Fraud Prevention pilot runs through December 2004.¹⁸
- Puerto Rico is storing beneficiary health information on smart cards, which beneficiaries give to providers when requesting service. Providers update the cards to reflect the service provided.¹⁹
- The New England PARTNERS Project is a joint initiative of the States of Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont in cooperation with the U.S. Department of Agriculture's Food and Nutrition Service to develop and implement a hybrid card-based (the card contains both a magnetic stripe and smart card chip) delivery system to meet service and benefit needs of participants from a variety of public health and human service programs.²⁰
- The Western Governors Association sponsored the Health Passport project, which used smart cards to capture and share health information.²¹
- Several countries, including France, Germany and Taiwan have implemented national smart card health systems.²² The European Union (EU) plans to issue a common EU health card using smart cards in the future.²³
- The U.S. government has used smart card technology for debit cards and for identification cards. There are plans to add health information on cards issued to military personnel.²⁴

Recommendations

- A. Within 90 days of the publication of the Medi-Cal error rate study, the Department of Health Services, or its successor, should analyze the findings to determine whether the use of smart cards could be effective for preventing or mitigating Medi-Cal fraud and abuse. If the analysis demonstrates that smart cards would be cost effective, the following recommendations should be implemented.**



- B. The Governor should work with the Legislature to modify the California Welfare and Institutions Code Section 10830.²⁵**
- C. Within 60 days from the approval of the state legislation, the Department of Health Services, or its successor, should submit a change to the Medicaid State Plan for California, requesting federal approval of 75% federal funding for the development, operation, and maintenance of smart cards for the Medi-Cal program.²⁶**
- D. Within 30 days of completing the error rate analysis, the Department of Health Services, or its successor, should assess the success of the Texas pilot and specifically identify how Texas dealt with implementation issues, such as issuing cards on behalf of children.**
- E. Within 60 days of the completion of the analysis in recommendation D, the Department of Health Services, or its successor, should develop an implementation plan to install smart cards in the Medi-Cal program, including a feasibility study report and a plan to procure a vendor.**

Implementation would include all services where a beneficiary or a beneficiary's representative must be present for the beneficiary to receive the service.

- F. The Department of Health Services, or its successor, should implement the use of smart cards on an incremental basis, rather than implementing statewide. This will allow the state to resolve problems before there is any significant investment.²⁷**
- G. After the vendor contract is awarded, the Department of Health Services, or its successor, should establish an executive steering committee to establish a governance structure for this project. Members should include individuals from both the provider community and beneficiary advocacy groups.**

Fiscal Impact

Estimates of fraud and abuse in the Medi-Cal program range from \$1.8 billion, estimated by the California Legislative Analyst's Office (LAO), to \$3 billion, estimated by the California Office of the Attorney General.²⁸ Utilizing smart card technology could reduce the amount of fraud and abuse in the Medi-Cal program by an estimated \$130 million (\$65 million General Fund). These estimated savings are based on the experiences in Texas and the LAO estimate of fraud and abuse.

Significant upfront costs to implement this system would be required. The state would need to provide smart card readers or other hardware to most of the 140,000 active Medi-Cal providers.²⁹ The state would need to provide smart cards to all Medi-Cal clients (or their parent(s) or guardians) who are not enrolled in managed care plans. There will be costs

associated with vendor development, state oversight, policy changes, and provider relations. The total one-time costs could be more than \$50 million. Similar to Texas, the state would request 75 percent federal funding for the costs of this system.³⁰ The estimated General Fund share of the one-time costs would be about \$13 million.

The ongoing annual costs to replace or augment devices in providers' offices, to replace or issue new smart cards, for vendor maintenance costs (including software licenses), and for state support is estimated to be \$20 million (approximately \$5 million GF).

When smart card technology is fully operational in Fiscal Year 2008–09, the state could realize net annual savings of \$100 million (approximately \$60 million GF). Federal impact cannot be estimated at this time.

General Fund
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	Change in PYs
2004–05	\$0	\$75	(\$75)	0.75
2005–06	\$0	\$3,375	(\$3,375)	1.5
2006–07	\$5,328	\$5,336	(\$8)	1.5
2007–08	\$30,983	\$7,847	\$23,136	1.5
2008–09	\$63,966	\$5,969	\$57,997	1.5

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Endnotes

- ¹ Department of Health Services, "Medi-Cal May 2004 Local Assistance Estimate for Fiscal Years 2003–04 and 2004–05," Sacramento, California, May 2004.
- ² California Legislative Analyst's Office, "2004–05 Analysis of the Health and Social Services Budget" (Sacramento, California, February 2004), p. C-112; and California Office of the Attorney General, "Attorney General Lockyer and Legislators Unveil Bi-Partisan, 10-point Plan to Fight Medi-Cal Fraud," Sacramento, California, April 21, 2004. (Press Release).
- ³ Texas Comptroller of Public Accounts, "Medicaid Fee-for-Service-Study, Appendix, Table A16," "Texas Health Care Claims Study" (Austin, Texas, March 2003), <http://www.window.state.tx.us/specialrpt/hcc2003/section1/app1.pdf> (last visited June 18, 2004).
- ⁴ U.S. Department of Health and Human Services, "Synopsis of Proceedings, Combating Health Care Fraud and Abuse: Technologies and Approaches for the 21st Century," p. 2. (Crystal City, Virginia, June 26–28, 2000), <http://www.cms.hhs.gov/states/fraud/tech1.pdf> (last visited June 18, 2004).



- ⁵ Steve Petri, "Introduction to Smart Cards" (Reston, Virginia, December 1998). http://www.spsolutions.com/solutions/whitepapers/introduction_to_smartcards/?page= (last visited June 19, 2004).
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- ⁷ Smart Card Alliance, "HIPAA Compliance and Smart Cards: Solutions to Privacy and Security Requirements" (Princeton, New Jersey, September 2003), p. 12.
- ⁸ E-mail from Robb Miller, RMC Consulting, to the California Performance Review, Sacramento, California (April 19, 2004).
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- ¹⁰ eMedicalFiles, "eMedicalFiles System, Product Overview," Sacramento, California, April 9, 2004. (Presentation)
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- ²⁷ There are currently eight California counties in which virtually all Medi-Cal beneficiaries are in managed care plans. Smart cards would not be issued to beneficiaries in these counties.
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Redirect Medi-Cal Hospital Disproportionate Share Payments from Hospitals that are not Providing Core Medi-Cal Services

Summary

The state should redirect payment for hospital inpatient services for Medi-Cal to hospitals providing core Medi-Cal services to low-income Californians, and to hospitals making credible plans to achieve seismic safety requirements.

Background

Most California hospitals provide core Medi-Cal services to low-income Californians including emergency room services, obstetrical care, and neo-natal intensive care units. However, there are some hospitals receiving “Disproportionate Share Funding” (DSH) that are not providing these critical services.¹ DSH funding consists of county or university funds matched with federal funds in the Medi-Cal program.

Hospitals receive payment from Medi-Cal through multiple funding sources. These funding sources include the following:

- Selective provider contracting through the California Medical Assistance Commission (CMAC) for fee-for-service payments;
- Discretionary emergency services Disproportionate Share Funding (DSH) funding through CMAC, as authorized by Senate Bill 1255;
- DSH payments based on a formula that requires a minimum of 25 percent of a hospital’s inpatient days be Medi-Cal patients or a sufficient portion of the hospital revenue be Medi-Cal or charity care;
- Payments from managed care local initiative and commercial health plans which negotiate insurance premiums with the Department of Health Services;
- Payments from managed care commercial health plans delivering services in the Geographic Managed Care counties of Sacramento and San Diego with contracts that are negotiated by CMAC; and
- Payments from managed care county organized health systems that negotiate with CMAC.²

Not counting revenue from Medi-Cal managed care health plans, payments by Medi-Cal—including DSH—for inpatient hospital services are \$7.6 billion for Fiscal Year 2003–2004.³

The policy goal of DSH payments to hospitals is the maintenance of critical hospital services for low-income patients. With the multiplicity of payment streams from Medi-Cal, and the negotiation of managed care premiums from two different state agencies, there is no single entity that is charged with, or even aware of, the total reimbursement from Medi-Cal funding sources for specific hospitals. Self-reported hospital data to the Office of Statewide Health Planning and Development (OSHPD) indicate that some private for-profit hospitals that do not deliver high priority Medi-Cal services such as emergency, obstetrical, or neo-natal intensive care units have significant revenue from the Medi-Cal program by qualifying for DSH payments.⁴

The consequences of not focusing on total Medi-Cal reimbursement from the various sources is aggravated by the advent and growth of Medi-Cal managed care. As fee-for-service Medi-Cal payments decline with increased managed care enrollment, the relationship of hospital Medi-Cal managed care payments to DSH gains in significance because managed care hospital days increase as a portion of the universe of total hospital days.⁵

The number of days and payments from Medi-Cal managed care health plans are gathered by the Medi-Cal Rates Branch to calculate hospital qualification for DSH.⁶ Managed care health plan revenue to hospitals is not considered in developing other negotiated rates for hospitals.

There are core hospital services that are critical to the Medi-Cal population and to the population at large. Among these services are emergency room services, obstetrical services, and neo-natal intensive care services. In addition, the retrofitting of hospital infrastructure to meet seismic safety standards is a looming significant capital cost to hospitals in California with a requirement to meet these standards by January 1, 2008, with the potential to receive an extension from OSHPD to 2013.⁷

Medi-Cal revenue should be directed to those hospitals that provide the desirable core services and which are likely to make the capital investment necessary for seismic safety retrofitting. Hospitals that do not provide the desirable core services and which do not intend to make the seismic safety investment are not the hospitals that should be receiving enhanced funding from Medi-Cal through the various Medi-Cal hospital funding streams. There are currently non-profit private hospitals that do not receive DSH funding, yet these hospitals are providing core Medi-Cal services at a loss and these hospitals are making credible plans to meet seismic safety requirements.

Recommendation

The Governor should work with the Legislature to amend Disproportionate Share Funding (DSH) statutes to give the California Medical Assistance Commission (CMAC), or its successor, the authority to discontinue DSH payments to hospitals that do not provide desirable core hospital services, or hospitals that are not developing credible plans to meet seismic safety requirements.



Fiscal Impact

This recommendation does not result in a fiscal impact to the state. Disallowing DSH payments to hospitals that are not providing core Medi-Cal hospital services would have a negative impact on those hospitals' revenue.

Endnotes

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- ² California Medical Assistance Commission (CMAC), "Description of Programs Administered Within the Commission," (Sacramento, California, January 2004).
- ³ California Department of Health Services, "Medi-Cal November 2003 Local Assistance Estimate for Fiscal Years 2003–04 and 2004–05" (Sacramento, California, November 2003).
- ⁴ Good Samaritan Hospital, "Request for Equitable Medi-Cal Reimbursement."
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Centralize Medi-Cal Treatment Authorization Process

Summary

The Department of Health Services has eight Medi-Cal field offices located throughout the state to process treatment authorization requests. These field offices, which were established prior to the advent of modern technology, are no longer necessary to effectively deliver services. The state could realize significant savings by consolidating these field offices into one regional processing center.

Background

Centralizing TARs processing

The Medi-Cal program is California's version of the federal Medicaid program that provides health coverage to more than 6.5 million public assistance and low income beneficiaries. State law requires Medi-Cal health care providers to submit treatment authorization requests (TARs) to obtain authorization for reimbursement for specific procedures and services.¹ The Department of Health Services' (DHS) Medi-Cal Operations Division processes the TARs in eight field offices spread throughout the state. Facility costs for the field offices are more than \$8.6 million.² DHS has about 160 employees in these eight field offices to process TARs.

In addition, the field offices provide office space to about 300 nurses who perform medical case management reviews on high cost beneficiaries. Although the two functions have been co-located for quite some time, the case management function is completely separate from the TAR processing function and could be separated with no effect on either. Furthermore, since the case management nurses spend most of their time at the health facilities or homes where the patients reside, their need for office space is minimal. Eliminating the need to provide office space for case management nurses would allow DHS to centralize TARs processing operations into one location, thus eliminating up to seven field office locations. This would allow the state to realize significant savings in facility costs.

Automating TARs processing

Processing TARs in remote field locations was set up decades ago when computers, faxes and current technology did not exist. The process is manual and paper intensive. TARs are primarily submitted via fax, mail or hand delivery. Even though the method for processing TARs has not changed, the volume of TARs has increased significantly over the past three years, led by a surge in drug prescriptions. The volume of TARs is now at more than

3.7 million annually, with 60 percent of those for drugs.³ TAR processing time typically averages between 24 to 48 hours for drugs and five to 10 days for medical services.⁴ A delay in TAR processing causes a delay in provider reimbursement.

Field offices manage their backlogs by shipping the TARs to another field office with lower volume. Employees working in the eight different offices often struggle with consistently applying TAR review criteria and keeping up with the large volume. Inconsistent application of review criteria causes inequities when one office approves a TARs and another office denies it for the same service. The high cost of living in some of the field office locations and civil service salary levels also makes recruitment of clinical personnel difficult.

DHS initiated a pilot project over the past three years to test online adjudication of both medical and drug TARs. The Service Utilization Review Guidance and Evaluation (SURGE) system that evolved from the pilot project, also referred to as e-TARs, will allow providers to input and submit TAR information via the Internet. Online submission of TARs will enhance timeliness of receipt and approval. DHS is adding only the smaller pharmacy providers to the e-TAR system at this time. Large volume pharmacy providers such as retail pharmacies are already connected to point-of-service devices that will eventually allow submission of TARs online. Point-of-service devices currently allow providers to verify beneficiary's Medi-Cal eligibility.

Statewide implementation of SURGE online adjudication has been delayed until July 2005. The delay was due to major system revisions required to implement the Health Insurance Portability and Accountability Act requirements for electronic transmission of health-related data. An enhancement to the point-of-service network to accommodate high volume submission of TARs was also necessary.⁵

Recommendations

A. The Department of Health Services, or its successor, should centralize treatment authorization request (TARs) field office operations.

Centralization of TARs processing would result in significant savings in facility costs; improve communication among field office staff to promote consistency on TAR decisions; and reduce labor costs by consolidating data entry, filing, retrieval and scanning of online submission of TARs.

B. The Department of Health Services, or its successor, should ensure adequate resources are devoted to automating the TAR process as scheduled for July 2005.

Automation of the TARs process will improve customer service by enhancing timeliness of TAR receipt/approval and reimbursement to providers.



C. The Department of Health Services, or its successor, should adopt telecommuting procedures for medical case management nurses currently located in TAR field offices.

Medical case management nurses already spend much of their time at health facilities or patients’ homes. Telecommuting and using existing technology, including laptop computers and web-based medical reviews, would eliminate the need to continue to provide office space for these employees.

Fiscal Impact

Co-locating 300 of the 460 field staff in health facilities where they monitor the patients, at no cost to the state, and consolidating the remaining 160 staff from eight field offices into one or two regional TAR processing centers, reduces the facility lease cost by an estimated \$4.3 million. Facility costs are funded 50 percent federal and 50 percent general fund.⁶

Consolidating the processing centers produces efficiencies that require an estimated eight fewer field offices support staff. The cost savings for eight less staff is estimated to be \$280 thousand.⁷ TAR staffing is funded at 75 percent federal and 25 percent general fund.⁸

Implementation is based on a two-year period to phase out the existing lease agreements.

Special/General Fund
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	General Fund Net Savings (Costs)	Change in PYs
2004–05	\$0	\$0	\$0	\$0	0
2005–06	\$0	\$0	\$0	\$0	0
2006–07	\$4,580	\$0	\$4,580	\$2,220	(8)
2007–08	\$4,580	\$0	\$4,580	\$2,220	(8)
2008–09	\$4,580	\$0	\$4,580	\$2,220	(8)

Note: The dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Endnotes

- ¹ *Medi-Cal Operations Division Field Offices and Pharmacy Sections website, <http://www.dhs.ca.gov> (last visited June 18, 2004) and California Code of Regulations, Title 22, Medical Care Services, Article 1, Section 51003, XXII, Prior Authorization.*
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- ³ *Interview with Ruben Gonzales, chief of Field Operations Southern Branch, Department of Health Services, interview, Sacramento, California (April 8, 2004).*
- ⁴ *Medi-Cal Policy Institute report: "Medi-Cal Treatment Authorizations," by Outlook Associates Inc. (Sacramento, California July 2003), p. 2*
- ⁵ *Interview with Maria Enriquez, chief of Performance and Change Management Branch, Department of Health Services, Sacramento, California (April 7, 2004).*
- ⁶ *Interview with Maura Donovan, chief of Fiscal Forecasting and Data Management Branch, Department of Health Services, Sacramento, California (May 4, 2004).*
- ⁷ *Governor's 2004–2005 Budget, Salaries and Wages Supplement, HHS pp. 44–45.*
- ⁸ *Interview with Sunni Burns, chief of Field Office Operations Support Branch, Department of Health Services, Sacramento, California (March 24, 2004).*



Medi-Cal Fraud Targeting Misses Mark

Summary

Taxpayer dollars are wasted and access to care is threatened in California's Medicaid (Medi-Cal) program because of the burdensome and ineffective anti-fraud strategies used to sign up or "enroll" Medi-Cal providers. The enrollment process should be improved to reduce costs.

Background

The Medicaid program, called Medi-Cal in California, is a federal and state partnership that provides health care to children, the poor and the disabled. In 1999, publicity about fraud and abuse in the Medicare and Medicaid programs created a major political movement nationwide.¹ Fraud and abuse can be perpetrated by providers of service, such as physicians or physician groups; individuals or organizations that represent providers, such as billers, attorneys, and management companies; and recipients of Medi-Cal services. In the last five years significant legislative and regulatory action has occurred at both the state and federal levels to address this problem. To protect the integrity of the Medi-Cal program, California responded by enacting anti-fraud legislation, implementing regulations, and enhancing its administrative processes to sign up or "enroll" providers in the Medi-Cal program.

California responds

Beginning in 1999, a number of bills that addressed fraud and abuse in the Medi-Cal program were enacted by the California Legislature.² These bills increase the requirements for new providers that want to enroll in the program; require the periodic re-enrollment of current Medi-Cal providers; and allow for moratoriums on the enrollment of certain provider types.³ The Department of Health Services (DHS) is responsible for administering the Medi-Cal program. DHS adopted regulations to implement these legislative mandates. As a result, the Department began a rigorous process to screen applicants. In addition to requiring each prospective Medi-Cal provider to submit a lengthy application, each applicant is subject to a background check. This process can take six months or longer to complete. The objective is to identify and "weed out" applicants and providers who do not meet program requirements or who have shown a tendency to commit fraud or abuse.

Organizational strategy and growth

Prior to the passage of the fraud and abuse laws and regulations, the provider enrollment function was performed by a small unit of about 30 employees, most of which were clerical and program technicians.⁴ By comparison, today's provider enrollment organization has grown into a branch with about 116 employees and an annual operating budget in Fiscal Year 2003–2004 of \$10.1 million.⁵ Most of the employees performing the enrollment and re-enrollment functions today are analysts.

DHS' Audits and Investigations Division has 39 auditor positions to help detect fraud and abuse during the enrollment and re-enrollment processes at an annual cost of \$3 million.⁶ Additionally, under a separate contract there are about 20 positions dedicated to the enrollment of dentists into the program at an annual cost of \$1.9 million.⁷ Taken together, there are 175 positions dedicated to Medi-Cal provider enrollment and re-enrollment processing for FY 2003–2004 at a cost of about \$15 million.

DHS has submitted a budget change proposal for FY 2004–2005 to request the conversion of 14 limited-term positions to permanent status; 9 positions in the Provider Enrollment Branch and five in the Audits and Investigations Division. The justification for this request is the ongoing re-enrollment requirements in existing law.⁸

Application processing statistics

Before the anti-fraud and abuse legislation of 1999 was implemented, it took less than 30 days to process applications from those who wanted to become Medi-Cal providers of service.⁹ When DHS adopted regulations to implement the changes in law, the timeframe for application processing was increased to 180 days.¹⁰ This timeframe was chosen to allow enough time to complete a background check and to review the expanded application package. It was believed most applications could be processed within 90 days and only those with deficiencies, or other background check problems, would require the full 180 days.¹¹ With 3,000 applications received each month a significant “inventory” of applications began to build in DHS.¹² This inventory eventually peaked at about 15,000 in early 2004, requiring the full 180 days to process an application.¹³ According to DHS staff, recent efforts to streamline the process has resulted in reducing processing time to about 100 days and a current inventory of just under 11,000.¹⁴

DHS reports that only about 3.89 percent of all initial applications and resubmitted applications are denied, which means over 96 percent are approved.¹⁵ Of the applications that are denied, the reasons for denial fall into three general categories: failure to meet legal requirements or to disclose required information (51 percent); the applicant has a history of fraud and abuse or is under investigation for fraud and abuse (23 percent); and other (27 percent).¹⁶ This information shows that only 1 percent of all applications processed, are denied because of a fraud and abuse issue.

Inadequate telephone assistance

Nearly 40 percent of all applications are returned to the applicant because of deficiencies.¹⁷ The Provider Enrollment Branch has a toll-free number for applicants and/or providers to call about the status of their application or the application process. Because the workload is so heavy, however, a caller cannot reach a “live” person. The caller experiences a lengthy recorded message and telephone selections that never lead to a live person or to resolution of the issues. Provider Enrollment staff cite the lack of appropriate customer service as unnecessarily contributing to their workload because applicants and providers cannot get the



needed assistance to submit a properly completed application in the first place.¹⁸ DHS has recently added new information, such as forms and frequently asked questions, to its Medi-Cal website in an attempt to provide instruction to applicants, but has not improved its telephone system.

Fraud cost avoidance and savings

The benefits of denying a provider from enrolling in the Medi-Cal program, or from disenrolling an active provider, are described in terms of cost avoidance and cost savings.¹⁹ Cost avoidance results when applicants viewed as potentially fraudulent are prevented from enrolling in the program.²⁰ DHS calculates a dollar value of cost avoidance by taking a profile of a “like provider,” examining previous sanctions against that provider, and extrapolating this figure across the universe of similar denied providers.²¹ Savings are deemed to occur when providers already enrolled in the program are found to be engaging in fraud or abuse and their activities are stopped.²²

Impact on access to care

While enrollment and re-enrollment laws and regulations have been implemented to target providers who commit fraud and abuse, they are having a negative effect on all providers of service. This has created some barriers to accessing appropriate care. Hospitals report that due to the long and complicated Medi-Cal enrollment process, they are having difficulty filling critical physician slots in their emergency rooms.²³ Physician groups are experiencing difficulty in attracting physicians to come to California because of this burdensome process.²⁴ Further, there is a sentiment among medical providers that these policies and practices are not only overly bureaucratic, they are ineffective at addressing fraud and abuse.²⁵ The delays caused by this extensive application process are creating unnecessary financial challenges and are driving more practitioners away from the program.²⁶

Legislative Analyst’s Office (LAO) analysis

In its 2004 Budget Analysis, the Legislative Analyst’s Office (LAO) assessed DHS’ fraud and abuse budget change proposal. LAO recommended to the Legislature that it deny an additional 41 positions requested by DHS to expand fraud and abuse activities until DHS completes a strategic planning process and reports its findings to the Legislature on January 1, 2005.²⁷ LAO recommended that the department adopt the assessment and planning model developed by Professor Malcolm K. Sparrow, a noted authority in health care fraud and abuse from Harvard’s John F. Kennedy School of Governance.²⁸ Sparrow’s model adopts a strategic and data-driven process that is divided into seven components.²⁹

According to Sparrow:

“Most insurers, public and private, do no systematic measurement of the fraud problem. They fly blind, oblivious to the magnitude of the problem. No insurers base resource-allocation decisions logically upon valid estimates of the size of the problem . . . Many fraud units remain bogged down in a reactive, case-making mode,

unable to see the forest for the trees . . . Insurers need problem solving as a rational, integrating, control-oriented framework.”³⁰

Bureau of State Audits recommendations

Similar to the LAO analysis, a 2003 report by the Bureau of State Audits recommended that DHS adopt a strategic planning model to shape its Medi-Cal fraud and abuse program.³¹ The report also states that DHS’ methodology for projecting cost avoidance savings is flawed and may be overstating savings.³²

Other California agency recommendations

In its 10-point plan to fight Medi-Cal fraud released this year, the Office of the Attorney General recommended that DHS “devise a methodology to measure the level of improper payments and identify those areas within the Medi-Cal program that are suffering the highest losses” to ensure that they are allocating their resources appropriately.³³ Similarly, the Little Hoover Commission in its May 2004 report, *Improving Health and Human Services*, concluded that public agencies spend extraordinary resources on compliance, auditing and other “oversight” activities that do not provide meaningful accountability that leads to improved performance.³⁴

Department conducting study

DHS has received federal funding and is engaged in an error-rate study to determine the nature and amount of fraud and abuse in the Medi-Cal program. This study is scheduled to be complete by November 2004.³⁵ The study will allow DHS to pinpoint the problem, develop specific strategies, and more effectively target efforts and resources to combat fraud and abuse. When complete, this study should address the findings and recommendations contained the reports issued by the LAO, the Bureau of State Audits and the Attorney General of California.

Other states’ experience

In 1999, a few other states reported adopting similar provider enrollment strategies to combat fraud and abuse in their respective Medicaid programs.³⁶ The State of Texas initially used strategies like California, but abandoned them for approaches that reduced the burdensome enrollment and re-enrollment processes for more streamlined, cost-effective processes.³⁷ This streamlining enables Texas to process applications in one month. Connecticut has developed an expanded application and performs background checks, but processes its Medicaid provider applications in less than one month. Connecticut’s application process is streamlined because it targets its fraud and abuse efforts to specific provider types and does not use across-the-board strategies.³⁸ Likewise, the State of Florida has adopted fraud and abuse strategies that are targeted, data-driven and not a “one-size-fits-all” approach.³⁹

Streamlining California’s provider enrollment process

Fraud and abuse in California’s Medi-Cal program is a serious issue that deserves the attention of state officials. Fraud and abuse draws critical administrative and program dollars away



from a program that could be better used to serve California's needs. Despite increased funding and staffing levels within DHS for enhanced Medi-Cal anti-fraud and abuse activities, the current Medi-Cal enrollment and re-enrollment processes are ineffective, inefficient and create barriers to care. The process to enroll and re-enroll Medi-Cal providers must be streamlined to and address these issues.

Recommendations

- A. The Department of Health Services (DHS), or its successor, should complete the Medi-Cal enrollment error rate study currently underway and publish its results by November 2004.**
- B. DHS, or its successor, should adopt anti-fraud and abuse strategies that are data-driven, targeted and specifically related to the findings in the error-rate study, using the fraud and abuse model outlined by Malcolm K. Sparrow. This should be implemented by July 1, 2005. Stakeholders should be invited to participate in the development of these new, targeted anti-fraud and abuse strategies.**
- C. The Governor should work with the Legislature to create specific anti-fraud strategies consistent with the findings in DHS' error rate study.**
- D. DHS, or its successor, should revamp the provider enrollment and re-enrollment processes to focus on identified fraud targets and reduce the administrative burden and process timeframes for all Medi-Cal applications, thereby reducing overall workload.**
- E. DHS, or its successor, should conduct a desk audit after November 2004 to identify the appropriate type or level of position needed to perform the various enrollment tasks. The number and type of positions should be realigned to reflect the findings in the audit.**
- F. DHS, or its successor, should redirect unneeded positions to other critical areas in DHS, if supported by the desk audit.**
- G. DHS, or its successor, should establish a call center within the Provider Enrollment Branch to give information and assistance to Medi-Cal providers or prospective providers in the enrollment and re-enrollment processes. This is expected to reduce the workload created by deficient applications being returned to providers. Staff to support this function will come from redirected positions from other areas within the Provider Enrollment Branch. This should be implemented by April 2005.**

H. DHS, or its successor, should continually reassess the prevalence of fraud and abuse in the Medi-Cal program utilizing the Sparrow model and make appropriate adjustments to the enrollment and re-enrollment processes.

Fiscal Impact

An actual or accurate fiscal analysis cannot be calculated until DHS completes its error-rate study and develops its anti-fraud and abuse strategies and applicable staffing and budgeting plans. It is expected that the revised anti-fraud and abuse strategies would result in savings due to a shortened enrollment process. These savings could be seen as an actual reduction in costs and/or a redirection of resources to address the new targeted, anti-fraud and abuse initiatives. Because Medi-Cal is a state/federal partnership with the federal government paying about half of the costs of the program, 50 percent of the savings would be General Fund savings and 50 percent would be federal funds.

An analysis of anti-fraud and abuse strategies employed in other state Medicaid agencies, including their approach to enrolling providers, would suggest that California could realize a significant reduction in provider enrollment costs.⁴⁰ The state's use of 175 positions to perform this work is much greater than even the largest states' Medicaid programs and points to significant opportunity to reduce costs.

The establishment of the recommended call center staff, at a projected annual cost of \$393,000 (\$196,500 General Fund, \$196,500 federal funds), would be offset by savings. No new state General Fund would be needed.

Endnotes

- ¹ *Health Care Financing Administration, "Controlling Fraud and Abuse in Medicaid: Innovations and Obstacles: A Report from the Executive Seminars on Fraud and Abuse in Medicaid," by Malcolm Sparrow (September 24, 1999), p. 2.*
- ² *Assembly Bill 1107 (Ch. 146, Stats. of 1999); Senate Bill (SB) 1699 (Ch. 768, Stats. of 2002); and SB 857 (Ch. 601, Stats. of 2003).*
- ³ *Interview with Judy Gelein, Provider Enrollment Branch, California Department of Health Services, Sacramento, California (April 16, 2004).*
- ⁴ *Interview with Mike Lynskey, Department of Health Services, former Manager, Provider Enrollment Unit, Sacramento, California (April 28, 2004).*
- ⁵ *Interview with Jerry Stanger, chief, Payment Systems Division, California Department of Health Services, Sacramento, California (April 16, 2004).*
- ⁶ *E-mail from John Mendoza, Audits and Investigations, California Department of Health Services (April 28, 2004).*
- ⁷ *Interview with Shelley Thomas, chief, Medi-Cal Dental Services Branch, California Department of Health Services, Sacramento, California (May 14, 2004).*



- ⁸ Department of Health Services, “Provider Fraud—Convert Limited Term Positions to Permanent Status,” Budget Change Proposal (FY 2004–2005).
- ⁹ Interview with Mike Lynskey (April 28, 2004).
- ¹⁰ California Code of Regulations, Title 22, Division 3, Section 51000.50.
- ¹¹ Interview with Nancy Hutchison, former manager, Provider Enrollment Branch, Department of Health Services, Sacramento, California (June 1, 2004).
- ¹² Interview with Jerry Stanger (April 16, 2004).
- ¹³ Interview with Judy Gelein (April 16, 2004).
- ¹⁴ E-mail from Judy Gelein, Provider Enrollment Branch, Department of Health Services (April 22, 2004).
- ¹⁵ E-mail from Judy Gelein (April 22, 2004).
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- ¹⁸ Interview with Provider Enrollment Branch staff, Department of Health Services, Sacramento, California (April 16, 2004).
- ¹⁹ Legislative Analyst’s Office, “2004 Budget Analysis: California Medical Assistance Program” (Sacramento, California, February 2003), p. 30.
- ²⁰ Legislative Analyst’s Office, “2004 Budget Analysis: California Medical Assistance Program,” p. 30.
- ²¹ Interview with Jan English, Audits and Investigations Division, California Department of Health Services, Sacramento, California (April 16, 2004).
- ²² Legislative Analyst’s Office, “2004 Budget Analysis: California Medical Assistance Program,” p. 30.
- ²³ Interview with Sherita Lane, vice president of Reimbursements, California Healthcare Association, Sacramento, California (April 30, 2004).
- ²⁴ Interview with Erin Aaberg-Givens, executive director, Children’s Specialty Coalition, Sacramento, California (April 30, 2004).
- ²⁵ Interview with Heather Campbell, associate director of Government Relations, California Medical Association, Sacramento, California (April 30, 2004).
- ²⁶ Interview with Heather Campbell (April 30, 2004).
- ²⁷ Legislative Analyst’s Office, “2004 Budget Analysis: California Medical Assistance Program,” pp. 35–36.
- ²⁸ Legislative Analyst’s Office, “2004 Budget Analysis: California Medical Assistance Program,” pp. 30–31.
- ²⁹ Malcolm K. Sparrow, “License to Steal: How Fraud Bleeds America’s Health Care System,” (Boulder: Westview Press, 2000) pp. 203–227.
- ³⁰ Sparrow, “License to Steal: How Fraud Bleeds America’s Health Care System,” p. 227.
- ³¹ California State Auditor, “Department of Health Services: It Needs to Better Plan and Coordinate Its Medi-Cal Antifraud Activities,” Report 2003-112 (Sacramento, California, December 2003), pp. 24–25.
- ³² California State Auditor “Department of Health Services: It Needs to Better Plan and Coordinate Its Medi-Cal Antifraud Activities,” pp. 23–25.
- ³³ Office of the Attorney General, “Attorney General Lockyer and Legislators Unveil Bi-Partisan, 10-Point Plan to Fight Medi-Cal Fraud,” April 21, 2004. (Press release.)
- ³⁴ The Little Hoover Commission, “Real Lives, Real Reforms: Improving Health and Human Services,” May 2004, p. xvi.
- ³⁵ Legislative Analyst’s Office, “2004 Budget Analysis: California Medical Assistance Program,” p. 32.
- ³⁶ Health Care Financing Administration, “Controlling Fraud and Abuse in Medicaid: Innovations and Obstacles,” p. 2.

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- ³⁷ *Interview with Aurora LeBron, associate commissioner, Texas Health and Human Services Commission, Austin, Texas (April 16, 2004).*
- ³⁸ *Interview with James Wietrack, director of Quality Assurance, State of Connecticut's Medicaid Program, Hartford, Connecticut (May 5, 2004).*
- ³⁹ *Interview with Tim Brynes, director of Program Integrity, Division of State Health Purchasing, State of Florida, Tallahassee, Florida (May 10, 2004).*
- ⁴⁰ *Interview with Aurora LeBron (April 16, 2004); Interview with Tim Brynes (May 10, 2004); and Interview with James Wietrack (May 5, 2004).*



Transfer the In-Home Supportive Services Program to the Department of Health Services

Summary

The state department responsible for administering the In-Home Supportive Services (IHSS) program is not the same department responsible for securing federal reimbursement for that program. Administrative delays experienced between the two departments result in the state not receiving millions of dollars in federal funds. Relocating the responsibility to administer the IHSS program into the department responsible to seek federal reimbursement would increase those reimbursements and reduce administrative costs.

Background

The Department of Social Services (DSS) administers the In-Home Supportive Services (IHSS) program providing supportive services to eligible aged, blind and disabled individuals to allow them to remain safely in their own homes as an alternative to more costly institutional care. Counties administer the program under supervision by the state. IHSS is California's third largest social services program and its fastest growing, so program effectiveness and efficiency are critical. IHSS budget has increased by an average of 19 percent a year between Fiscal Years 1993 and 2001. The total cost of the IHSS program was \$2.8 billion in FY 2002–2003.¹

IHSS consists of two separate programs: the Personal Care Services Program (PCSP) and the Residual IHSS program. Funding is the main difference between the programs. PCSP is a Medi-Cal benefit and services provided to Medi-Cal recipients are partially funded by the federal government. In contrast, the Residual IHSS program is funded by state and county resources. The IHSS program is currently comprised of approximately 80 percent PCSP beneficiaries and 20 percent Residual IHSS beneficiaries.²

Because IHSS is within DSS, it is separate from the administration of the Medi-Cal program, which is vested with the Department of Health Services.³ This disconnect hinders benefits that the state is missing such as increased federal reimbursements and better program service delivery.

Federal funding opportunities

Integrating the computer system for IHSS with the Medi-Cal computer systems would increase the amount of federal reimbursements California currently receives. The Case Management

Information and Payrolling System (CMIPS) is the automated system for IHSS located within DSS that stores recipient case records, provides statistical and fiscal data, and provides for the authorization and issuance of warrants for payments to service providers.⁴ The California Medicaid Management Information System (CA-MMIS) is the automated system for Medi-Cal located within DHS.⁵ Linking these two systems would increase the federal reimbursement rate from 50 percent of federally allowable costs to 75 percent of federally allowable maintenance and operations costs and 90 percent for system development costs. This would increase federal reimbursements from \$27.5 to \$37 million over the first three years and then save \$23.8–\$32 million in maintenance and operations costs over the next seven years.⁶

In addition, if DHS were to administer the IHSS program, it would eliminate the delay in receiving federal reimbursements that the state is now experiencing, resulting in lost investment interest. For example, in FY 2003, because the Interagency Agreement between DSS and DHS took over eight months to complete, DHS could not request federal reimbursement of \$700 million of IHSS costs which the General Fund had paid for. Because the General Fund was not reimbursed, it lost potential investment interest of approximately \$42 million.⁷

Moreover, DSS' proposed budget for FY 2004–2005 contains an item for \$195 million to pay for the costs of delays in reimbursements. If the IHSS program were part of DHS it would be within the same department receiving Medi-Cal funding and there would be no delay in receiving funds, so this item would not be needed.⁸

Increased efficiency of service delivery

Moving the IHSS program into DHS will increase efficiency by eliminating the need for complicated coordination arrangements with the Department of Social Services, the Department of Health Services and the Department of General Services.⁹ Currently, there are two programs that must estimate IHSS costs and manage claims, resulting in complex interagency agreements and billing procedures which take up staff time and delay program activities. Integration would eliminate this and allow DHS to quickly obtain reimbursement of IHSS costs from the federal government.¹⁰

The change will also allow for more integrated benefit determinations. One state agency would be responsible for both Medi-Cal eligibility determinations and county IHSS eligibility determinations. This would allow the agency to more fully work with counties to establish a unified procedure for eligibility determinations. Full integration should improve the efficiency and accuracy of Medi-Cal determinations made by county workers and eliminate work that is redundant of existing Medi-Cal review.¹¹



Also, there are other opportunities for efficiencies such as the following:

- Applying existing Medi-Cal anti-fraud resources to combat abuse in the IHSS system;¹²
- Better eligibility determinations for service providers;¹³
- The availability of higher quality personnel to manage the combined computer systems;¹⁴
- Making it easier for county computer systems to interface with electronic information on IHSS beneficiaries;¹⁵ and
- Closer coordination with other programs within DHS.¹⁶

Recommendation

The Governor should work with the Legislature transfer the IHSS program from the Department of Social Services to the Department of Health Services, or their successors.

Fiscal Impact

As discussed above, significant savings are expected to be generated from the availability of greater federal funds and the elimination of delays in expenditure reimbursements. No savings are anticipated in FY 2004–2005 due to time required for implementation. Estimated general fund savings for future fiscal years would range from \$23 to \$32 million depending on system maintenance and operation requirements.

Endnotes

- ¹ California Department of Social Services, “Transition Binder” (Sacramento, California November 2003), pp. 63–64; and Legislative Analyst’s Office, “Analysis of the 2002–03 Budget Bill” (Health and Human Services), http://www.lao.ca.gov/analysis_2002/health_ss/healthss_20_IHSS_anl02.htm (last visited June 21, 2004).
- ² Interview with Joe Carlin, assistant deputy director, California Department of Social Services, Sacramento, California (March 2004).
- ³ E-mail from Mary Lamar Wiley, manager, Medi-Cal Program, California Department of Health Services, to California Performance Review (March 23, 2004).
- ⁴ California Department of Social Services, “Transition Binder;” and California Department of Social Services, “Move State administration of the IHSS program from CDSS to DHS” (Sacramento, California, April 1, 2004).
- ⁵ E-mail from Joe Carlin, assistant deputy director, California Department of Social Services, to California Performance Review (April 14, 2004).
- ⁶ E-mail from Donna Mandelstam, deputy director, California Department of Social Services, to California Performance Review (March 29, 2004); and E-mail from Joe Carlin, assistant deputy director, California Department of Social Services, to California Performance Review (March 18, 2004).
- ⁷ Interview with Carlene Kistler, chief, Accounting Bureau, California Department of Social Services, Sacramento, California (April 2, 2004).
- ⁸ Interview with Carlene Kistler.
- ⁹ California Department of Social Services, “Move State administration of the IHSS program from CDSS to DHS” (Sacramento, California, April 1, 2004).

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- ¹⁰ *Interview with Carlene Kistler.*
- ¹¹ *California Department of Social Services, "Move State administration of the IHSS program from CDSS to DHS" (Sacramento, California, April 1, 2004).*
- ¹² *California Department of Social Services, "Move State administration of the IHSS program from CDSS to DHS" (Sacramento, California, April 1, 2004).*
- ¹³ *California Department of Social Services, "Move State administration of the IHSS program from CDSS to DHS" (Sacramento, California, April 1, 2004).*
- ¹⁴ *California Department of Social Services, "Move State administration of the IHSS program from CDSS to DHS" (Sacramento, California, April 1, 2004).*
- ¹⁵ *California Department of Social Services, "Move State administration of the IHSS program from CDSS to DHS" (Sacramento, California, April 1, 2004).*
- ¹⁶ *California Department of Social Services, "Move State administration of the IHSS program from CDSS to DHS" (Sacramento, California, April 1, 2004).*



Eliminate Dual Capitation for Medicare/ Medi-Cal Managed Care Plans

Summary

The state is incurring unnecessary program costs for nearly 1,000 beneficiaries who are enrolled in both a Medi-Cal managed care plan and a Medicare managed plan. The regulations prohibiting this should be followed and either these beneficiaries should be disenrolled from the Medi-Cal managed care plan or the state should negotiate a premium rate for the Medi-Cal plan to reflect that the health plan is only responsible to provide a limited scope of benefits.

Background

The Medicaid program (called Medi-Cal in California) is a joint federal and state program that pays for health care for low-income people. The federal and state government each pay about 50 percent of the program costs. The Department of Health Services (DHS) is responsible for administering the program. Under state and federal law, Medi-Cal is the payor of last resort when a beneficiary has third-party health coverage or insurance.¹ That is, Medi-Cal is only required to pay for the costs that remain after all other insurance carriers have been billed.

Medicare is a federal program that provides health insurance to qualified aged, blind and disabled beneficiaries. Approximately 970,000 beneficiaries are eligible for both Medi-Cal and Medicare. These beneficiaries are known as dual eligibles. Because Medi-Cal is the payor of last resort Medicare, pays for most of the costs of the health care provided to beneficiaries with dual eligibility.

Managed care plans

Slightly more than half of all Medi-Cal beneficiaries are enrolled in managed care plans; the rest receive services from providers that have been enrolled in the Medi-Cal program to provide health care on a fee-for-service basis.² Fee-for-service providers are paid for each service rendered.

Some Medi-Cal beneficiaries must enroll in a managed care plan; other beneficiaries have the option to do so. In eight counties, virtually all Medi-Cal beneficiaries are enrolled in a County Organized Health System (COHS).³ There are currently managed care plans in 14 other counties; these plans are known as either Two Plan models or Geographic Managed Care plans. In these counties, beneficiaries linked to the Temporary Assistance to Needy Families program (in California, known as CalWORKs) must enroll in a health plan while other Medi-Cal beneficiaries have the option to enroll in a managed care plan or to receive services from fee-for-service Medi-Cal providers.

The state has contracts with all managed care plans for which contract amendments may be introduced at any time at the state's discretion. The state and each managed care plan negotiate the amount of the monthly premium paid for each managed care beneficiary.⁴ This is referred to as the capitation rate. The beneficiary receives all covered health care services without any further charges to the Medi-Cal program. Capitation rates paid to the COHS plans have been reduced to reflect that some COHS beneficiaries also have other health insurance. COHS can bill the other health insurance for services provided to these beneficiaries.⁵ There is a concern about the potential solvency of some COHS plans and whether all COHS plans will be able to continue to provide a successful low-cost service delivery system.⁶

Problem or opportunity

DHS uses a Health Care Options (HCO) vendor to assist with Medi-Cal managed care enrollments. If it is known at the time an individual becomes eligible for Medi-Cal that he or she is already enrolled in a managed care plan or has other insurance, enrollment in a Medi-Cal managed care plan will not be made. If, however, it is discovered that a beneficiary enrolled in a Two Plan model or Geographic Managed Care plan is enrolled in another health plan, the state continues to pay capitation to the managed care plan to maintain the beneficiary's continuity of care.⁷

In slightly over 4,900 cases, beneficiaries are concurrently enrolled in both a Medi-Cal managed care plan and a Medicare managed care plan.⁸ This means that beneficiaries' health care needs are being paid for twice. In some cases, both the state and the federal government are paying capitation to the same plan for the same client for the same time period.⁹ Approximately 80 percent of these dually capitated beneficiaries are in COHS plans and 20 percent are in non-COHS plans.¹⁰ In non-COHS counties, the state could save money by discontinuing payment of the Medi-Cal capitation for 900 to 1,000 of these dually capitated beneficiaries, without compromising the continuity or quality of care. An alternative solution would be to reduce the rate paid to the Medi-Cal plan to reflect that this health plan has to provide only those health care services not provided by the Medicare managed care plan.

If these beneficiaries were discontinued from the Medi-Cal plan, they would receive most of their health services from the Medicare HMO. For those services not covered by the Medi-Cal plan, the beneficiary would use an authorized fee-for-service Medi-Cal provider. The cost to the state to pay the fee-for-service costs would be only 20 to 25 percent of the cost now paid for capitation.¹¹

Although regulations require removing beneficiaries with other health coverage from Medi-Cal managed care plans, DHS made a policy decision in 1997 not to take this action based on an argument by client advocacy groups that this would interfere with the beneficiaries' relationship with the managed care provider and interrupt the continuity of care.¹² If the state were to discontinue coverage in the Medi-Cal managed care plan for dually capitated



beneficiaries, however, not all would have to change providers because some health plans cover both Medicare and Medi-Cal beneficiaries, as discussed above.

In addition, there is ample evidence demonstrating that changing providers is a common occurrence for many Californians. There are a variety of reasons for changing health care providers, but the most common reason is a change in an employer-sponsored health plan. Employer-sponsored health care is available to almost 60 percent of all Americans.¹³ In 2003, over 20 percent of all employers who provided health care to their employees changed health plans.¹⁴ In 2003, Health Maintenance Organizations covering approximately 14 percent of the employer-insured workers reduced the number of providers in their network.¹⁵

Since changing providers happens with some frequency for American workers, it is not unreasonable to expect that some dually capitated Medi-Cal beneficiaries would also have to change providers.

Recommendations

The Department of Health Services (DHS), or its successor, should comply with the regulations in California Code of Regulations, Title 22, Section 53891(a)(10). This would require either removing the client from the Medi-Cal managed care plan or negotiating a reduced premium, which would be equivalent to what the state would have to pay for the health services not covered by the Medicare health plan.

- A. The DHS, or its successor, should either modify the health plan contract language to state that DHS will terminate the capitation if a beneficiary client has certain types of health insurance, including enrollment in a Medicare managed care plan, or develop a blended rate for beneficiaries that are dually capitated, so that the Medi-Cal rate only reflects payment for services not covered by the Medicare program.
- B. The DHS, or its successor, should notify the Health Care Options vendor that the state wishes to enforce the existing contract provisions regarding disenrollment because of other health insurance.
- C. The DHS, or its successor, should make all necessary programming changes to reflect the policy change in recommendation A. Some of the associated programming changes have already been coded, but were never installed.
- D. The DHS, or its successor, should review and analyze the policy to permit County Organized Health System (COHS) beneficiaries to also be enrolled in Medicare health plans. The analysis should determine whether it is more cost-effective to provide those health care services not covered by Medicare through a fee-for-service arrangement with the COHS plans or other local providers.

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- E. If the DHS decision is to continue the existing policy of allowing COHS beneficiaries to be concurrently enrolled in Medicare managed plans, then DHS, or its successor, should make programming changes to provide the COHS plans with a list of their beneficiaries who have other health insurance, including Medicare HMO coverage.

Fiscal Impact

Savings would be realized from removing the 900 to 1,000 dually enrolled beneficiaries in non-COHS counties from the Medi-Cal HMO or if the state modified the amount of the premiums paid to the Medi-Cal managed care plan to reflect the limited scope of service for the Medi-Cal plan. Either approach would result in the state only paying for those services which are in the Medi-Cal scope of benefits, but not covered by Medicare, saving \$2 million per year. Fifty percent of these savings would be General Fund dollars.

Annual savings could increase by an additional \$6 million in Fiscal Year 2006–2007 (not reflected below) because the number of dual eligibles is expected to more than quadruple as a result of the planned expansion of enrolling aged, blind and disabled beneficiaries into Medi-Cal health plans.

Special/General Funds
(dollars in thousands)

Fiscal Year	Savings	Costs	Net Savings (Costs)	General Fund Net Savings (Costs)	Change in PYs
2004–05	\$629	\$0	\$ 629	\$315	0
2005–06	\$2,121	\$0	\$ 2,121	\$1,061	0
2006–07	\$2,121	\$0	\$ 2,121	\$1,061	0
2007–08	\$2,121	\$0	\$ 2,121	\$1,061	0
2008–09	\$2,121	\$0	\$ 2,121	\$1,061	0

Note: the dollars and PYs for each year in the above chart reflect the total change for that year from 2003–04 expenditures, revenues and PYs.

Endnotes

- ¹ The state law referenced is the Welfare and Institutions Code, Section 14124.90. The federal law is the Social Security Act, Section 1902 (a)(25).
- ² California Department of Health Services, “Medi-Cal Reform Concept Paper” (Sacramento, California, May 2004), Attachment II.



- ³ Interview with Mary Menz, chief, Medi-Cal Policy and Contracts Section, California Department of Health Services, Sacramento, California (May 20, 2004). The only Medi-Cal clients excluded from COHS are those eligible only for limited scope benefits.
- ⁴ E-mail from Marcine Crane, chief, COHS, GMC, and Other Contracts Section, California Department of Health Services, to California Performance Review (June 17, 2004); and interview with Marcine Crane, COHS, GMC, and Other Contracts Section, California Department of Health Services, Sacramento, California (June 17, 2004). Rates for the Two-Plan managed care model are public record; the rates for the Geographic Managed Care Plans and the County Organized Health Systems are confidential.
- ⁵ Interview with Mary Menz.
- ⁶ California Legislative Analyst's Office, "2004–05 Analysis of Health and Human Services Budget" (Sacramento, California, February 18, 2004), p. C-104; and e-mail from Marcine Crane, chief, COHS, GMC, and Other Contracts Section, California Department of Health Services, to California Performance Review (June 10, 2004).
- ⁷ Interview with Pete Olson, senior information systems analyst, Information Technology Services Division, California Department of Health Services, Sacramento, California (March 26, 2004). Other health coverage information could be identified either through a client report or a data match.
- ⁸ E-mail from Pete Olson, senior information systems analyst, Information Technology Services Division, California Department of Health Services, to California Performance Review (February 6, 2004); and interview with Pete Olson.
- ⁹ E-mail from Pete Olson, senior information systems analyst, Information Technology Services Division, California Department of Health Services, to California Performance Review (May 12, 2004).
- ¹⁰ In May 2004, Pete Olson, Information Technology Services Division, California Department of Health Services, performed a data match to identify clients for whom the state paid dual capitation in April 2004. 80.9 percent of these clients were in COHS plans.
- ¹¹ Interview with Jim Klein, research program specialist, Fiscal Forecasting, Department of Health Services, Sacramento, California (June 18, 2004.) The average per capita cost for fee-for-service costs for clients enrolled in Medicare HMOs in Fiscal Year 2002–2003 was \$69.92 per month.
- ¹² Title 22, California Code of Regulations, Section 53891a(10).
- ¹³ The Henry J. Kaiser Foundation, "2003 Annual Survey of Employers," p.1, <http://www.kff.org/insurance/ehbs2003-1-set.cfm> (last visited June 19, 2004).
- ¹⁴ The Henry J. Kaiser Foundation, "2003 Annual Survey of Employers," exhibit 12.1; and interview with Johann DeKayzer, Hewitt Associates, Lincolnshire, Illinois (May 24, 2004).
- ¹⁵ The Henry J. Kaiser Foundation, "2003 Annual Survey of Employers," exhibit 8.5.



**Health and Human Services
Fiscal Impact Table**

(Dollars Displayed in Thousands)

Issue Number	Issue Description	2004-05		2005-06		2006-07		2007-08		2008-09		5-Year Cum. Total All Funds
		Savings/General Fund	(Costs)/Revenue Other Funds									
HHS 01	Transform Eligibility Processing	(\$625)	(\$375)	\$189,031	\$320,863	\$453,060	\$716,723	\$453,060	\$716,723	\$453,060	\$716,723	\$4,018,243
HHS 02	Realigning the Administration of Health and Human Service Programs	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
HHS 03	Improve the Performance and Reduce the Cost of California's Child Support Program	\$0	\$0	\$2,552	\$4,954	\$2,552	\$4,954	\$12,190	\$23,664	\$12,190	\$23,664	\$86,720
HHS 04	Simplify California's Subsidized Child Care System to Deliver Better Service to Families	CBE	CBE	CBE								
HHS 05	Improving Protection for Children Receiving Child Care from Unlicensed Providers	CBE	CBE	CBE								
HHS 06	Foster Care Criminal Background Checks	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
HHS 07	Increase Subsidized Child Care Quality	\$0	\$0	\$41,017	\$41,018	\$67,476	\$67,476	\$0	\$0	\$0	\$0	\$216,987
HHS 08	State Leadership Needed to Repair a Foster Care System in Crisis	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
HHS 09	Finding Permanent Homes for Foster Children	\$0	\$0	(\$151)	\$0	(\$151)	\$0	(\$151)	\$0	(\$151)	\$0	(\$604)
HHS 10	Align State Law Regarding the \$50 Child Support Disregard Payments	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

Health and Human Services

Fiscal Impact Table

(Dollars Displayed in Thousands)

Issue Number	Issue Description	2004-05		2005-06		2006-07		2007-08		2008-09		5-Year Cum. Total All Funds
		Savings/General Fund	(Costs)/Revenue Other Funds									
HHS 11	Use Technology to Promote Ease of Use and Improve Efficiency in the Women, Infants and Children Supplemental Nutrition Program	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
HHS 12	Simplify Public Health Funding Agreements	CBE	CBE	CBE								
HHS 13	Create a State Public Health Officer to Strengthen Public Health in California	\$0	\$0	(\$275)	\$0	(\$275)	\$0	(\$275)	\$0	(\$275)	\$0	(\$1,100)
HHS 14	Make California's HIV Reporting System Consistent With its AIDS Reporting System, and Improve AIDS Reporting	CBE	CBE	CBE								
HHS 15	Consolidate the State's Mental Health and Alcohol and Drug Programs to Better Serve Californians	\$0	\$0	\$180	\$1,673	\$180	\$1,673	\$180	\$1,673	\$180	\$1,673	\$7,412
HHS 16	Protect California's Children by Implementing a Statewide Online Immunization Registry	CBE	CBE	CBE								
HHS 17	City-Level Mental Health Programs Are Outdated, Inconsistent With Laws	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
HHS 18	Relocate the Vocational Rehabilitation Program to Improve Employment Outcomes of People with Disabilities	\$0	\$0	\$494	\$2,093	\$594	\$2,193	\$594	\$2,193	\$594	\$2,193	\$10,948



**Health and Human Services
Fiscal Impact Table**

(Dollars Displayed in Thousands)

Issue Number	Issue Description	2004-05		2005-06		2006-07		2007-08		2008-09		5-Year Cum. Total All Funds
		Savings/General Fund	(Costs)/Revenue Other Funds									
HHS 19	Standardize Criminal Background Reviews in Health and Human Services Agency	(\$2,100)	(\$2,100)	(\$3,528)	(\$3,528)	(\$3,528)	(\$3,528)	(\$3,528)	(\$3,528)	(\$3,528)	(\$3,528)	(\$32,424)
HHS 20	Maximize Revenue Collections in the Department of Health Services	CBE	CBE	CBE								
HHS 21	Consolidate Licensing and Certification Functions	\$0	\$0	\$4,652	\$11,961	\$4,652	\$11,961	\$4,652	\$11,961	\$4,652	\$11,961	\$66,452
HHS 22	Issue Fee-Supported Licenses Without Delay	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
HHS 23	Streamline Oversight Requirements for Conducting Medical Survey/Audits of Health Plans	CBE	CBE	CBE								
HHS 24	Intermediate Care Facilities for Individuals with Developmental Disabilities not Benefiting from Full Federal Participation	\$0	\$0	\$21,750	\$0	\$43,500	\$0	\$43,500	\$0	\$43,500	\$0	\$152,250
HHS 25	Obtain Best Prices on Durable Medical Equipment	\$3,300	\$3,300	\$6,600	\$6,600	\$6,600	\$6,600	\$6,600	\$6,600	\$6,600	\$6,600	\$59,400
HHS 26	Maximize Federal Funding by Shifting Medi-Cal Costs to Medicare	\$0	\$0	\$3,477	\$0	\$3,824	\$0	\$4,837	\$0	\$6,390	\$0	\$18,528
HHS 27	Automate Identification of Other Health Coverage for Medi-Cal Beneficiaries	\$0	\$0	\$26,800	\$26,900	\$26,800	\$26,900	\$26,800	\$26,900	\$26,800	\$26,900	\$214,800

Health and Human Services Fiscal Impact Table

(Dollars Displayed in Thousands)

Issue Number	Issue Description	2004-05		2005-06		2006-07		2007-08		2008-09		5-Year Cum. Total All Funds
		Savings/General Fund	(Costs)/Revenue Other Funds									
HHS 28	Improve Integrity in Medi-Cal Through the Use of Smart Cards	(\$75)	\$0	(\$3,375)	\$0	(\$8)	\$0	\$23,136	\$0	\$57,997	\$0	\$77,675
HHS 29	Redirect Medi-Cal Hospital Disproportionate Share Payments from Hospitals that are not Providing Core Medi-Cal Services	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
HHS 30	Centralize Medi-Cal Treatment Authorization Process	\$0	\$0	\$0	\$0	\$2,220	\$2,360	\$2,220	\$2,360	\$2,200	\$2,360	\$13,720
HHS 31	Medi-Cal Fraud Targeting Misses Mark	CBE	CBE	CBE								
HHS 32	Transfer the In-Home Supportive Services Program to the Department of Health Services	CBE	CBE	CBE								
HHS 33	Eliminate Dual Capitation for Medicare/Medi-Cal Managed Care Plans	\$315	\$314	\$1,061	\$1,060	\$1,061	\$1,060	\$1,061	\$1,060	\$1,061	\$1,060	\$9,113
Health & Human Services Total		\$815	\$1,139	\$290,285	\$413,594	\$608,557	\$838,372	\$574,876	\$789,606	\$611,270	\$789,606	\$4,918,120

The amounts shown for each year in the above chart reflect the total change for that year from Fiscal Year 2003-04

CBE - Cannot Be Estimated