Senate Office of Research

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MAJOR PROJECTS

California Children's Services

SOR issued ***California's Ailing System of Caring for Children with Special Health Care Needs*** (May 2000) in response to a June 1998 request from the Senate Health and Human Services Committee to study the California Children's Services (CCS) program to determine the extent to which the program is providing timely access to services for children eligible for the program.

CCS provides specialized health care services to children with qualifying health care conditions, including serious and chronic conditions such as birth defects, heart conditions, spina bifida, chronic illnesses, cancers, blood disorders, genetic diseases, perinatal conditions, and the effects of serious injuries such as fractures, spinal cord injuries, and burns. CCS provides medical diagnosis, treatment, case management, and therapies to children under age 21 with defined handicapping conditions that can be cured, ameliorated, improved, or stabilized through intervention. Children must meet certain income and eligibility requirements to qualify for CCS services.

SOR's report summarized its main findings and presented options for addressing growing barriers to the provision of services to families under the program. Despite the success of the CCS program in helping children with special health care needs gain access to medical treatment and therapy necessary to restore and improve their functioning and long-term prognosis, SOR concluded that a number of problems limit the ability of the program to provide timely and seamless services to eligible children. These problems—which result in very lengthy delays in children receiving services in some cases—include the following:

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• *Growing problems with the adequacy of provider participation.* SOR found that low reimbursement rates for CCS and Medi-Cal services are causing many physicians and other providers to cease seeing CCS/Medi-Cal patients or to limit the number of such patients they will treat. The report outlined options to increase rates, expedite payment, and better track provider participation in the CCS and Medi-Cal programs.

• *Inadequate case management staffing.* According to material reviewed by SOR, existing staffing standards permit staff-to-client ratios in excess of 500-to-1 in larger counties and in excess of 1,000-to-1 in the state centers serving smaller counties, far too high to permit timely eligibility determinations, treatment authorizations, and claims payment in many counties. SOR recommended that CCS staffing standards be updated and made more consistent with those used in other programs serving children and adolescents.

• *Need for better state oversight and enforcement of program standards.* A lack of resources for state oversight of the CCS program and delays in implementation of CMS Net 47, a state-county linked management information system, are resulting in a lack of compliance in many counties with basic program standards, including timeliness standards. SOR outlined a number of options for addressing this problem, including increasing the frequency of county and provider site reviews and expediting implementation of the CMS Net management information system.

• *Inadequate attention to family-centered care as a program goal.* SOR found that a lack of focus on family-centered approaches to care has rendered the CCS program confusing for families and difficult to participate in. SOR identified a number of options for addressing this problem, including increased training for CCS staff and providers, greater efforts to make CCS documents and materials more understandable, establishment of a family ombudsperson and a toll-free telephone number, and clarification of standards regarding access to medical transportation services.

• *Inconsistent county application of program standards.* SOR found that county funding pressures may lead to an inconsistent application of program standards. This has resulted in children with similar conditions receiving publicly financed health services in some counties but not in others, or receiving different types of care. SOR suggested several options, including providing CCS staff with better training on program standards, conducting more frequent county site reviews, making it easier for families to access CCS services while their Medi-Cal applications are pending, and returning the county share of cost for CCS to the 25% level that existed prior to the 1991 program realignment.

• *Fragmented service delivery as a result of managed care carve-out.* Because CCS services are provided separately from other services children receive when they are enrolled in Medi-Cal managed care plans (which is referred to as being "carved out" of the plan contracts), delays and disruptions in continuity of care frequently result. SOR detailed several options in this area, including implementing a "medical home" concept for CCS-eligible children, in which responsibility for primary care and care coordination would be assigned to a primary care provider or specialist, depending on the nature of the condition. In addition, DHS could be required to contract for a study of medical outcomes, family satisfaction, and health status of CCS-eligible children enrolled in managed care plans.

• *Outdated income eligibility standards.* In 1982, the financial ceiling for eligibility for the CCS program was reduced from $100,000 in annual gross household income to $40,000. SOR recommended several options to increase or index the financial eligibility limit to a standard that more realistically reflects the financial burdens CCS conditions can impose on families.

• *Need to develop more flexible medical eligibility standards.* A number of stakeholder representatives expressed a desire to see medical eligibility for the CCS program eventually be based on general criteria, including a child's functional status, level of condition, or need for services, rather than on defined medical conditions, which they believe acts to exclude some children who could benefit from the services provided by the program. SOR recommended that DHS be required to study the feasibility of developing alternative medical eligibility criteria.

California's Jobless Benefits

FYI: Lagging the Nation: California's Jobless Benefits (August 2000) compares California's unemployment benefits with those paid by other states. SOR noted that jobless workers receive unemployment insurance (UI) amounts based on their work histories and previous salaries up to a maximum of $230 per week; the average paid in California is $150 per week. According to SOR, 44 other states and the District of Columbia pay higher UI benefits than California. The report looked at the structure of UI benefits, compared case scenarios for UI payment in Texas and California, and suggested options for raising the maximum UI benefit in California.

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The Rising Cost of Prescription Drugs

In February 2001, SOR released ***Options for Assisting Vulnerable Populations With Rising Costs and Declining Insurance Coverage for Prescription Drugs***, which explored the avenues being taken by states to address the problems of rising out-of-pocket costs and declining insurance coverage of prescription drugs for vulnerable populations, particularly the elderly and the disabled. Prescription drug spending increased 15% from 1997 to 1998—two to four times faster than costs for most other health services. Medicare does not provide coverage for prescription drugs, which means that seniors and the disabled must rely on supplemental coverage or pay expenses out of their own pockets. Almost one in three supplemental insurers cap drug benefit payments at $500 per year, far less than prescription drugs cost for most beneficiaries. Prescription drug coverage under many types of supplemental insurance is declining as insurers cope with rising costs.

In its report, SOR discussed recent state initiatives to increase access to prescription drugs, including state prescription drug programs that subsidize coverage for the elderly and/or the disabled, discount purchasing programs, expansion of safety net purchasing programs, increasing enrollment in the Medicaid program, subsidizing existing Medicare HMO coverage options, consumer education, state purchasing pools, and direct price controls. The report also noted the possibility of new federal drug assistance under President Bush's proposal to allocate funds to states to provide prescription drug coverage to certain Medicare-eligible individuals.

Natural Gas Issues in California

In ***FYI: Natural Gas Issues in California*** (April 2001), SOR analyzed reasons for the wave of price jumps in the natural gas market in California, discussed issues related to the pipeline capacity, and offered policy options to address these issues (see agency report on PUBLIC UTILITIES COMMISSION for related discussion).

According to SOR, daily consumption of natural gas rose from 6.13 billion cubic feet in 1999 to an estimated 7 billion cubic feet in 2000, driven by a need to fuel the growth in natural gas-fired power generators. Pipeline capacity is 7.15 billion cubic feet per day. California imports nearly 85% of its natural gas from outside the state via a pipeline system from producer states and from Canada.

SOR cited three main reasons for rising natural gas prices in California: (1) tight supply and demand balance of natural gas markets nationally; (2) the lack of extra pipeline capacity for delivering additional natural gas to California; and (3) purchase strategies employed by the state's natural gas utilities. To address these issues, SOR suggested increasing pipeline capacity, increasing storage capacity and storage requirements, limiting the improper exercise of market power, encouraging a balanced portfolio approach to procurement, increasing dual fuel requirements, strengthening assessment of regional short-term and long-term supply and demand by the California Energy Commission, and monitoring regional circumstances beyond California.

Publicly Funded Early Education and Child Care Programs

Publicly Funded Programs for Low Income Families: An Overview of Early Education and Child Care in Cali-

fornia (April 2001) provides an overview of the state's child care system for children from low-income families and a history of key public policies that shape the system. These programs may be funded by federal or state governments and may be either part-day or full-day programs. In its report, SOR examined several child care programs including Head Start (which is federally funded), State Preschool (California's state-funded version of Head Start), Title 5 child care centers, family child care providers, alternative payment contractors, and resource and referral programs. The report also assessed the impact that the state's welfare-to-work program, CalWORKs, has had on both child care needs and funding. According to a California Budget Project estimate, current services meet only two-thirds of the state's child care needs for low-income families, and an additional 280,000 eligible children would enroll if subsidized care were available. Universal preschool, the need for increased funding for subsidized care, the shortage of child care teachers, and quality of care were policy issues identified for the next legislative session.