

**BUDGET REVIEW AND ANALYSIS
OF THE
PUBLIC WELFARE
FINANCIAL ASSISTANCE PROGRAMS**

A Report to the Legislature of the State of Hawaii

**Submitted by the
Legislative Auditor of the State of Hawaii**

**Report No. 84-10
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FOREWORD

Pursuant to legislative direction, the Office of the Legislative Auditor has undertaken a budget review and analysis program aimed at providing the Legislature with additional assistance and perspectives in its consideration of program and budget requests coming before it for action.

In this second year of the program, we have focused upon selective aspects of the major programs of social services and health in addition to following up on the first two programs reviewed last year (lower education and higher education).

Presented in this report are the results of our examination of the public welfare financial assistance programs under the major program area of social services.

We wish to acknowledge the cooperation and assistance extended to our staff by officials and staff members of the Department of Social Services, the Department of Budget and Finance, the Department of Accounting and General Services, the Department of Health, and the Hawaii Medical Service Association.

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Chapter 1

INTRODUCTION

Purpose and Focus of Budget Review and Analysis

This budget review and analysis effort was undertaken in response to provisions contained in the legislative appropriation acts of 1981 and 1982, which directed the Legislative Auditor to initiate a program of budget review and analysis. The overall purpose of this effort is to assist the Legislature in gaining a better understanding of the program and budget requests coming before it for consideration.

More specifically, the objectives of budget review and analysis are:

1. To assess the processes by which budgets are developed and executed, with emphasis on quality of review and analysis at key decision points.
2. To identify and assess significant internal and external factors which influence or constrain budget preparation and execution.
3. To identify areas where the Legislature has expressed specific interest or concern and determine and assess the adequacy of the executive's responses.
4. To identify significant budget changes and evaluate the justifications or explanations provided to support those changes.
5. To examine and evaluate the content and presentation of existing budget information, provide additional or supplemental information, or suggest alternative means of presentation.

Attention was directed in our current budget review cycle to the general areas of social services and health. This report concerns the social services program. Within the social services program, Medicaid and the financial assistance programs were selected for analysis in this report, as was the budget process in general.

Organization of the Report

This report consists of seven chapters. Chapter 1 is this introductory chapter. Chapter 2 provides an overview of budgeting for the social services program and its financial assistance programs. Chapter 3 examines budgeting for financial assistance programs as practiced by the Department of Social Services and Housing. Chapters 4 through 7, respectively, contain analyses of problems relating to budgeting for the programs of Health Care Payments; Aid to Families with Dependent Children; Aid to the Aged, Blind and Disabled; and General Assistance.

Glossary

In this report we use numerous acronyms in discussions of the subject programs. To facilitate understanding of these terms, we list them here:

1. AABD—Aid to the Aged, Blind and Disabled.
2. AFDC—Aid to Families with Dependent Children.
3. AG—Attorney General or Department of the Attorney General.
4. ASO—Administrative Services Office of the Department of Social Services and Housing.
5. B&F—Department of Budget and Finance.
6. COLA—cost-of-living allowance.
7. COPP—Committee on Payment Projection.
8. DSSH—Department of Social Services and Housing.
9. FB—fiscal biennium.
10. FY—fiscal year.
11. GA—General Assistance.
12. HMSA—Hawaii Medical Services Association.
13. ICF—intermediate care facility.
14. MCAS—Medical Care Administrative Services of the Department of Social Services and Housing.

15. OBRA – Omnibus Budget Reconciliation Act of 1981.
16. PPS – Prospective Payment System.
17. R&S – Research and Statistics Office of the Department of Social Services and Housing.
18. SNF – skilled nursing facility.
19. SSI – Supplemental Security Income.
20. TEFRA – Tax Equity and Fiscal Responsibility Act of 1982.

Chapter 2

OVERVIEW OF BUDGETING FOR FINANCIAL ASSISTANCE PROGRAMS

This report is concerned with four programs within the Social Services major program area. The largest of these is a program entitled "Health Care Payments" (Medicaid). The other three are components of the program "Monetary Assistance." These three programs are: (1) "Payments to Families with Dependent Children" (AFDC); (2) "Payments to Assist the Aged, Blind, and Disabled" (AABD); and (3) "Other General Assistance" (GA).

The Magnitude of the Task of Budgeting for Financial Assistance

The four financial assistance programs that are covered by this report are the principal elements in the State's public welfare program. They are all administered by the Department of Social Services and Housing (DSSH) through its Public Welfare Division. Table 2.1 presents appropriations for the entire public welfare program, broken down by budget and appropriation categories and source of funding.

It can be seen from the table that public welfare has required over \$350 million per year in this biennium, of which more than \$190 million came from the general fund. Medicaid, AFDC, AABD, and GA account for about 90 percent of these amounts.

Even these large figures understate the total amount of public welfare expenditures, however, because they do not include food stamps, financed from federal funds but administered through the DSSH. Food stamps augment other welfare support by about \$72 million a year, according to DSSH. If added to appropriations, food stamps bring the total welfare "bill" in Hawaii to around \$425 million annually.

Table 2.1

Public Welfare Program Appropriations
By Source of Funds
Fiscal Years 1983-84 and 1984-85

		Total	General	Federal	Transfer
FY 1983-84					
SOC 111	Services to Individuals and Families	\$ 17,447,385	\$ 5,692,042	\$ 11,626,463	\$ 128,880
SOC 201	Payments for AFDC	93,217,149	44,445,715	48,771,434	---
SOC 202	Payments for AABD	7,044,476	6,709,476	335,000*	---
SOC 203	Payments for Child Welfare—Foster Care	1,878,681	1,806,306	72,375	---
SOC 204	Payments for Other GA	21,736,314	18,686,314	3,050,000*	---
SOC 230	Health Care Payments	190,317,124	103,801,937	79,067,080	7,448,107
SOC 236	Eligibility Determination	15,410,168	8,284,058	7,126,110	---
SOC 903	General Support for Public Welfare	3,573,263	1,552,855	2,020,408	---
	TOTAL (FY 1983-84)	\$350,624,560	\$190,978,703	\$152,068,870	\$ 7,576,987
FY 1984-85					
SOC 111	Services to Individuals and Families	\$ 17,562,463	\$ 5,845,692	\$ 11,587,891	\$ 128,880
SOC 201	Payments for AFDC	97,367,635	46,429,672	50,937,963	---
SOC 202	Payments for AABD	7,143,985	6,808,985	335,000*	---
SOC 203	Payments for Child Welfare—Foster Care	2,013,503	1,936,067	77,436	---
SOC 204	Payments for Other GA	22,803,318	19,753,318	3,050,000*	---
SOC 230	Health Care Payments	187,924,454	101,592,753	78,003,600	8,328,101
SOC 236	Eligibility Determination	15,476,467	8,208,914	7,267,553	---
SOC 903	General Support for Public Welfare	3,655,796	1,591,009	2,054,787	---
	TOTAL (FY 1984-85)	\$353,947,621	\$192,166,410	\$153,314,230	\$ 8,456,981
	GRAND TOTAL (FY 1983-85)	\$704,572,181	\$383,145,113	\$305,383,100	\$ 16,033,968
	Percent of Grand Total		54.4%	43.3%	2.3%

*Represents low income energy and refugee resettlement program appropriations.

Source: Act 301, SLH 1983.

Public welfare is large in numbers as well as dollars. DSSH reports an average of 68,000 persons receiving monetary payments and 99,200 receiving food stamps in fiscal year 1982. There were also 87,000 eligible for Medicaid benefits. Considering also the multitude of private physicians, hospitals, store owners, and landlords who affect and are affected by welfare programs, the magnitude of the task involved in estimating the costs and needs for these programs is indeed formidable.

The Complexity of Budgeting for Public Welfare

Besides being very large, public welfare programs and especially financial assistance programs, have certain unique characteristics that make budgeting for them quite different from the ordinary run of government activities. None of the money programs discussed in this report includes any personal services in their budgets, nor do they provide for other current expenses or equipment expenditures. Money payments only are involved, whether to beneficiaries or providers. Hence, the factors causing budgetary outlays are for the most part outside the ordinary administrative processes.

These programs are entitlement programs, and hence, have virtually no budget ceiling. Budgeting depends upon predicting caseloads and levels of payments, both of which are subject to considerable error. Then, if projections are wrong, expenditures are still extraordinarily difficult to control, without changes in eligibility or standards. Such changes are usually in the province of legal or political action, not administration.

Most of these programs are joint federal-state undertakings, and are therefore subject to two sets of laws, policies, regulations, and restrictions. These constraints are often voluminous, detailed, and complex, even when they are not in conflict. All of this gives rise to uncertainties, the clarification of which often lags behind budgetary, appropriation, and expenditure schedules. Sometimes changes occur in law or policy at a time when they cannot be incorporated in budgets or appropriations in a timely manner. This can, and has, given rise to erratic projections, appropriation crises, and even lawsuits.

The basic budget complication, however, is that money programs depend on socio-economic factors that change rapidly with low predictability. Analyzing these factors and converting them to dollar and caseload amounts is not easy, nor can it be exactly precise. But it has to be done.

Chapter 3

BUDGETING AS PRACTICED BY THE DSSH FOR ITS FINANCIAL ASSISTANCE PROGRAMS

In the preceding chapter we developed the idea that budgeting for financial assistance programs is a difficult and challenging operation. In this chapter we examine some aspects of budgets and budgeting as practiced in the DSSH and relate this examination to the challenges we found to exist.

Summary of Findings

With respect to DSSH budgeting in general we find that, while the department is adhering to a program budget format, it is not budgeting programmatically and is not meeting effectively the budgeting challenge it faces with respect to its financial assistance programs.

More specifically, we find that DSSH:

1. Does not adequately portray those financial assistance programs which it administers but which are funded exclusively by the federal government.
2. Does not formulate workable objectives and priorities to guide budgetary decisionmaking.
3. Does not develop adequate information bases and related capabilities to provide reasonable projections of its budgetary requirements.

Need for More Adequate Presentation of Programs Exclusively Supported by the Federal Government

Financial assistance programs administered by the State fall into three funding categories: (1) jointly financed by the state and federal governments, (2) exclusively financed by the State, and (3) exclusively financed out of federal sources. However, as the budgets for these programs are now presented, it is difficult to obtain a clear picture of these differentiations or of the overall amount of financial assistance being provided. The reason for this is the manner in which the exclusively federally financed programs are treated in the budget.

In the case of the low income energy and refugee resettlement programs, the costs are distributed among AFDC, AABD, and GA even though these two programs are quite discrete and identifiable on their own. The effects of this treatment is to create the appearance that some exclusively general funded programs are supported in part by federal funds and to inflate the apparent federal participation in joint federal-state programs.

In the case of the Food Stamp program, it does not appear in the budget at all. Considering that this program expends more than \$70 million a year and affects 100,000 recipients, its omission from the budget leaves an incomplete and badly distorted picture of the financial assistance efforts being carried out in Hawaii.

Recommendation

We recommend that DSSH work with the Department of Budget and Finance (B&F) to come up with a clearer and more complete budget portrayal of the financial assistance programs being administered by the State, including the programs which are fully financed by the federal government.

Failure to Develop Workable Priorities

For FB 1983-85, budget ceilings were prescribed for each department within which departments had considerable flexibility in allocating requests among individual programs and organizations. This method gave department heads considerable opportunity to fine tune their budgets.

When, in June 1983, the Governor announced restrictions on the FY 1983-84 appropriations, a similar technique was used. Departments were told how much to take out, but not whence to take it. In DSSH, subordinate units were asked to prepare expenditure plans that would give maximum savings, in the hope that the sum of those savings would equal the amount of the departmentwide restriction.

This method recognized that some programs could reduce costs more than others, and enabled managers to make decisions in the light of their programs. The instructions, however, gave little guidance as to how to evaluate services or assess where cost reductions would least threaten program accomplishment. The restriction goal was reached, but it could have been easier, and perhaps more generally equitable, if more top-level guidance had been available.

No general program priorities exist for budget preparation or program changes within the DSSH. Managers, in the absence of such priorities try to avoid curtailment or reduction of services, but each person is pretty much on his own and there is little assurance of departmentwide consistency.

One program, "Services to Individuals and Families," does have a formal priority system. This program administers principally federal funds under Title XX of the Social Security Act, and recently experienced not only a reduction in funds, but also block funding of what had previously been categorized grants. To adjust to the new system, a set of ten basic criteria was developed to rate the importance of and priorities for the various services offered. These criteria provide a good starting point for allocating funds, or distributing fund reductions. A similar plan probably could be used in the budget process for all of the public welfare programs, since budgeting within ceilings is similar to budgeting for block grants.

Recommendation

We recommend that program priorities be determined for the financial assistance programs to be used in developing budgets and, if necessary, in making decisions relating to cutbacks.

Need to Develop Adequate Information and Budgetary Projection Standards

There are problems in the DSSH concerning cost projections, overbudgeting, and data coordination. Inaccuracies and doubtful methodology plague the budget process in all the financial assistance programs, and often one branch of DSSH reports data different from another or interprets the same data differently. DSSH has recognized weaknesses in these vital areas, and has organized a Committee on Payment Projection (COPP) to try to resolve the problems.

One goal of COPP is to be make realistic projections for budgeting purposes. To do this requires a realistic and reliable cost and caseload data base for each of the financial assistance programs. A refined regression equation method using a number of variables, rather than one as at present, gives some promise of improving the mathematical projections. These will still, however, require informed and sophisticated adjustment to reflect the impact of the changing nature of

socio-economic factors, federal and state laws, and human behavior. COPP should help accomplish this, and thus improve budgeting for the financial assistance programs.

Overbudgeting for financial assistance is a major problem at present. Variances between budgeted amounts and actual expenditures have been significant in all programs—AFDC; AABD; and GA. Year end lapses of millions of dollars have occurred, especially in AFDC, and major transfers take place among these programs and between them and others within the DSSH. Budgeting certainly must come closer than it has if it is to serve its primary role as a statement of programs in financial terms. The continuing problem of appropriations running well ahead of expenditures, often by millions of dollars, is illustrated in Table 3.1. The result of this situation is that over the past six years, millions of dollars were transferred to other programs and millions more were lapsed.

Table 3.1
Financial Assistance Programs
General Fund Appropriations, Expenditures, and Lapses
Fiscal Years 1978 through 1983

	FY 1983	FY 1982	FY 1981	FY 1980	FY 1979	FY 1978
SOC 201—AFDC						
Appropriations	\$45,974,000.00	\$48,356,724.00	\$44,030,742.00	\$36,948,019.00	\$42,020,295.00	\$39,827,048.00
Expenditures	40,873,082.00	42,367,092.83	41,865,675.61	35,513,820.12	41,262,083.82	37,725,622.80
SOC 202—AABD						
Appropriations	\$ 7,400,000.00	\$ 7,544,553.00	\$ 9,174,000.00	\$ 7,759,000.00	\$ 6,729,140.00	\$ 6,473,566.00
Expenditures	6,153,434.28	6,492,483.43	6,585,563.12	6,027,501.05	6,208,311.66	6,172,033.80
SOC 204—GA						
Appropriations	\$16,990,000.00	\$17,654,508.00	\$20,000,000.00	\$19,000,000.00	\$24,174,492.00	\$24,576,198.00
Expenditures	17,403,111.00	15,749,604.76	14,994,601.91	15,515,821.68	18,313,605.98	24,689,127.33

Sources: Department of Accounting and General Services, *General Fund, Special Revenue Funds, Supplemental Detail to the Annual Financial Report of the State of Hawaii*, Fiscal Years 1978 through 1983; and Memorandum to Social Services and Housing, August 1, 1983, Subject: Statement of Operations for Appropriations for the Period July 1, 1982 to June 30, 1983.

There are a number of problems associated with overbudgeting. Most obviously, it sets aside unneeded moneys that presumably could have been used elsewhere if available. A somewhat less apparent effect is that funds can be made available to other programs without legislative approval. Least clear, but possibly most important, there is no real incentive for accurate budgeting or hard decisions as long as everyone is sure there is enough money.

Further comments on the impact of overbudgeting on individual programs appear in subsequent chapters of this report.

Recommendation

We recommend that the Committee on Payment Projections vigorously pursue its goal to refine and standardize the budgetary data base and projection methodology for the fiscal biennium 1985-87, with the objective of reducing overappropriations in the financial assistance programs.

Chapter 4

PROBLEMS RELATED TO BUDGETING FOR HEALTH CARE PAYMENTS

The Health Care Payments subprogram (usually referred to as medical assistance or "Medicaid") is the largest program in the Department of Social Services and Housing (DSSH). It is administered by the Medical Care Administrative Services (MCAS) within the Public Welfare Division.

Medicaid is a broad-based program that differs from other financial assistance programs in that it does not make payments directly to beneficiaries. Rather, it pays the providers who render hospital, physician, long-term care, and other services to eligible persons. This feature makes it among the most difficult programs to budget for, as the price of services vary and have, in recent years, gone up dramatically. This chapter examines a number of the problems associated with developing and administering Medicaid budgets.

Summary of Findings

With respect to the Health Care Payments (Medicaid) program, we find that:

1. The DSSH has not refined its budget making capabilities sufficiently to avoid shortfalls and carryovers at the end of fiscal periods and wide variances between projections and actual costs for services.
2. Financing for Medicaid from other than State sources is jeopardized to some extent by an inability to meet federal standards and a lack of an adequate system of collection from liable third parties.
3. Medicaid costs continue to escalate and DSSH has proposed certain cost cutting measures. However, DSSH has not systematically analyzed the various alternatives for cost containment in terms of the weighted impact and has not presented a consistent plan of action.
4. Recent legislation relating to reimbursements to long-term and acute care facilities represent potential means to reduce Medicaid costs. However, the proposals are clouded by uncertainty as to timing, fiscal impact, and clientele impact.

5. The program budget request for Medicaid does not adequately explain all pertinent and relevant factors such as the Omnibus Budget Reconciliation Act (OBRA) proviso on federal financial participation.

Background

Medicaid was established by the addition of Title XIX to the Social Security Act in 1967. With its amendments, Title XIX sets up a federally aided program which must be made available to needy persons receiving financial assistance under other titles of the act, and may be provided to the medically needy falling into several defined situations. Eligible persons must receive support for nine specified medical services, and may receive seven others at the option of the states. All services to all eligibles are paid for by a 50-50 matching arrangement between states and the federal government.

Hawaii offers all permitted services to all classes of eligibles, mandatory or not. This is a costly undertaking, and is becoming much more costly as time goes on. In the first year of the program, 1967, Hawaii's Medicaid cost was \$6.6 million; by 1978 it had increased almost 1,400 percent to \$90 million; and five years later, 1982, it had gone up another 80 percent to \$163 million. Continuing increases are forecast by appropriations of over \$190 million and \$187 million in fiscal years 1984 and 1985, respectively.

Increases since 1978 are entirely due to increased costs of services. While estimated program costs will rise by 120 percent from 1978 to 1984, the number of eligible participants is expected to drop by nearly 12 percent. This phenomenon explains much of the present concern for cost containment action.

Inadequacies of Budgeting for Medicaid

The principal task in budget preparation for Medicaid is projecting costs for the various services, which are determined by the number of recipients and the amount of vendor payments made on behalf of each. This is difficult enough, but even if projections are reasonably accurate, they may not correspond to actual cash expenditures in a given fiscal period because providers have one year after rendering service in which to submit their bills.

Erratic projections. Budget projections must be reasonably accurate, as they are the principal source of information on programs as well as the primary statement of the need for funds. Projections in the Medicaid budget do not meet the reasonably accurate standard by any means, as shown in Table 4.1, which compares budget estimates with actual expenditures for major vendor payments in recent years.

The table shows differences between projections and actual costs so great that the usefulness of budget figures for either program review or financial planning appears to have been almost zero. Intermediate care facility (ICF) projections were never within 35 percent in any of the three years and in 1983 were 68.9 percent lower than actual costs. Most of the other estimates were at least 20 percent off one way or the other. These significant variations suggest a lack of analysis on the part of DSSH in preparing budgets for the Medicaid program and either the misuse of good data or reliance upon erroneous data.

Three sets of data are available for analysis. Most important, of course, are the actual budget requests made by MCAS. These are the result of modification of data originally prepared by the Research and Statistics (R&S) division of DSSH. The third set was prepared by the Hawaii Medical Services Association (HMSA), but not directly used in budget preparation. Unfortunately, we were unable to determine the methodology used by R&S or by MCAS and no supporting information or documentation exists for either set of data. HMSA did submit supporting data and reported its methodology. With these limitations, we cannot truly evaluate the estimates—we can only report what they were and point out the discrepancies between MCAS budgets and the R&S and HMSA estimates.

A review of the 1983 projections by the three agencies and comparison with actual preliminary costs as reported by HMSA is revealing. Table 4.2 presents comparisons among fiscal year 1983 projections and the tentative actual expenditures for 1983 for six major services. The MCAS estimates are by far the lowest for in-patient hospital care and ICF and the highest for all the others, which nets out to a somewhat lower total for all services.

Table 4.1

Medicaid
Projected and Actual Costs for Specified Services
Fiscal Years 1981 through 1983

<i>Service</i>	<i>(1)</i> <i>Projected¹</i>	<i>(2)</i> <i>Actual²</i>	<i>(3)</i> <i>% Variance</i> <i>Col. 1</i> <i>less</i> <i>Col. 2</i>
Institutional Care Services			
Hospitals In-Patient			
FY 1981	\$26,485,207	\$28,978,252	(9.4)
FY 1982	30,373,947	34,249,807	(12.7)
FY 1983	33,482,703	42,563,252	(27.1)
Skilled Nursing Services			
FY 1981	25,559,971	18,736,621	26.7
FY 1982	29,309,400	22,874,683	22.0
FY 1983	32,306,688	25,261,349	21.8
Intermediate Care			
FY 1981	19,642,451	26,664,527	(35.7)
FY 1982	22,523,370	33,598,856	(49.2)
FY 1983	24,838,563	41,940,198	(68.9)
Other Major Services			
Physicians			
FY 1981	21,226,608	21,055,000	0.8
FY 1982	24,345,176	21,411,058	12.1
FY 1983	26,836,142	23,767,721	11.4
Dental Services			
FY 1981	9,958,503	8,877,021	10.9
FY 1982	11,443,199	8,792,498	23.2
FY 1983	12,639,948	8,927,404	29.3
Drugs			
FY 1981	7,851,929	6,066,917	22.7
FY 1982	9,026,603	6,538,656	27.6
FY 1983	9,952,758	8,056,493	19.1

¹Program Budget Request for Medicaid Program, Fiscal Year 1982-83.

²Medicaid Reports 1981 and 1982, and preliminary data 1983 from HMSA.

Table 4.2

Comparison of Budget Estimates
By MCAS, R&S, and HMSA with
Actual Tentative Expenditures
Fiscal Year 1983
(thousands of dollars)

Service	Expenditure	MCAS Estimate		R&S Estimate		HMSA Estimate	
		Amount	Percent Variance	Amount	Percent Variance	Amount	Percent Variance
Institutional Care Services							
1. Hospital In-Patient	\$42,563	\$33,483	(21.3)	\$41,727	(2.0)	\$40,543	(4.8)
2. Skilled Nursing Facilities	25,261	32,307	+27.9	27,140	+ 7.3	25,708	+ 1.8
3. Intermediate Care Facilities	41,940	26,762	(36.2)	37,760	(10.0)	41,000	(2.2)
Other Major Services							
4. Physicians Services	23,768	26,836	+12.9	24,835	+ 4.5	23,429	(1.4)
5. Dental Services	8,927	12,640	+41.6	8,918	(0.1)	8,856	(0.8)
6. Drugs	8,057	9,953	+23.5	6,686	(17.0)	7,075	(12.2)

Sources: Preliminary expenditure data from HMSA and projections reported by MCAS, R&S, and HMSA.

The importance of this table is in the amount of variance of each of the three estimates from actual expenditures. Except for drugs, HMSA and R&S were within 5 percent in eight of 10 estimates, and never over 10 percent off. MCAS, on the other hand, never came within 10 percent and missed by over 20 percent in five cases out of six.

The R&S and HMSA projections were not bad, and new methodology may make them better for the next biennium. But, however good they may be, they will not produce an accurate budget unless they are utilized by MCAS.

The carryover problem. The purpose of budgeting (and of the appropriations proceeding therefrom) is, of course, to provide funds to meet program expenditure requirements during a given fiscal period. If the appropriations and expenditures coincide, it can be said that the budget was an accurate description of the program in financial terms—which is all it is intended to be. If the two differ substantially, the budget can be said to either overstate or understate the program and in either case to be somewhat misleading.

DSSH regularly carries over Medicaid funds from one year to the next. This is supposed to be a hedge against unbilled services and is called an encumbrance, but it seriously distorts the budget and makes appropriations and expenditures somewhat independent of each other. This being the case, there is small reason to be overly precise in budgeting—the only test will be whether there is money at the end of the year, not whether the budget did really describe the program. Only when the carryover from the previous year happens to coincide with that of the current year, would expenditures and appropriations also coincide. This has happened only once since 1976.

In fiscal year 1981, for example, expenditures were less than 95 percent of appropriations, but a year later they were more than 105 percent. In dollars, these variances gave the appearance that the program was overbudgeted by \$7.4 million in 1981 and underbudgeted by \$7.6 million in 1982. This all happened because of an \$18 million carryover from 1981. This simply is not good budgeting, as it deprives the reviewing agencies, both executive and legislative, of any real means of grasping the nature and size of the program.

At the very least, the carryover system is confusing and misleading. It does not even accomplish its purpose, if that purpose is to offset unbilled obligations. In fiscal years 1981, 1982, and 1983, payment of prior year claims exceeded carryover funds available by \$27.5 million. Sound budgeting, prompt payment, and ordinary fiscal year cash accounting certainly can serve the needs of the Medicaid program without the problems incurred by the carryover system. No valid reason seems to exist for its continuation.

Need to Avoid Penalties and Enforce Third Party Liabilities

The topics discussed in this section are treated together because both have at least a potential impact upon non-state participation in Medicaid costs. Penalties can reduce federal contributions; collecting on third party liabilities can increase revenues from agencies other than federal or state Medicaid.

The State has been or is potentially liable for a \$6.8 million sanction for violating federal standards concerning: (1) untimely certification or recertification of patients in long-term care facilities; (2) untimely independent review of

long-term care facilities; and (3) quality control (eligibility) errors. DSSH has taken some steps to rectify the situation, but it is imperative that the agency do all it can to insure that errors are corrected to maximize federal participation.

Third party liability refers to those parties such as private health and accident insurance carriers, Medicare, and workers' compensation, which are liable for health service payments on behalf of their clients. There are two aspects to third party liabilities—prepayment when the liable third party is identified prior to reimbursements to providers, and post-payment when the third party is identified after the fact. Third party liabilities on a prepayment basis (e.g., Medicare) are under reasonable control by MCAS through its fiscal intermediary. Third party liability on a post-payment basis, which is predominantly related to no-fault insurance, has not been adequately addressed.

DSSH sources indicate \$2,565,696 was outstanding in post-payment third party liabilities as of May 1983. Three agencies are in some way involved in the effort to collect these moneys—the Attorney General (AG); Administrative Services Office (ASO) of DSSH; and MCAS. The AG has indicated to DSSH officials that the press of higher priority matters is such that he is unable to pursue collections because of lack of personnel; ASO says it wants to do it but it also lacks personnel and so it never has; and MCAS wants to retain a collection agency but has not been authorized to do so. Hence, the problem remains.

Failure to Address Cost Containment Adequately

DSSH, through its fiscal intermediary, has instituted some measures in the past to control costs by restricting payments to authorized vendors for authorized recipients, preventing duplicate payments, and shifting costs to liable third parties. Yet, costs continue to escalate. For example, the \$190 million appropriated for fiscal year 1984 is \$27 million (16 percent) over fiscal year 1983 and \$97 million (104 percent) over fiscal 1978, six years before. Efforts to reduce this problem through cost containment, however, have been sporadic and non-comprehensive.

Efforts at containment. In 1978, DSSH, responding to a legislative request, proposed several cost containment alternatives. Its report discussed the potential fiscal impact of eliminating the general assistance and medical assistance categories, and also the impact on medically needy patients. Some consideration

was given to the fiscal and social impact of eliminating optional services, such as dental treatment, eyeglasses, and hearing aids, but only superficially.

Four years later, DSSH considered some alternatives solely in terms of cost savings. It included a statement on the provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) which authorize states to impose liens on the real property of recipients under certain conditions, but did not discuss the Omnibus Budget Reconciliation Act of 1981 (OBRA) which authorized states to restrict patient freedom of choice to primary care physicians. This latter concept, according to a DSSH-retained consultant, will produce reductions in Medicaid expenditures as rapidly as any means with the least impact on the program and a minimal effect on recipients.

Prior to the 1983 session, DSSH considered cost containment possibilities of a number of actions, such as cutting services, restricting or eliminating eligibles, and copayments. No action was taken then except a proviso in the 1983 appropriation act reducing payments to individual providers by 10 percent. Then, in September 1983, DSSH held public hearings on a proposal to contain costs which included: elimination of family planning for general assistance clients and early periodic screening and testing outreach, limitations on the frequency of giving new eyeglasses and hearing aids, using eye screening instead of examination, and copayments by recipients. Of these, all are now in effect except copayments, which was not approved because of adverse testimony received.

In addition to the matters considered at the public hearings, DSSH is currently considering three proposals to increase cost effectiveness. These are to contract for drug costs and dental services and to make the existing contract of the fiscal intermediary subject to competitive bidding. There also is a possibility that the State may devise its own less costly system of paying for Medicaid acute care, as described in the discussion of the forthcoming federal prospective payment system in a subsequent section of this chapter.

Finally, the 1983 Legislature also requested DSSH and other agencies to investigate limiting freedom of choice (HR 18) and the Legislative Reference Bureau to study the feasibility of using home equity to obtain services (HR 19, H.D. 1).

All these efforts have involved a lot of work, but put together they still represent a "shotgun" approach. It has been sporadic, unsystemitized, and incomplete. Better and more concentrated efforts are needed.

The Waimano experience. Although not exactly the same kind of action as discussed above, two recent developments concerning Waimano Training School and Hospital either would have, or will have, the effect of reducing DSSH costs for Medicaid. These developments are discussed at length in our companion report on mental health and mental retardation, but in brief they consisted of: (1) an attempt to remove mental retardation intermediate care from the Medicaid program (which would essentially have eliminated Waimano as a provider); and (2) reclassification of some beds at Waimano from mental retardation to less expensive standard intermediate care. The former was stopped in the 1983 Legislature; the latter is now under way.

While both these ideas would reduce Medicaid costs, they can reduce state treasury revenue from the federal government by considerably more. Why this is so is explained in our other report. Here we only caution that all aspects of cost containment ideas need to be explored before they are jumped into.

TEFRA and the Social Security Amendments of 1982

Skilled nursing and intermediate care facilities (SNF and ICF) are currently reimbursed on a dual standard—one for freestanding facilities and another for hospital based facilities. Higher rates are paid for hospital based facilities in accordance with the theory of cost reimbursement. Their costs are higher, so they get more.

TEFRA changed this arrangement by providing for reimbursements to all facilities based on the cost experience of freestanding facilities. This portends substantial savings for the program. For example, implementation of this act would reduce reimbursements to one Hawaii hospital from \$128 to \$67 per patient day. Applied to the state Medicaid program, the total savings based on 1981 cost figures would be in excess of \$7.4 million for fiscal year 1984.¹

1. Derived from HMSA, Comparison of costs for SNF and ICF providers (based on 1981 finalized cost reports).

Implementation of this system was originally scheduled for July 1983 but has been postponed to July 1984. There is still uncertainty among knowledgeable persons, however, whether this will actually occur, or be extended again. This uncertainty makes it virtually impossible to make a firm and accurate estimate of long-term care costs for fiscal year 1985.

The Social Security Amendments of 1982 altered the Medicare method of reimbursing acute care facilities from the reasonable cost or charges approach to the prospective payment system (PPS). Prospective payment proposes to reimburse acute care facilities on predetermined rates based on diagnostic related groups of services, regional rates, and national rates. Institutions and fiscal intermediaries are preparing for implementation on July 1, 1984. While authorities are uncertain as to the impact of these changes, PPS is predicated on the assumption that cost savings can be realized for Medicare/Medicaid programs.

Although PPS specifically applies only to Medicare, state agencies must use it for Medicaid as well, unless a state plan is devised that can be shown to produce fee rates below Medicare's maximums. Such a procedure is being considered by DSSH but no definite decision has yet been made on the matter.

The reimbursement scheme for long-term care facilities would have major effects on some providers of service. There are 18 hospitals currently participating in Medicaid long-term care programs, of which eight are private and ten are public (county/state hospitals).

Private providers have some choices as to how to react to the changes. They may, of course, absorb the reduced Medicaid payments in their operations, which would affect neither Medicaid nor the public. They also could change the mix of their patients, however, limiting service to needy clients, or even eliminate long-term care in toto. The effect of elimination could be serious—in fiscal year 1981 private hospitals provided over 90,000 patient days service, or about one-eighth of the statewide total.² Unless some replacement for these beds could be found, placing Medicaid recipients would be difficult indeed. Finally, one hospital is considering selling its long-term facility, presumably to be operated in the future as freestanding.

2. *Ibid.*

The county/state hospital system has fewer choices. In the absence of a wholly unexpected increase in freestanding facilities, the public hospitals will have to continue to accept Medicaid long-term patients at the new rate. This has been estimated to result in a revenue loss to the hospital system of over \$4.5 million a year.³ This alone would pose a major financing problem for the State, which would be exacerbated if a number of private hospitals went out of the long-term business, thus pushing more patients into the public system. Further, there could be serious space problems in some hospitals.

Inadequate Budget Presentation

OBRA established overall dollar target limits for federal financial participation in Medicaid. This action has had and will have major impact on the Hawaii budget, but it has barely been recognized in the DSSH budget presentations.

The importance of the target lies in the fact that a general reduction in federal payments is imposed for incurring federal costs in excess of the target. The reduction is 4 1/2 percent of the total federal contribution.

Federal target levels will increase at a declining rate in future years. This, together with the likelihood (almost the certainty) of incurring reductions for exceeding these limits, needs to be clearly in mind when considering budget requests. Furthermore, the cost containment measures that might mitigate reductions without impairing service should be identified. Yet, the DSSH program budget request for FB 1983-85 merely comments that "Projections . . . includes [sic] consideration of a 4.5% reduction of Federal funds for each biennium year in accordance with Public Law 97-35."⁴ This tells the reader practically nothing. The presentation also gives no hint of any other penalties that might be in the works.

This discussion has focussed on the single problem of the target and its implications. It can be generalized, however, to include any other peculiarity of federal law, past or present.

3. *Ibid.*

4. Program Budget Request, FB 1983-85, Public Welfare Division.

Recommendations

With respect to the Health Care Payments Program (Medicaid) we recommend that DSSH:

1. Analyze its budget preparation process and methods and devise a better process to derive budget projections. The improved process should minimize the difference between projections and actual needs and enable the program to avoid excessive carryovers in some years and shortfalls in others.

2. Make every effort to: (a) reduce errors to eliminate the possibility of sanctions; and (b) resolve internal differences to expedite collection from liable third parties.

3. Systematically analyze alternatives for cost containment in terms of cost savings, short-term and long-term effect on recipients, and effect on providers of services and other programs in the system. The alternatives should be rated according to the degree they threaten recipients and their feasibility as well as by fiscal results.

4. Closely monitor the progress of developments relating to recent federal legislation on reimbursements to long-term and acute care facilities as these developments may have impact on the state Medicaid budget and other State activities.

5. Concisely and explicitly explain federal statutory changes and their impact on program and financing when presenting its budget.

Chapter 5

PROBLEMS RELATED TO BUDGETING FOR AID TO FAMILIES WITH DEPENDENT CHILDREN

Aid to Families with Dependent Children (AFDC), under a slightly different name, was one of the original programs set up by the Social Security Act of 1935. It is a state-administered program, financed in its essential parts by equal funding from the federal and state governments. As provided in Title IV-A of the Act, eligibility for AFDC extends primarily to families with children under 18 years of age who are in need of support because a parent is absent, ill, or deceased. Families with unemployed parents may also be eligible, as well as certain 18-year-olds who are in school.

Summary of Findings

With respect to the Aid to Families with Dependent Children program we find that:

1. DSSH's continued inability to keep within federally mandated target error rates for AFDC places the State in jeopardy of sanctions now and in the future.
2. The Omnibus Budget Reconciliation Act of 1981 (OBRA) dramatically altered the AFDC program. Its short-term effects have been to decrease the rate of program growth and to complicate budget projections as well as the administration and operations of the program.
3. There have been significant variances in recent years between appropriations and expenditures for AFDC. These variances during FY 1982 and 1983 are large enough to create concern about the reliability of budget requests.

The AFDC Budget

Although the preponderance of AFDC funds are expended under Title IV-A matching provisions, there are some other items in the budget, and one revenue item is included as an offset to costs. Table 5.1 shows the detail of the budget.

Table 5.1
The AFDC Budget
Fiscal Biennium 1983-85

<i>Item</i>	<i>FY 1984</i>	<i>FY 1985*</i>
AFDC-IV-A	\$ 91,604,304	\$ 95,451,685
Additional Rent for AFDC Recipients	938,565	2,201,823
Energy Assistance	1,000,000	1,000,000
Refugee Assistance	1,500,000	1,500,000
Total AFDC Requirement	\$ 95,042,869	\$100,153,508
Less: State Share—Child Support Collections	1,825,720	2,008,291
ADJUSTED TOTAL	\$ 93,217,149	\$ 98,145,217

*FY 1985 budget shown is based on Department of Social Services and Housing projections and not the actual appropriation.

Source: Department of Social Services and Housing, "Statewide SOC 201, AFDC Updated Projections," July 14, 1983.

Cost elements other than Title IV-A. Components of the budget, other than basic Title IV-A payments, arise from recent changes in federal policy and law. Additional rent money is provided to welfare recipients residing in housing subject to federally-mandated rent increases. Similar provisions apply to AABD recipients, and costs are shared equally by the federal and state governments.

Energy assistance is a one-time payment to welfare recipients to compensate for increased energy costs, while refugee assistance is temporary help given qualified refugees for up to 36 months after arrival in the United States. After 36 months, refugees are supported, if necessary, by the categorical program for which they are eligible. Both the energy and refugee programs are entirely funded by the federal government and apply to all three major financial assistance programs—AFDC, AABD, and GA.

Child support offsets. Total AFDC program costs are offset in part by child support collections. AFDC recipients are required to sign over to the state all child support payments received. Half of what is collected is kept by the state and the other half is forwarded to the federal government. The state share of child support collections is subtracted from the total projected needs for AFDC and the adjusted total becomes the net budget request.

High Rates of Error in AFDC Determination

The federal government regularly tests the quality of AFDC administration by computing "error rates;"—i.e., the number of errors in eligibility determinations and overpayments as a percentage of all determinations. In 1979, Congress mandated that failure to meet target error rates would result in loss of federal financial participation. Hawaii has not been able to meet the targets set, and therefore is in jeopardy of having sanctions applied. If the sanctions are assessed, they would in effect require that general funds be used to replace the federal funds withheld. Table 5.2 summarizes Hawaii's AFDC error rate experience since 1981.

Table 5.2
Actual and Target Error Rates¹
Fiscal Years 1981 through 1984

<i>Federal Fiscal Year</i>	<i>Error Rate (Determined By State)</i>	<i>Error Rate (With Federal Adjustment)</i>	<i>Target Payment Error Rate</i>
1981	9.0	10.1	7.5
1982	7.0	—	5.8
1983	7.6 ²	—	4.0
1984	—	—	3.0

¹Error rates are for payments to ineligible and overpayments.

²First six months only.

Sources: Honolulu Office of Family Assistance, "Hawaii AFDC Actual & Target Error Rates," March 4, 1983. Department of Social Services and Housing, Income Maintenance Program Development Office.

As the table shows, Hawaii had a computed error rate of 10.1 percent during the first sanction period (FY 1981). As the target rate was only 7.5 percent, the Commissioner of Social Security levied a \$1.2 million sanction. Hawaii has requested a waiver of the sanction, the outcome of which was unknown when this report was prepared.

Not only is the 1981 sanction of concern, there are real possibilities of future sanctions also. The table shows that, despite some improvements, Hawaii's unadjusted rates fall farther and farther behind a steadily declining target rate. Assuming the tentative rates are confirmed (they are more likely to be increased),

more millions of dollars could be withheld. This is a matter of great concern that warrants priority attention.

There are plans for computerizing some aspects of eligibility determination, which may result in reducing errors, at least in the long run. Pending computer installation, DSSH has taken certain steps, such as creating a Corrective Action Committee and seeking to improve its utilization of personnel. These moves give some promise, but the Legislature should monitor the department's corrective efforts to see that they are sustained. The goal must be a steady reduction in errors, thus avoiding sanctions and improving the integrity of the program.

The Impact of OBRA on AFDC

For the past two years, the AFDC program has been adjusting to major changes in eligibility requirements as mandated by the Omnibus Budget Reconciliation Act of 1981 (OBRA). Nineteen OBRA provisions affected Hawaii's AFDC program. The five provisions with most impact on reducing costs and cases are outlined in Table 5.3.

Table 5.3
Major OBRA (1981) Provisions
Impacting Hawaii's AFDC Caseload and Costs

<i>OBRA Provision</i>	<i>Regulation Prior to OBRA</i>	<i>Estimated Payment Decrease</i>	<i>Estimated Cases Terminated</i>
1. Four month limit on earned income disregard (\$30 plus one-third).	No limit on earned income disregard deduction.	\$4.2 million (October 1981– August 1982).	700 (October 1981– September 1982)
2. 150 percent gross income limit for eligibility.	No gross income limit. Eligibility based on net income.	\$2.5 million (October 1981– September 1982)	1,200 (October 1981– August 1982)
3. Third trimester pregnancy qualification.	Women could qualify for AFDC as soon as they could verify pregnancy.	\$1.4 million (October 1981– September 1982)	200 (October 1981– September 1982)
4. Elimination of 18–21 year old dependents.	18–21 year olds could receive assistance so long as they were in school.	\$1.1 million (October 1981– September 1982)	350 (October 1981– September 1982)
5. Change in grant calculation order.	Deducted earned income disregard (\$30 and one-third) first rather than last.	\$1.0 million (October 1981– September 1982)	500 (October 1981– September 1982)

Source: Income Maintenance Program Development Office, Public Welfare Division.

The provision which had the most impact on decreasing payments was the four-month limit on the so-called earned income disregard. This is a system whereby \$30 plus one-third of income is deducted from earnings prior to determining the level of welfare payments. Prior to OBRA, there was no limit as to how long the disregard could be applied. DSSH estimates some \$4.2 million was saved during the first year the four-month limit was in effect.

The OBRA provision which terminated the most cases from the AFDC rolls was the 150 percent income limit for eligibility. The new requirements deny AFDC eligibility to families whose gross incomes are 150 percent or more of the State's welfare needs standard. Some 1,200 cases were terminated between October 1981 and August 1982 because of this provision.

Three other changes affected essentially procedures, rather than benefits. *First*, allowances for child care costs were applied to AFDC income calculations, rather than being paid through Title XX as previously. *Second*, a retrospective budgeting system now bases a recipient's grant amount on actual income and expenses incurred two months earlier, rather than on estimates of future budgets. *Third*, monthly reporting is now required of all AFDC recipients. These three changes have all changed the work assignments of a number of staff members, and some have probably increased the clerical aspects at the expense of time available for comprehensive case reviews and redeterminations.

Large Variances Between Appropriations and Expenditures

Prior to fiscal year 1982, differences between AFDC appropriations and expenditures were relatively small. During 1982, however, the variance increased a great deal, probably in large part because of the tightened eligibility requirements mandated by OBRA. Monthly AFDC caseload decreased 8.5 percent between October 1981 and June 1982, and monthly costs decreased from \$7.7 million to \$7.2 during the same period.

Large variances between general fund appropriations and expenditures occurred in both FY 1982 and FY 1983, amounting to over \$5 million each year, or more than 10 percent of the appropriations. Over-appropriations of this magnitude are of concern because: (1) they allow the executive branch to transfer millions of dollars to programs without legislative approval; (2) they could tie up money that

might be used to advantage in other state programs; and (3) they have been used to meet state funding restrictions, thus avoiding any real belt tightening or program review.

The likelihood of future large general fund balances in the FB 1983-85 appropriation remains unclear at this time. The impact of legal suits against the department may have an effect on total program costs in the future, and error rate sanctions could increase the general fund's percentage participation in AFDC. These variables add further complications to budgeting, but despite them, the budget should certainly come closer in the future than it has in the past.

Recommendations

With respect to the Aid to Families with Dependent Children program we recommend that the DSSH:

- 1. Devise both short-term and long-term measures to reduce its error rate problem;*
- 2. React as quickly as possible to changes in federal law and share such changes with appropriate legislative committees as soon as their impact can be estimated; and*
- 3. Refine its budget projections in the AFDC program to bring appropriations more in line with expenditures.*

Chapter 6

PROBLEMS RELATED TO BUDGETING FOR AID TO THE AGED, BLIND AND DISABLED

Aid to the Aged, Blind and Disabled (AABD) is a complex combination of financing arrangements designed to aid persons in various categories in a number of different ways. The basic program is Supplementary Security Income (SSI) which is administered and largely financed by the federal government. SSI replaced the former "AABD" categorical programs that dated from the original Social Security Act of 1935. The old program, like most others, was state-administered and supported in part by federal funds. SSI is just the reverse: a federally-administered program supported in part by state funds.

Besides SSI, other supplemental programs have developed at the state level, all of which are shown in the AABD budget. These are: (1) state supplements to bring up the income of recipients to the State's welfare standard; and (2) additional state payments to recipients in domiciliary care facilities. Additional rent payments, energy subsidies, and refugee assistance payments are also made to AABD clients, as they are to those of other financial assistance programs.

Summary of Findings

With respect to budgeting for the Aid to the Aged, Blind and Disabled Program, we find as follows:

1. Significant program appropriations have remained unexpended at the end of each recent fiscal year.
2. Insufficient information has been presented in justification of the budget, with the result that both executive and legislative reviews are hampered.
3. DSSH has not, as yet, identified the specific reasons for the inadequacy of AABD budget projections and thus has only limited capability for improvement.

Program Budget

The State includes six separate activities in its AABD budget. Table 6.1 shows the detail of appropriations for fiscal years 1984 and 1985.

Table 6.1
Aid to the Aged, Blind and Disabled
Allocation of Appropriations
Fiscal Years 1984 and 1985

	<i>FY 1984 Allocation</i>		<i>FY 1985 Allocation¹</i>	
	<i>Amount</i>	<i>Percent</i>	<i>Amount</i>	<i>Percent</i>
SSI State Share	\$4,500,000	63.9	\$4,500,000	62.4
AABD—State Supplement	496,838	7.1	517,705	7.2
Domiciliary Special Payments	1,637,065	23.2	1,676,600	23.2
Additional Rent for AABD Recipients	75,573	1.1	177,290	2.5
Energy Assistance ²	300,000	4.2	300,000	4.2
Refugee Assistance ²	35,000	0.5	35,000	0.5
TOTAL	\$7,044,476	100.0	\$7,206,595	100.0

¹ Fiscal year 1985 budget allocations shown are based on Department of Social Services and Housing projections and not actual appropriation.

² Federally funded.

Source: Department of Social Services and Housing, "Statewide SOC 202, AABD Updated Projections," July 14, 1983.

The table shows that well over 90 percent of the budget is attributable to the state share of SSI, the AABD state supplement, and domiciliary special payments programs. These activities are described below.

Almost two-thirds of the budget is attributable to the state's share of SSI payments. The amount was largely determined in 1974, when SSI first began. At that time, 24 states (including Hawaii) were providing assistance under the old AABD categorical programs at a higher level than the new SSI federal base amount. These states were required by the federal government to maintain pre-SSI benefit levels for previous recipients by paying the difference between the federal SSI base payment and the pre-SSI benefit level. Hawaii opted also to pay new SSI recipients at pre-SSI benefit levels—a step that relieved the State from paying certain future cost increases. State funds are remitted to the Social Security Administration which

makes direct payments to beneficiaries. The state share is now \$4.2 million, or about one-fourth of the total SSI benefits paid in Hawaii.¹

The AABD state supplement provides additional payments to needy aged, blind or disabled persons whose total incomes fall below the State's welfare needs standard. The amount of the state supplement is the difference between the recipient's income and the State's welfare standard. DSSH projects expenditures of \$496,838 for AABD supplemental payments in 1984—approximately 7 percent of the AABD budget.

Domiciliary care special payments are provided to eligible aged, blind or disabled persons needing care in licensed boarding and care homes. The SSI program pays recipients in domiciliary care at three levels, ranging from \$384.20 to \$496.20 a month. The State augments this with payments from \$55 to \$108 per month to help meet the high local cost of boarding home care. In fiscal year 1984, \$1.6 million or 23 percent of the AABD budget is projected for this activity.

Significant Program Appropriations Unexpended

We pointed out in Chapter 3 that in many of the financial assistance programs major amounts of appropriations were used for other programs or lapsed at the end of the fiscal year. For AABD these amounts were \$4.3 million lapsed in FB 1979-81; and \$2.5 million (mostly transfers) in FB 1981-83. These amounts represent 25 percent of the total appropriation in 1979-81 and 15 percent in 1981-83.

Attempting to alleviate future over-appropriations for AABD is complicated by the complexity of both the programs contained in the budget and the diverse variables which affect program costs. These are indeed extenuating circumstances, but the fact is that a budget that overstates needs by 17 percent (as in fiscal year 1983), let alone 28 percent (as in fiscal year 1981) is not really a budget. It is a guess on the high side and as such is of very little use to reviewing authorities in either evaluating program or allocating limited funds.

1. Federal and state cost figures cited in 1983-85 *Executive Budget and Program and Financial Plan*, p.1078.

Insufficient Information in Budget Justifications

The involved relationships among AABD programs indicates that full, careful, and precise budget presentations are necessary to clarify program and justify requests. Recent presentations have not been any of these things.

Most noticeably, the latest Program and Financial Plan narrative does not clearly differentiate between the SSI state share and the AABD state supplement. Separate cost projections are shown, but the limited narrative does not really tell the reader what the difference is or how the system works. Also, cost projections are not documented and historical cost data are not provided. Other examples of insufficient information in the budget document include: (1) the subprograms included in "AABD program caseload" figures are not specified; (2) data supporting the estimated cost increase in domiciliary special payments and AABD state supplements are not provided; and (3) background for increased shelter costs is not given. This lack of adequate information probably hampers B&F in its budget review and certainly limits the Legislature's ability to evaluate the request accurately.

Failure to Adequately Identify Specific Causes of Incorrect Budgeting

DSSH has not adequately identified specific sources of errors in budgeting in either the 1983 Variance Report or the FB 1983-85 executive budget document. The 1983 Variance Report does state that transfers from AABD were made to other DSSH programs in FY 1983 and notes the sharp decrease in AABD state supplement caseload as being a cause for overestimating expenditures. However, there is no mention of a significant overallocation for SSI state share costs in FY 83 and the reasons therefor. Since the Variance Report is the only document in which DSSH provides any analysis of proposed vs. actual expenditures, it is vital that all the causes for overestimates be provided to prevent future overappropriations.

Excess funds in the AABD state supplement allocation probably resulted from a decrease in AABD caseload during fiscal year 1983. Since most AABD state supplement recipients also receive SSI payments, any changes in SSI benefit levels have an impact on AABD caseload. Whenever federal SSI benefit levels rise because of cost-of-living (COLA) increases, more SSI recipients reach the state welfare standard, disqualifying them for AABD state supplements.

Between July 1980 and June 1983, there have been three COLA increases for SSI recipients, and state AABD caseloads have dropped by 78 percent. This dramatic decrease in caseload probably accounts for most of the drop in costs, but seems not to have been anticipated. Because another COLA increase for SSI recipients was scheduled for January 1, 1984, its impact on AABD state supplement caseload and costs should be carefully weighed in any forthcoming budget considerations.

The reason for the overallocation of the SSI state share budget in fiscal year 1983 is not clear, and the somewhat lower allocations for the next two years are encouraging signs. One variable that may further decrease the state share is reductions made in the level of payments when the July 1983 federal COLA increases took effect. Though this reduction would appear to decrease state costs, the federal authorities have been reluctant to confirm this assumption because of some technicalities in the SSI regulations. Perhaps by early 1984, this question will be resolved and DSSH will have a better idea of the actual impact of the reduction.

Recommendations

With respect to budgeting for the Aid to the Aged, Blind and Disabled Program, we recommend the following:

- 1. Because of major past overappropriations, B&F, the Legislature, and DSSH should carefully monitor program caseload and cost trends in fiscal year 1984 to determine whether reductions in current FB 1983-85 appropriations are warranted.*
- 2. DSSH should improve the quality and scope of the program descriptions and budget information which the department presents in the executive budget, especially for programs as complex as AABD.*
- 3. DSSH should attempt to identify specific causes for errors in budget projections and work towards reducing such errors.*

Chapter 7

PROBLEMS RELATING TO BUDGETING FOR GENERAL ASSISTANCE

General Assistance (GA) is a state program aimed at persons not eligible for federal financial assistance but who are still considered to be in need of support. GA eligibility criteria limit benefits to recipients who are unable to provide sufficient support for themselves or those dependent upon them and are: (1) disabled; (2) 55 years or older; or (3) families with dependent minor children.

The program budget for GA is a good deal simpler than those for the other major financial assistance programs. All money payments derive from the State's general fund so there are no problems of matching or conforming to federal accounting procedures. There is a relatively small federal contribution shown in the GA budget, but it is only for energy and refugee assistance. For fiscal year 1984, general fund appropriations are about \$18.7 million, rising to \$19.7 for 1985. Federal energy and refugee payments are estimated at \$3 million each year.

Summary of Findings

With respect to the General Assistance Program, we find as follows:

1. Payment error rates for the GA program were unacceptably high during fiscal year 1983, averaging 19.3 percent for the year. The problem of high payment error rates is compounded by DSSH's limited ability to recover overpayments from GA recipients.
2. Legislation since 1978 has created a GA program that is controllable both as to caseloads and costs. It is possible, however, that maximum advantage has not been taken of the cost control opportunities provided by the legislation.
3. Budgeting in recent years has been uncertain and inconsistent as evidenced by wide fluctuations in the relationships between appropriations and expenditures.

Unacceptably High Payment Error Rates

The quality control unit of DSSH computes error rates for general assistance, as well as for the federally-aided programs such as AFDC, food stamps, and Medicaid. There is a difference in the use made of computed rates, however. If, after confirmation, error rates for federal programs are over allowable limits, sanctions may be applied in the form of withholding federal payments. This forces the State to use its own money instead, so error rates have a clear and direct relationship to the financing of programs. The GA error rate has no such effect, because the GA program is financed by the State.

Use of GA error rates. The GA rate triggers nothing in itself. Regardless of how high or how low it is, there is no effect unless and until the errors themselves are corrected. Nevertheless, error rates in the GA program have great potential value to measure program efficiency and the effectiveness of operational controls. A high rate obviously means that the agency generally is not doing a good job. In addition, the nature of the errors can point the way toward activities that are particularly error prone and hence deserving of special attention. More important over the long run, error rates can point the way to areas of cost savings and recoveries.

The 1983 error rate determination. In fiscal year 1983, the quality control unit issued two error rate determinations—one for each half of the year. The results of the 1983 reviews are shown in Table 7.1.

Table 7.1

General Assistance Error Rates
Fiscal Year 1983

<i>Review Period</i>	<i>Payments to Ineligibles</i>	<i>Over-Payments</i>	<i>Combined</i>
July 1982–December 1982	20.0%	1.3%	21.3%
January 1983–June 1983	15.4%	1.9%	17.3%
YEAR AVERAGE	17.7%	1.6%	19.3%

Sources: Department of Social Services and Housing, Program Evaluation Office, "General Assistance, Semi-Annual Report: July 1982–December 1982," February 1982.

Department of Social Services and Housing, Program Evaluation Office, "General Assistance, QC Semi-Annual Report: January 1983–June 1983," September 1983.

While there probably is no “magic number” separating “good” rates from “bad” ones, we view the 17.7 percent rate of payments to ineligible as unacceptable. There are several reasons for this. *First*, there clearly are public funds being paid to persons who are not, under existing legislation, entitled to them. Theoretically, this could amount to as much as \$3 million a year. *Second*, the integrity of the program is called into question when one recipient out of six is being treated, however inadvertently, in a preferential manner. *Third*, error rates of this magnitude seem to indicate that recruitment, training, and supervision of staff might have deficiencies, even granting the fact that the rules are complicated and the work is hard.

Difficulty in making recoveries. The high payment error rates for the GA program lead to concern about the adequacy of the recovery system in place at DSSH to collect erroneous payments, especially from persons no longer receiving benefits.

DSSH's Investigation and Recovery Services is charged with collecting overpayments involving inactive financial assistance cases. However, under present conditions, it cannot keep up with the number of cases referred. Between October 1982 and June 1983, its active non-fraud caseload involving GA recipients rose 34 percent—from 1,242 to 1,663. During that same period, the amounts owed the department for non-fraud GA cases increased 42 percent, from \$631,989 to \$895,717.¹

The rapid increase in recovery caseload was probably due in large part to the high number of errors in fiscal year 1983, although some may also be attributable to inefficiencies in the current recovery system. Our concern is that should high error rates in the GA program continue and should the current recovery system not be improved, a substantial portion of the payments being given to ineligible recipients will never be recovered.

Possible Failure to Take Full Advantage of Legislation

Two major pieces of legislation in recent years have reshaped the GA program. Precipitous increases in caseloads between 1975 and 1978 led the Legislature to exclude from eligibility able-bodied single persons below the age of 55 with no dependent children (Act 103, SLH 1978). In 1982, tightened eligibility for AFDC

1. Caseload and cost data are from Investigation and Recovery Services.

created a situation where GA requirements were more liberal than AFDC. Consequently, the Legislature required a prior finding that GA applicants were ineligible for any federal-aided program before accepting them under general assistance and imposed stricter penalties for failure to comply with GA requirements (Act 99, SLH 1982).

These two amendments created a controllable system, but at the same time placed considerably more responsibility on the DSSH to enforce the new rules strictly and equitably. It remains to assess the success of the effort. Table 7.2 presents certain pertinent information on the financial and caseload trends from 1978 through 1983.

Table 7.2
General Assistance Caseload and Cost Trends
Fiscal Years 1978 through 1983

	FY 1978	FY 1979	FY 1980	FY 1981	FY 1982	FY 1983*
Average Monthly Caseload	8,139	6,327	5,923	5,999	5,974	5,966
Percentage Change		(22.3)	(6.4)	1.3	(0.4)	(0.1)
Expenditures	\$24,689,127	\$18,313,605	\$15,515,822	\$14,994,602	\$15,749,605	\$17,403,111
Percentage Change		(25.8)	(15.3)	(3.4)	5.0	10.5
Average Cost Per Case—Annual	\$ 3,033	\$ 2,894	\$ 2,620	\$ 2,500	\$ 2,636	\$ 2,917
Percentage Change		(4.6)	(9.5)	(4.6)	5.4	10.7

*Trial Balance.

Sources: Costs—Department of Accounting and General Services Annual Reports for fiscal years 1978 through 1982. Department of Accounting and General Services Trial Balance dated August 1, 1982 for fiscal year 1983. Caseloads—Department of Social Services and Housing Annual Reports for fiscal years 1978 through 1980. Research and Statistics Office caseload data for fiscal years 1981 through 1983.

If the test of the legislation is control of caseloads, the data on Table 7.2 indicate considerable success. There was a dramatic 22 percent reduction in cases following the 1978 law. The caseload has been virtually constant for the last four years, at a level substantially under the 1978 figure. Costs, however, have gone up significantly in the last two years. Costs per case have also risen to the highest level since 1978.

The cost-per-case figures are not easily explained, as unit costs declined during the high inflation years of 1978 to 1981 and then shot back up as inflation moderated in 1982-83. Two reasons suggest themselves: (1) higher housing costs have caused more recipients to reach the shelter maximum than before; and (2) continued and worsening unemployment has reduced the earnings of recipients and therefore increased their welfare payments.

These reasons are speculative at this time, and we believe that DSSH should investigate the matter. Greater knowledge of the specifics of per-case cost increases might reveal cost control opportunities.

Uncertain and Inconsistent Budgeting

Budgeting for the GA program has been erratic in recent years. Table 7.3 shows appropriations and expenditures from fiscal years 1978 through 1983.

Table 7.3
Appropriations, Expenditures and Variances
General Assistance Program
Fiscal Years 1978 through 1983
(amounts in thousands)

<i>Fiscal Year</i>	<i>(1) Appropriations</i>	<i>(2) Expenditures</i>	<i>(3) Difference (Col. 1 less Col. 2)</i>	<i>(4) As Percentage of Appropriations</i>
1978	\$24,576	\$24,689	(\$ 113)	(0.5)
1979	\$24,174	18,314	5,860	24.2
1980	19,000	15,516	3,484	18.3
1981	20,000	14,995	5,005	25.0
1982	17,655	15,750	1,905	10.8
1983	16,990	17,403	(413)	(2.4)

Sources: Department of Accounting and General Services Annual Reports for fiscal years 1978 through 1982; Department of Accounting and General Services Trial Balance dated August 1, 1983 for fiscal year 1983; and Department of Social Services and Housing Transfer Authorizations for fiscal year 1983.

Inspection of the table reveals that there was a minor shortfall in appropriations in 1978, followed by very large overappropriations in the next three years, a smaller overappropriation in 1982 and another, larger, shortfall in 1983. One of these wide variances is understandable. In fiscal year 1979, caseloads decreased sharply as a result of Act 103, SLH 1978.

However, in the 1979-81 biennium, major overappropriations occurred, even though a lower level of caseloads was known to exist. During the most recent biennium, 1981-83, caseload remained about the same but costs per case began to increase again. The result was an overappropriation in 1982, but a shortfall in 1983. In that year costs went up by \$281 per case, and total costs were badly underestimated. The appropriation for 1983 was \$665,000 lower than the preceding year, but the expenditures were \$1,653,000 higher for substantially the same caseload.

Recommendations

With respect to the General Assistance Program, we recommend that:

- 1. Because the threat of federal fiscal sanctions does not hang over the GA program to stress improved quality control, DSSH itself must place reduction of GA errors in higher priority for the sake of improving internal control, ensuring program integrity, and controlling costs.*
- 2. DSSH should analyze the causes of the large increases in general assistance cost per case during FB 1981-83 and determine whether any of the causes can be controlled to stabilize future costs.*
- 3. As with the other financial assistance programs, DSSH should improve its budget projections for the GA program through better and more detailed analyses of factors that have impact upon program costs.*