REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

CALIFORNIA CAN REDUCE STATE AND COUNTY EXPENDITURES FOR MEDICAL SERVICES TO CHILDREN

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Telephone:
(916) 445-0255

Thomas W. Hayes
Auditor General

STATE OF CALIFORNIA
Office of the Auditor General
660 J STREET, SUITE 300
SACRAMENTO, CA 95814

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Honorable Art Agnos, Chairman
Members, Joint Legislative
Audit Committee
State Capitol, Room 3151
Sacramento, California 95814

Dear Mr. Chairman and Members:

The Office of the Auditor General presents its report concerning the California Children Services program (CCS). The Department of Health Services through the CCS could reduce state and county expenditures for medical services. The CCS is paying for medical costs of some children although the children's medical insurance or the Medi-Cal program could pay for all or a portion of the medical costs. In addition, the CCS could collect delinquent repayments from families by withholding all or a portion of families' state income tax refunds. Finally, the CCS should determine a child's financial eligibility for CCS services by using the family's assets and income.

We conducted this audit to comply with Item 4260-001-001 of the Supplemental Report of the 1984 Budget Act.

Respectfully submitted,

for THOMAS W. HAYES
Auditor General

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SUMMARY

California could have reduced its expenditures for medical services for children by millions of dollars between January 1, 1983, and October 31, 1984. The Department of Health Services is the state agency responsible for administering the California Children Services program (CCS). We reviewed CCS activities in four counties and found that CCS expenditures could have been lower by at least $1 million if the CCS had required providers of medical services to submit bills to children's medical insurance companies and by $370,000 if the CCS had referred to the Medi-Cal program all children eligible for Medi-Cal benefits. In addition, the CCS could have reduced expenditures by as much as $2.7 million if state law had permitted the CCS to consider family assets in determining a child's eligibility for CCS care. Further, the CCS could have increased its collection of delinquent repayments by at least $26,000 if it had used the State's tax intercept program.

Failure To Require Providers To Bill Insurance Companies

In Los Angeles, Sacramento, San Diego, and San Francisco counties, we examined a random sample of files for children for whom the CCS provided medical services from January 1, 1983, through October 31, 1984. The CCS pays for medical care for children who have certain severe medical conditions and whose families meet criteria for financial eligibility. Some children are also insured by private medical insurance companies. The state CCS Manual of Procedures requires that providers of medical services bill children's insurance companies before submitting bills to the CCS.

The CCS, however, does not always require providers to bill insurance companies; consequently, the CCS pays bills that insurance companies may pay. In the four counties we visited, the CCS paid

medical bills for 3,148 children whose insurance companies could have paid all or a portion of the medical bills. We estimate that the CCS paid medical costs of at least $1 million that should have been billed to insurance companies.

Lack of Authorization To Consider Family Assets

Under current law, the CCS determines a child's financial eligibility based on the adjusted gross income of the child's family, as reported on the most recent California income tax return. Children are eligible for CCS care if the family's adjusted gross income does not exceed $40,000. State law does not permit the CCS to consider the assets of the family in determining financial eligibility.

We examined state income tax returns for families of children in our sample for calendar year 1983 and estimated that 1,427 families had savings accounts, stocks, and rental property worth over $40,000. We did not include a family's residence and business assets. These families represent 4 percent of the families whose children were eligible for CCS care in the four counties. The families could have used these assets to pay for the children's medical care. Between January 1, 1983, and October 31, 1984, the CCS in the four counties we visited could have reduced expenditures by as much as $2.7 million if the CCS had statutory authority to consider family assets worth over $40,000 in determining financial eligibility. Although the Department of Health Services opposes using family assets in determining financial eligibility, our survey of county CCS administrators found that the majority favor a system that considers family assets in addition to family income.

Failure To Refer Children Eligible for Medi-Cal

The CCS is not referring to the Medi-Cal program all children potentially eligible for Medi-Cal benefits. Because the federal government contributes approximately 50 percent of the cost of the Medi-Cal program but only 10 percent of the cost of CCS care, referring eligible children to the Medi-Cal program reduces state and county expenses. Although the Medi-Cal program considers the assets of a child's family in determining the child's eligibility for Medi-Cal benefits, the CCS guidelines for referring children to the Medi-Cal program consider only a family's adjusted gross income. Consequently, the CCS does not identify all children potentially eligible for the Medi-Cal program.

We reviewed the state income tax returns of families of children in our sample and estimated that 3,305 children, 10 percent of children eligible for CCS care, were potentially eligible for Medi-Cal benefits because their families had few assets. We also found that county CCS staff did not always follow the current CCS guidelines for referring children to the Medi-Cal program. If the CCS staff in the four counties we visited had referred to the Medi-Cal program all children potentially eligible for Medi-Cal benefits during the period covered by our review, we estimate that the CCS could have reduced state and county expenditures in the four counties by $370,000.

Failure To Use the Tax Intercept Program

The CCS is not using the tax intercept program to obtain state income tax refunds due families whose repayments to the CCS are delinquent. The CCS requires families who have incomes that exceed specified levels for the size of the family to repay the CCS all or a portion of their children's medical costs. State law permits the CCS to use the tax intercept program to collect delinquent repayments.

We examined state income tax returns for 1983 for families in our sample whose repayments to the CCS were delinquent. During 1983, delinquent repayments in the four counties totaled approximately $471,000. Tax refunds due families whose repayments were delinquent totaled an estimated $26,000 for 1983. If the four counties had used the tax intercept program to obtain these tax refunds, the CCS could have increased its collection of repayments in 1983 by at least $26,000.

Other Policy Issues

We found no demonstrated need for a statewide pool of funds to assist the CCS in paying for medical costs in catastrophic cases; these costs exceed $100,000 per year. Only two counties postponed or denied services to children because of medical costs in catastrophic cases in the four years preceding the date of our survey. Further, the Medi-Cal program, not the CCS, has paid the majority of medical costs in catastrophic cases, and the county and state CCS can request additional funds from counties and the State when needed.

In addition, the CCS does not need a statewide commission. The Department of Health Services can determine medical conditions eligible for CCS care. Creating an additional commission would duplicate work of an existing advisory council and would be an unnecessary expense.

Recommendations

To reduce state and county expenditures for medical services provided by the California Children Services program, county CCS administrators should ensure that providers of medical services bill insurance companies before the administrators authorize the CCS to pay for the services. Also, the CCS should develop new guidelines for identifying children potentially eligible for the Medi-Cal benefits and

for referring the children to the Medi-Cal program. These guidelines should consider family assets in addition to income. In addition, the CCS should use the tax intercept program to collect delinquent repayments from families. Finally, the Legislature should amend the California Health and Safety Code to permit the CCS to consider family assets and income in determining financial eligibility for CCS care.

INTRODUCTION

The Department of Health Services (department) provides specialized medical care and rehabilitation for over 74,000 physically handicapped children through the California Children Services program (CCS). To receive CCS benefits, a child must be under 21 years of age, be a California resident, and have a medical condition that qualifies the child for medical care under the program. In addition, the adjusted gross income of the child's family must not exceed $40,000, unless the cost of the child's care is expected to exceed 20 percent of the family's adjusted gross income. The child's family must repay all or a portion of the costs of the medical care that the CCS provides if the family's income exceeds specified levels for the size of the family.

A child is eligible for services funded by the CCS if the child's medical condition is catastrophic or severely handicapping and the condition can be arrested, improved, or corrected. Conditions that qualify a child for the CCS include defects requiring plastic surgery, diseases that affect the heart, circulatory, digestive, and respiratory systems, and diseases such as leukemia.

If a child is eligible for the CCS, the CCS provides medical services through various medical resources, including hospitals, physicians, and therapists. The medical services include diagnosis, medical and surgical treatment, hospital care, physical therapy,

occupational therapy, materials, and appliances. To provide medical care, participating physicians generally must be certified by their specialty boards. Further, the CCS and the Department of Health Services must review and approve all participating hospitals.

The State's Medi-Cal program pays the medical expenses for children who are eligible for both the Medi-Cal program and the CCS. The CCS is responsible for managing these cases. As of June 30, 1984, approximately 27,000 children, or 37 percent of the total number of children eligible for CCS care, were determined to be eligible for both Medi-Cal and CCS benefits.

The department, through the state CCS office, provides statewide administration and supervision of the CCS.* In addition, the department operates three regional offices to assist counties in providing CCS care. At the local level, the county or the State administers the CCS. Counties that have populations of at least 200,000 people must administer the CCS locally through the county health department or social welfare department. Counties that have populations of less than 200,000 people may also administer the CCS locally. Counties that administer the CCS locally are known as "independent counties." Counties that do not administer the CCS locally are known as "dependent counties." Dependent counties rely on

*In this report, the term "state CCS" denotes the CCS unit within the Department of Health Services. The term "county CCS" denotes the CCS unit within either a county health department or social welfare department.

the department's three regional offices to assist in administering the CCS. Of California's 58 counties, 26 are currently independent counties and 32 are dependent counties.

Budgetary Information

For fiscal year 1983-84, the CCS estimates that state expenditures for the CCS totaled approximately $37.7 million, including $2.3 million for county CCS administrative costs. In addition, the counties contributed an estimated $19.4 million consisting of $14.2 million for medical services and $5.2 million for county administrative costs, and the federal government contributed an estimated $6.5 million. Further, the State's Medi-Cal program paid for medical expenses of children receiving CCS care who were eligible for Medi-Cal benefits. The Medi-Cal program also contributed $3.1 million to pay for county CCS administrative costs. Private insurance companies paid at least $15 million for services provided to children who received CCS care and who were also covered by medical insurance. Finally, the CCS estimates that the children's families repaid the CCS an estimated $.9 million for the medical care that the CCS provided for their children.

The state and federal government pay counties three dollars for every dollar that the counties contribute for CCS medical costs. The California Health and Safety Code requires counties to contribute to the CCS based on each county's assessed valuation of property.

Also, the state CCS contributes to counties a maximum of 4.1 percent of the CCS costs of providing CCS care to pay for county expenses in administering the program.

SCOPE AND METHODOLOGY

We conducted this audit to comply with Item 4260-001-001 of the Supplemental Report of the 1984 Budget Act, which requires the Auditor General to evaluate the California Children Services program. Our audit included the following areas: the extent to which the CCS pays bills that medical providers should first submit to insurance companies for payment; the extent to which CCS criteria for financial eligibility adequately determine a family's ability to pay for medical services; the extent to which CCS criteria for identifying children eligible for Medi-Cal benefits enable the CCS to identify all such children; and the extent to which the CCS uses the State's tax intercept program to collect delinquent repayments. We also examined information on whether the CCS should contract with hospitals for medical services, the types of utilization reviews that counties conduct, and the formula that the State uses in reimbursing counties for their costs of administering the CCS. In addition, we evaluated the need for a statewide commission to determine medical conditions eligible for CCS care and the need for a statewide pool of funds to pay for medical costs in catastrophic cases.

To evaluate the CCS, we reviewed pertinent state laws, the state CCS Manual of Procedures, the Case Coordinator Procedure Manual, and the CCS guidelines. To obtain additional information on CCS procedures, we interviewed officials involved in the CCS at the Department of Health Services and CCS officials at the county level. In addition, we visited and interviewed staff at three hospitals that provide CCS medical care. We also contacted representatives of private insurance companies and the Public Employees' Retirement System to obtain information on medical insurance coverage.

In addition, we visited the following four independent counties: Los Angeles, Sacramento, San Diego, and San Francisco. We reviewed a random sample of 439 case files out of 33,600 case files for children who are eligible for CCS care in these four counties. From the children's files, we collected information relating to insurance coverage, Medi-Cal referrals, bills for medical treatments, and family repayments from January 1, 1983, through October 31, 1984.

Using the information collected from the case files, we statistically estimated the number of cases that the providers of medical services did not bill to insurance companies. We also statistically estimated the number of children in the four counties who the CCS should have referred to the Medi-Cal program and the amount of money that the CCS paid that either insurance companies or the Medi-Cal program could have paid. We did not examine cases of children who were approved for Medi-Cal benefits during the entire review period.

Using the same random sample of children's files, we obtained from the Franchise Tax Board the California income tax returns of the children's families for calendar year 1983. We examined the tax returns to determine family assets and to identify families who could pay for all or a portion of the medical costs of their children. We identified families who had liquid assets and rental property worth over $40,000. Based on our sample, we estimated the total number of families in the four counties who could pay all or a portion of the medical costs that the CCS provided for their children. We also estimated the amount by which the CCS could have reduced its expenditures if it had required these families to pay all or a portion of the medical costs of their children.

To obtain information from other counties in the State, we mailed a questionnaire to all county CCS administrators requesting information about their procedures and asking for their opinions on the CCS. We also asked them to provide statistical data on the CCS in their counties. To obtain information on other areas of our audit, we reviewed the California Medical Assistance Commission's report on contracting with hospitals and the department's report to the Legislature on utilization reviews. We also interviewed officials at the commission and the department regarding the contents of these reports.

In preparing our report, we discussed our analyses with and considered the comments of CCS officials in the four counties that we

visited. We also discussed our findings with representatives of the California Medical Assistance Commission, officials in the Department of Health Services, and members of a Department of Health Services task force to study the relationship between the CCS and other health programs for children. We considered the comments of these persons in preparing this report.

CHAPTER I

CALIFORNIA CAN REDUCE STATE AND COUNTY EXPENDITURES FOR MEDICAL SERVICES FUNDED BY THE CALIFORNIA CHILDREN SERVICES PROGRAM

Between January 1, 1983, and October 31, 1984, the State of California and the counties paid millions of dollars for children's medical costs that insurance companies, the Medi-Cal program, and the children's families could have paid. Because the California Children Services program (CCS) did not ensure that providers of medical services submitted bills to insurance companies, the CCS paid at least $1 million in medical bills that insurance companies might have paid in the four counties we visited. In addition, because state law does not allow the CCS to consider family assets when determining children's eligibility for CCS care, the CCS paid as much as $2.7 million for medical expenses that the children's families with assets worth over $40,000 could have paid. Moreover, because the CCS did not refer to the Medi-Cal program all children potentially eligible for Medi-Cal benefits, the State and the four counties paid $370,000 in medical costs that the federal government could have paid through the Medi-Cal program. Finally, although state law does allow the CCS to use the State's tax intercept program to collect delinquent repayments from families, the CCS did not use the tax intercept program to collect at least $26,000 in delinquent repayments.

THE STATE DOES NOT ENSURE THAT PROVIDERS BILL INSURANCE COMPANIES FOR MEDICAL SERVICES

The CCS does not always require providers of medical services for children to submit bills to medical insurance companies. As a result, the CCS pays medical costs that insurance companies may pay. In the four counties we visited, the CCS paid at least $1 million in medical bills that providers should have submitted to insurance companies for payment. Insurance companies would have paid many of these bills, thus reducing state and county expenditures. Failure of providers to bill insurance companies occurred because the CCS did not always inform the providers that children were insured, because county CCS officials believed that insurance companies would not pay for the medical treatments, and because CCS staff did not review children's files for insurance coverage before authorizing CCS payment.

The Process for Billing Insurance Companies

As part of the process for determining a child's eligibility, the CCS determines if the child is insured for medical services. If a child is insured, the CCS obtains the name of the insurance company and the policy number. Using this information, the CCS notifies the providers of medical services that the child is covered by insurance. The state CCS Manual of Procedures requires providers of medical services to bill insurance companies first before the providers submit bills to the CCS. When the CCS authorizes medical treatment, the CCS

informs the providers of this requirement. Also, if the providers bill the CCS before billing the insurance company, the CCS must return the medical bills unpaid to the providers so that the providers can bill the insurance companies.

The CCS requires that providers bill insurance companies first because the CCS, providers, and the families generally do not know the extent of a child's insurance coverage. Further, insurance coverage may change without the CCS learning of the change. Finally, the many types of insurance policies available make it difficult for the CCS to know in advance when an insurance company will pay for medical expenses. Requiring providers to submit the medical bills to a child's insurance company for payment is an effective way for the CCS to determine the extent of the child's insurance coverage.

It is also to the providers' advantage to bill insurance companies first before billing the CCS. Generally, insurance companies pay providers more money for the same medical treatment than the CCS pays. Although the CCS cannot pay providers more than the State Schedule of Maximum Allowances, insurance companies may pay providers up to the limits of the insurance policy. Providers may keep all of the insurance payments, even if the payments exceed the limits in the State Schedule of Maximum Allowances.

Failure of Counties To Require Providers To Bill Insurance Companies

The CCS staff in four counties we visited did not always ensure that providers billed insurance companies before submitting the bills to the CCS. Based on our review of children's case files, we estimate that the CCS paid bills that providers did not submit to insurance companies in 3,148 cases, 9 percent of all cases in the four counties. As a result, the four counties used state and county CCS funds to pay at least $1 million in medical bills that providers should have submitted first to insurance companies. Table 1 shows our estimates of the number of cases in which providers did not bill insurance companies for medical services and the amounts that the CCS paid for such medical services from January 1, 1983, through October 31, 1984.

TABLE 1

NUMBER OF CASES IN WHICH THE CCS PAID BILLS THAT PROVIDERS DID NOT SUBMIT TO INSURANCE COMPANIES JANUARY 1, 1983 THROUGH OCTOBER 31, 1984

County	Cases in Which Providers Did Not Submit Bills to Insurance Companies	Percent of Total Cases in County	Amount Paid by the CCS
Los Angeles	1,936	8	$ 459,000
Sacramento	372	13	146,000
San Diego	663	15	317,000
San Francisco	177	12	82,000
Total	3,148	9	$1,004,000

Although we cannot determine the amount of money that insurance companies would have paid on these bills, an analysis of the medical treatment expenses shows that insurance companies would probably have paid many of the bills. In some cases, for example, some of the medical bills were for the same type of service that the children's insurance companies had paid for on other occasions. In one case, the CCS paid approximately $350 for equipment. The child's insurance company had paid the same provider for equipment for the same child on other occasions. Because the insurance company had previously paid for equipment for this child, it is reasonable to conclude that the insurance company would probably have paid for the equipment again.

In other cases, providers did not submit to insurance companies medical bills that insurance companies normally pay. Such bills include bills for hospitalization and fees for surgery. In one case, the CCS paid nearly $1,000 for surgery costs for a child, including the operating room fee and related physician charges. Because hospital and surgical costs are generally items covered in an insurance policy, the insurance company might have paid for these services if the provider had submitted the bill to the company.

Finally, providers did not submit bills to insurance companies that companies sometimes pay, depending upon the type of coverage. These bills include bills for medical equipment such as wheelchairs, hearing and speech services, and dental treatments. Since we do not know the extent of insurance coverage in these cases, we cannot

determine if the insurance companies would have paid for the medical treatments.

Although the state CCS Manual of Procedures requires that providers bill insurance companies first before the CCS pays for any medical treatment, the CCS staff in the counties we visited failed to follow the state requirements for three reasons: the staff did not believe that insurance companies would pay for the medical treatments; the staff did not notify providers that the children were covered by insurance; or the staff did not review the children's files to determine if the children were covered by insurance before authorizing CCS payments.

In some cases, the CCS did not require providers to bill the insurance companies because the CCS staff did not believe that insurance companies would pay for certain types of treatment. For example, the CCS did not return to providers bills for such items as medical equipment and dental, hearing, and speech services. In these cases, the case files contained no documentation from either the insurance companies or the providers stating that the insurance companies would not pay for the medical treatments. However, we found cases in which insurance companies did pay for these types of treatment. In one instance, for example, the CCS did not return to a provider three bills totalling $724 for medical equipment because the CCS believed that the child's insurance company would not pay for the equipment; instead, the CCS paid $585 for the equipment. Later, a

provider sent to the same insurance company two other bills for the same kind of medical equipment; the insurance company paid approximately $1,600 for the equipment.

In other cases, the CCS did not notify the providers that the children were covered by insurance. Without accurate insurance information, the providers could not bill the insurance companies. For example, in one case, the CCS paid approximately $2,200 in medical bills that the provider did not submit to the insurance company because the CCS did not include the insurance information on the form authorizing the medical services.

Finally, although the State requires the CCS to determine if children have insurance and to ensure that providers bill insurance companies first, the CCS did not always review the children's files for insurance coverage when providers submitted bills for payment. For example, the CCS paid approximately $15,400 for pediatric care for a child without reviewing the child's file for insurance coverage. If the staff had reviewed the child's file, the staff would have found that the child was covered by insurance and that the company had paid for similar medical care in the past.

THE STATE DOES NOT CONSIDER A FAMILY'S ASSETS WHEN DETERMINING A CHILD'S ELIGIBILITY FOR CCS CARE

State law does not allow the CCS to consider the assets of a child's family when determining financial eligibility for CCS care. The CCS can use only the adjusted gross income from the family's most recent California income tax return. The CCS also uses the family's tax liability from the same tax return to determine the amount of the family's repayments to the CCS. However, considering only a family's adjusted gross income and tax liability, without considering the family's assets, does not always enable the CCS to determine accurately a family's ability to pay for medical treatment. Although only a small percentage of the families in our sample had substantial assets, the CCS could have reduced state and county expenditures for medical treatment by as much as $2.7 million between January 1, 1983, and October 31, 1984, in the four counties we visited if the CCS were allowed to consider family assets worth over $40,000 in addition to income.

Determining Financial Eligibility

To be eligible for CCS care, a child must be under age 21, be a California resident, have a medical condition that qualifies the child for CCS medical care, and be "financially eligible." Section 255 of the California Health and Safety Code states that a child is financially eligible for CCS care if the annual adjusted gross income

of the child's family, as stated on the family's most recent California income tax return, does not exceed $40,000. In some cases, the CCS can provide services to a child whose family earns over $40,000 annually if the child's medical expenses are expected to exceed 20 percent of the family's adjusted gross income.

The CCS requires the child's family to repay the CCS all or a portion of the medical expenses if the family's adjusted gross income exceeds specified income levels for the size of family. However, the family's repayment is limited to twice the amount of the family's state income tax liability. The family's repayment is also reduced if the family paid insurance premiums for medical insurance. The CCS does not consider a family's assets when determining if a child is eligible for services or when determining the family's ability to repay the CCS for medical costs.

CCS Administrators' Positions on Financial Eligibility

The Department of Health Services believes the current system of using a family's adjusted gross income and income tax liability is an efficient method of determining financial eligibility and the amounts that families must repay to the CCS. Further, the department has concluded that identifying family assets and determining their value is difficult and costly. However, our review of state income tax returns for the families in our sample showed that the process of determining the value of assets is simple and not time consuming.

Moreover, the administrator of the San Diego County CCS also believes that counties can easily determine family assets. She told us that the southern California CCS administrators' group, an association composed of CCS administrators from southern California counties, has developed financial screening procedures that allow county staff to determine easily the value of family assets.

In contrast to the position stated by the department, the majority of county CCS administrators who responded to our survey believe that financial eligibility for CCS care should be based on the income and the assets of the child's family. In our survey of county CCS administrators, 31 of 55 administrators who responded believe that the CCS should consider assets and income when determining financial eligibility. Some administrators said that they prefer using assets in addition to income because they believe considering assets and income is a fairer method of determining financial eligibility. Further, some administrators stated that adjusted gross income may not accurately reflect a family's ability to pay since a family can reduce its adjusted gross income and thereby reduce its tax liability by using income tax shelters such as rental property. The administrator of the San Diego County CCS cited several examples of families who are eligible for services under the current system but would probably not be eligible if the CCS could consider family assets in determining financial eligibility. (Appendix A shows the results of our survey of the county CCS administrators on the preferred method of determining financial eligibility.)

Families Have Assets Worth Over $40,000 But Are Still Eligible for CCS Services

We determined the value of assets owned by families in our sample by reviewing their California income tax returns for calendar year 1983. Based upon our review, we estimate that as many as 4 percent of the families whose children were eligible for CCS care in the four counties had assets worth over $40,000. We also estimated that the CCS could have reduced its expenditures by as much as $2.7 million if it could have considered family assets worth over $40,000 in determining financial eligibility.

For our review, we defined "assets" as liquid assets, such as savings accounts and investments in stocks and bonds, and rental properties. We did not include a family's residence and business assets. We estimated the value of the assets using various methods depending on the type of asset. For example, if a family's tax return showed interest income, we computed the value of the investment by dividing an appropriate interest rate into the interest income to arrive at the value of the investment. We determined investment values for dividend income by dividing an appropriate rate of return into the amount of the dividend income. We based our determination of the value of rental property on the property taxes or the cost of the property when acquired by the family, whichever was greater. We reduced our estimate of the value of rental property by the estimated amounts of loans on the property.

Table 2 shows the results of our review. As the table shows, we estimated that 1,427 families eligible to receive CCS care in the four counties had assets worth over $40,000. These families constituted approximately 4 percent of the total number of families whose children were eligible to receive CCS care.

TABLE 2

NUMBER OF FAMILIES ELIGIBLE TO RECEIVE CCS CARE WHO HAD ASSETS WORTH OVER $40,000, CALENDAR YEAR 1983

County	Families Having Assets Worth Over $40,000	Percent of Total Cases in County
Los Angeles	1,165	5
Sacramento	47	2
San Diego	130	3
San Francisco	85	6
Total	1,427	4

We also estimated the amount of money that the CCS in the four counties could have saved if it were allowed to consider family assets worth over $40,000 when determining financial eligibility or requiring families to repay the CCS. We estimate that the CCS could have reduced its expenditures by as much as $2.7 million if the CCS could have considered family assets worth over $40,000.* The potential savings of

*We used assets worth over $40,000 to calculate the potential savings of $2.7 million. However, the amount of savings could be higher or lower depending upon the asset level selected.

$2.7 million represents CCS expenditures for children in these families, less the amount that the families would repay based on their adjusted gross income.

The following are examples of families whose children were eligible for CCS care even though the families owned assets worth over $40,000. One family reported a negative adjusted gross income on its state income tax return even though the family had savings, stock investments, and rental property worth substantially over $40,000. The family reported losses from the rental property and partnerships of approximately $57,000. The losses, which exceeded the family's reported income of $55,000 from interest, dividends, sale of property, and business profits, resulted from tax shelter investments. From January 1, 1983, through October 31, 1984, the CCS paid approximately $1,500 in medical treatment costs for the child, who was not covered by medical insurance. Because the family paid no state income tax, the family did not have to repay the CCS for the child's medical care. This child's financial eligibility for CCS care was based solely on the family's adjusted gross income, which did not accurately reflect the family's ability to pay the child's medical expenses.

In another example, a family reported an adjusted gross income of $39,130 which qualified the family's child for CCS care. However, we estimated the value of this family's assets at substantially over $40,000, consisting of savings and rental property. The child's medical expenses totaled $1,370. The child's insurance company paid

$30 of the child's medical expenses; the CCS paid $1,340. The CCS required the family to repay $820 of the child's medical expenses. Thus, the CCS expenditures for this child were $520. However, the family could have paid all of the child's medical expenses.

The process of determining the value of assets was simple and not time consuming. Since the CCS currently reviews state income tax returns to identify a family's adjusted gross income, the CCS could also review the tax returns to determine a family's assets. After quickly reviewing the return for assets, the CCS could easily estimate the value of the assets, using the methodology that we used. To identify assets that are not indicated on a tax return, such as tax-free governmental bonds and stocks that do not earn dividends, the CCS could modify the CCS application form to require this information. Finally, since most families receiving CCS care have few assets, the CCS could review and determine the value of assets quickly.

THE STATE DOES NOT REFER TO THE MEDI-CAL PROGRAM ALL CHILDREN POTENTIALLY ELIGIBLE FOR MEDI-CAL BENEFITS

The CCS does not refer to the Medi-Cal program all children potentially eligible for Medi-Cal benefits. As directed by the state CCS Manual of Procedures, the CCS currently refers children to the Medi-Cal program based on family income. The Medi-Cal program, however, initially determines financial eligibility based on family assets. Consequently, the CCS is not referring all children potentially

eligible for the Medi-Cal program. Because the federal government contributes approximately one-half of the cost of the Medi-Cal program, referring children to the Medi-Cal program reduces state and county expenditures for the CCS. If the CCS had referred to the Medi-Cal program all children potentially eligible for Medi-Cal benefits, the CCS could have reduced state and county expenditures in the four counties we visited by $370,000 from January 1, 1983, through October 31, 1984. Finally, the CCS needs to implement procedures to ensure that county CCS staff follows its guidelines.

Need To Develop New Guidelines for Referring Children to the Medi-Cal Program

Section 4260-111-001 of the Budget Act of 1984 mandates that the CCS require children who are potentially eligible for the Medi-Cal program to apply for Medi-Cal benefits. The Medi-Cal program is a joint federal/state health care program that pays for all or part of the medical expenses of eligible recipients. The Medi-Cal program will pay for most types of medical treatment that the CCS authorizes for children eligible for Medi-Cal benefits. Under the Medi-Cal program, the federal government contributes approximately 50 percent of the funding while the State contributes the remaining 50 percent. By contrast, in fiscal year 1983-84, the State and counties paid nearly 90 percent of the costs of the CCS program while the federal government contributed only 10 percent. Thus, the CCS can reduce state and county expenditures by referring to the Medi-Cal program children receiving CCS care who are eligible for Medi-Cal benefits.

The department's guidelines for referring children to the Medi-Cal program, effective February 1983, require a family to apply for Medi-Cal benefits if the family's adjusted gross income, as stated on its most recent state income tax return, is less than a specified amount for the size of the family. In contrast, the Medi-Cal program initially determines financial eligibility based on a family's assets. To be eligible for Medi-Cal benefits, an applicant must own assets worth less than a specified amount for the size of the applicant's family at the time of application. Applicants who are otherwise eligible for Medi-Cal benefits but have income exceeding the specified amount must pay or obligate themselves to pay a share of their medical expenses before they can receive Medi-Cal benefits. The CCS cannot deny services to families if they refuse to pay or obligate themselves to pay their share of medical expenses.

Because the CCS considers a family's adjusted gross income but not a family's assets when referring children to the Medi-Cal program, the CCS is not referring to the Medi-Cal program all children potentially eligible for Medi-Cal benefits. Based on our review of calendar year 1983 tax returns at the Franchise Tax Board, we estimated that at least 3,305 children, or 10 percent of all children eligible for CCS care in the four counties we visited, were potentially eligible for Medi-Cal benefits based on their families' assets. Yet, the CCS did not refer these children to the Medi-Cal program because CCS guidelines consider only a family's adjusted gross income. Table 3 shows our estimate of the number of children whom the CCS should have

referred to the Medi-Cal program based on the assets of the children's families in 1983. The table also shows the estimated CCS expenditures for these children from January 1, 1983, through October 31, 1984.

TABLE 3

NUMBER OF CHILDREN RECEIVING CCS CARE WHO WERE POTENTIALLY ELIGIBLE FOR MEDI-CAL BENEFITS

County	Children Potentially Eligible for Medi-Cal Benefits Calendar Year 1983	CCS Expenditures for These Children, January 1, 1983, Through October 31, 1984
Los Angeles	2,402	$787,000
Sacramento	265	34,000
San Diego	496	49,000
San Francisco	142	19,000
Total	3,305	$889,000

As the table shows, the CCS paid at least $889,000 from January 1, 1983, through October 31, 1984, for the care of 3,305 children potentially eligible for Medi-Cal benefits in the four counties. The federal government could have paid up to 50 percent of these costs through the Medi-Cal program. In contrast, the federal government paid approximately 10 percent of CCS costs in fiscal year 1983-84. Therefore, if the CCS had referred all these children to the Medi-Cal program, the CCS could have reduced state and county expenditures for these children by approximately 40 percent, or $359,000, in the four counties. However, the savings would be less if

some families with incomes above specified amounts are ineligible for Medi-Cal benefits because they refused to pay or obligate themselves to pay their share of medical expenses.

As we stated earlier in this report, the department believes that identifying family assets and determining their value is very difficult and costly. However, our review of state income tax returns showed that the process of determining assets was simple and not time consuming. Further, the state CCS and the Medi-Cal program should jointly develop new referral guidelines to ensure that the guidelines are reasonable and effective in identifying children potentially eligible for Medi-Cal benefits.

Need To Ensure That Counties Follow CCS Guidelines for Referring Children to the Medi-Cal Program

In addition to the need for new guidelines for identifying children potentially eligible for the Medi-Cal program, the CCS needs to ensure that county CCS staff follow its guidelines. Current CCS guidelines require a family to apply for Medi-Cal benefits if the family's adjusted gross income on its most recent state income tax return is less than a specified amount for the size of the family. Yet, based on our review of the 1983 state tax returns for the families in our sample, we estimate that the CCS staff in Sacramento and San Francisco counties did not refer to the Medi-Cal program as many as 372 of 1,852 children eligible for Medi-Cal benefits in the two

counties according to criteria specified in the CCS guidelines. The CCS staff in Sacramento County did not refer to the Medi-Cal program approximately 5 percent of the children potentially eligible for Medi-Cal benefits; the number of children that the CCS staff in San Francisco County did not properly refer to the Medi-Cal program constituted approximately 15 percent of the eligible children. In contrast, the CCS staff in Los Angeles and San Diego counties, properly referred to the Medi-Cal program all but one percent of the children potentially eligible for Medi-Cal benefits according to the CCS guidelines. If the four counties had properly referred all children eligible for the Medi-Cal program, the CCS could have reduced state and county expenditures by at least $11,000. Table 4 shows our estimate of the total number of children not properly referred to the Medi-Cal program in the four counties.

TABLE 4

NUMBER OF CHILDREN ELIGIBLE FOR MEDI-CAL BENEFITS ACCORDING TO CCS GUIDELINES BUT NOT REFERRED TO THE MEDI-CAL PROGRAM

County	Children Eligible for Medi-Cal Benefits But Not Referred	Percent of Children Eligible for Medi-Cal Benefits
Los Angeles	224	1
Sacramento	150	5
San Diego	59	1
San Francisco	222	15

Counties failed to refer these children to the Medi-Cal program, as required by CCS referral guidelines, primarily because some county CCS administrators did not strictly enforce the referral procedures. In addition, county CCS staff often mistakenly determined that applicants were ineligible for Medi-Cal benefits. For example, the CCS staff in San Francisco County failed to refer some children to the Medi-Cal program because the children's families possessed private insurance. Yet, a family can still be eligible for Medi-Cal benefits even if the family has private insurance.

In addition, county CCS staff did not refer some families to the Medi-Cal program because the staff believed the value of the families' assets made the families ineligible for Medi-Cal benefits. An analyst from the department's Medi-Cal Eligibility Branch told us, however, that only Medi-Cal staff should determine eligibility for Medi-Cal benefits since the screening procedures are complex. The analyst stated that CCS staff are not qualified to determine an applicant's eligibility for Medi-Cal benefits.

THE STATE DOES NOT USE THE TAX INTERCEPT PROGRAM TO COLLECT DELINQUENT REPAYMENTS

The CCS could use the tax intercept program operated by the Franchise Tax Board and the State Controller to obtain all or a portion of state income tax refunds due families whose repayments to the CCS are delinquent. The tax intercept program allows the State to obtain any state income tax refund due a taxpayer when the taxpayer owes money

to the State. In the four counties we visited, family repayments that were delinquent totaled approximately $471,000 in calendar year 1983. If these four counties had used the tax intercept program to obtain all or a portion of the tax refunds due these families for calendar year 1983, the CCS could have increased collections from these families by at least $26,000.

The CCS requires families whose income exceeds certain levels to sign annually a plan for repaying the CCS for medical care provided to their children. This plan requires the families to repay the CCS all or a portion of the cost of treating their children. Each family's repayment is limited to twice the amount of the family's total state income tax liability stated on the family's most recent tax return.

Our review of CCS repayments in four counties showed that many families have failed to repay the CCS for the cost of care provided to their children. Some county CCS administrators stated that collecting delinquent accounts is not a high priority since the collection process is costly and the delinquent amounts are relatively small. In addition, counties have little incentive to actively pursue collections since they must turn over 75 percent of the amounts collected to the State.

The CCS, however, could efficiently increase its collections of delinquent repayments by using the tax intercept program operated by the Franchise Tax Board and the State Controller. The director of the

CCS told us that he was unaware that the CCS could use the tax intercept program to collect delinquent repayments. However, according to an opinion of the Legislative Counsel, Section 12419.5 of the California Government Code permits the State Controller to obtain the state income tax refunds of families who are delinquent in paying their debts to the state CCS if certain procedural requirments are met.

In the four counties we visited, the total amount of delinquent repayments in 1983 was approximately $471,000. We reviewed the tax returns of families in our sample whose repayments were delinquent. Based on our sample, we estimated that the tax refunds due the families whose repayments were delinquent in the four counties totaled at least $26,000. Table 5 shows the total amount of delinquent repayments for each of the four counties and our estimate of the amounts that the CCS could have collected from the families through the tax intercept program.

TABLE 5

DELINQUENT REPAYMENTS AND AMOUNTS COLLECTABLE THROUGH THE TAX INTERCEPT PROGRAM, CALENDAR YEAR 1983

County	Delinquent Repayments	Amounts Collectable Through the Tax Intercept Program
Los Angeles	$410,000	$14,000
Sacramento	19,000	4,000
San Diego	30,000	7,000
San Francisco	12,000	1,000
Total	$471,000	$26,000

Although the table shows that tax refunds due the families in Los Angeles County amounted to at least $14,000, the county CCS could not have collected this amount because the Los Angeles County CCS had the families sign an agreement to repay Los Angeles County instead of the state CCS. Because the families do not owe the State, the State Controller is not permitted to obtain the tax refunds of these families unless the debts have been reduced to a court judgment or are contained in an order of a court. The Los Angeles County CCS could avoid this problem by modifying its repayment contract so that families agree to repay the state CCS instead of the county.

Improper Billing in San Francisco County

In addition to using the tax intercept program to obtain all or a portion of state income tax refunds, the San Francisco County CCS can increase collections from families who have repayment obligations by assuring that families are billed properly. Because the San Francisco County CCS does not always inform families of their obligations to pay the CCS for medical services, the families are not obligated to make repayments to the CCS.

We found that the San Francisco County CCS did not bill 22 families for $2,623 included in their repayment plans. The county CCS did not bill the families primarily because of a lack of coordination between the county's social workers and billing clerks. For example, the social workers did not always list the dates of the family's repayment period on the repayment contract. As a result, the billing clerks did not bill the families for the cost of some medical services.

CONCLUSION

Based on our review of four California counties, we estimate the California Children Services (CCS) paid millions of dollars for children's medical costs that insurance companies, the Medi-Cal program, and the children's families could have paid. In the four counties we visited, the CCS paid at least $1 million in medical bills that providers should have first

submitted to insurance companies for payment, as required by the state CCS Manual of Procedures. Moreover, the CCS could have reduced state and county expenditures for medical services by up to $2.7 million if state law allowed the CCS to consider family assets worth over $40,000 when determining financial eligibility. The majority of the county CCS administrators believe that financial eligibility for CCS care should be based on the income and the assets of the children's families.

In addition, the CCS paid $370,000 in medical costs that the federal government could have paid through the Medi-Cal program. The counties did not refer to the Medi-Cal program all children potentially eligible for Medi-Cal benefits because the State's current referral guidelines do not allow counties to consider family assets in determining a child's potential eligibility for Medi-Cal benefits. In addition, county staff do not always follow the current CCS guidelines.

Finally, the CCS could have used the tax intercept program to collect at least $26,000 in delinquent repayments from families. The CCS did not use the tax intercept program to collect delinquent repayments because the director of the CCS was not aware that the CCS could use the program.

RECOMMENDATIONS

To ensure that medical providers bill medical insurance companies for medical costs that should be paid by insurance companies, the Department of Health Services, through the California Children Services program, should ensure that the CCS staff give the providers all necessary information on the child's medical insurance coverage, including name of the insurance company and the policy number. This information should be included on the CCS form that authorizes treatment.

The department should ensure that providers of medical services submit the medical bills first to the insurance company for payment as required by the state CCS Manual of Procedures. The CCS staff should review each child's file to determine if the child has medical insurance coverage before paying the child's medical bills. If the child has medical insurance, the CCS staff should not authorize payment unless the provider has submitted with the request for CCS payment a copy of the insurance company's denial of coverage or a statement showing the amount of funds that the insurance company paid.

To reduce state and county expenditures for children whose families are able to pay all or a portion of their medical expenses, the Legislature should amend Section 255 of the

California Health and Safety Code to authorize the CCS to consider family income and assets when determining a child's financial eligibility for CCS care and the family's repayment obligation. The CCS can determine the value of assets by using the family's most recent state income tax return.

To reduce state and county expenditures for the CCS program, the department should develop new guidelines to identify children potentially eligible for the Medi-Cal program. These new guidelines should direct CCS administrators to consider the value of family assets when referring children to the Medi-Cal program. In developing the guidelines, the state CCS should consult with representatives of the Medi-Cal program to ensure that the new guidelines are a reasonable and effective method of identifying children potentially eligible for Medi-Cal benefits. The department should ensure that CCS administrators follow the guidelines when initially determining a child's eligibility for CCS care and at each annual renewal of a child's eligibility for CCS care.

Finally, to increase collection from families who have delinquent repayments, the CCS should use the tax intercept program to obtain all or a portion of state income tax refunds due families who are delinquent in their payments to the CCS. Further, to facilitate the tax intercept process, the Los Angeles County CCS should modify its repayment contract

with families so that families agree to repay the state CCS, not the County of Los Angeles, the cost of treating their children. In addition, the San Francisco County CCS should establish written procedures to ensure that county's billing clerks properly notify families of their obligations to pay the CCS for medical services.

CHAPTER II

INFORMATION ON OTHER ACTIVITIES OF THE CALIFORNIA CHILDREN SERVICES PROGRAM

This chapter contains information on five policy issues pertaining to the California Children Services program. Based on our review, we reached the following conclusions on these issues: (1) the State does not need a statewide pool of funds to assist the CCS in paying medical costs of children in catastrophic cases; (2) county CCS staff conduct varying types of utilization reviews, ranging from limited examination of medical information by medical personnel in smaller counties to extensive examinations in larger counties; (3) the California Medical Assistance Commission has recommended that the CCS not contract for hospital services; (4) the State does not need to establish a statewide commission to determine medical conditions eligible for CCS care; and (5) the amount that the state CCS pays for county administrative costs is less than the amounts paid by the Medi-Cal program or the counties.

A STATEWIDE POOL OF FUNDS IS NOT NEEDED TO PAY MEDICAL COSTS IN CATASTROPHIC CASES

We found no demonstrated need for a statewide pool of funds to assist either the state or county CCS in paying medical costs for services provided in catastrophic cases. Although most counties favor establishing a statewide pool of funds for catastrophic cases, only two counties reported that they postponed or denied services to children

eligible for CCS care in the four years preceding the date of our survey because of costs of medical care in catastrophic cases. Further, the Medi-Cal program, not the CCS, has paid the majority of the medical costs in catastrophic cases. Finally, the state and county CCS can seek supplemental funds to pay for medical services when additional funds are needed.

Based on our discussions with CCS officials, we defined a "catastrophic case" as one in which the medical expenses of a child are $100,000 or more per year. Catastrophic cases can be both unpredictable and costly. For example, the medical costs for a child born prematurely in 1983 were approximately $600,000. This child required multiple surgeries and highly specialized, expensive care over an 18-month period. The child will continue to require extensive medical care. In another case, a county CCS paid for four bone marrow transplants for three children during 1983 and 1984. Each transplant cost approximately $100,000.

In our survey of the county CCS administrators, 30 of the 55 responding administrators reported that their counties had incurred medical costs in catastrophic cases. In these 30 counties, the CCS paid medical costs totaling $10.4 million in catastrophic cases during the four years preceding the survey. The highest reported medical expense that the CCS paid for one child was $1.5 million. Twenty-five counties reported no catastrophic cases.

Although the CCS in 30 counties incurred medical costs in catastrophic cases, 48 of the 55 county CCS administrators favored establishing a statewide pool of funds to pay medical costs in catastrophic cases. Seven county CCS administrators either had no opinion or did not believe a statewide pool of funds is necessary. Some county CCS administrators commented that catastrophic cases could deplete a county's CCS funds and cause the county to postpone or deny services to other children eligible for CCS care. For example, the CCS administrator in Marin County stated that two catastrophic cases in one year would deplete the county's entire CCS budget.

Nevertheless, we believe that a statewide pool of funds to pay medical costs in catastrophic cases is not needed. Our survey revealed that only two counties postponed or denied treatment to eligible children in the last four years as a result of catastrophic cases. The CCS administrators in Monterey and Santa Clara counties reported that their counties either postponed or denied medical services to children because of budgetary constraints created by catastrophic cases. The Monterey County CCS denied all new case referrals from January 1984 through June 1984 because the county paid medical costs in many cases, including two catastrophic cases, during fiscal years 1982-83 and 1983-84. The Santa Clara County CCS did not authorize CCS treatment for children during one month and denied new case referrals for two months in 1983.

In addition, a pool of funds is not needed because the Medi-Cal program, not the CCS, pays the majority of the medical costs for children in catastrophic cases. County CCS administrators responding to our questionnaire noted that the Medi-Cal program paid the majority of medical expenses in 196 of 270 catastrophic cases reported. A child may be eligible for Medi-Cal benefits on the basis of the eligibility of the child's family. However, a child may also receive Medi-Cal benefits if the child is disabled and receiving Social Security Income/State Supplemental Program (SSI/SSP) benefits or is expected to need long-term care. A child is also eligible for Medi-Cal benefits as a long-term care patient if the child is hospitalized and is expected to remain in the hospital 30 days following the month of admission. To qualify for SSI/SSP benefits, a child must meet disability standards established by the federal Social Security Administration.

Finally, a statewide pool of funds is not needed because the CCS can seek supplemental funds from counties or the State to pay for medical services needed by children. For example, Section 266 of the California Health and Safety Code provides that the state CCS may use state funds to pay for emergency medical services needed by children in counties. The state CCS uses state funds under two conditions: (1) the total appropriation of county and state CCS funds for the county does not exceed $250,000; and (2) the county has spent funds for CCS medical services equal to at least one-twentieth mill of the assessed valuation of taxable property in the county. Currently eight

California counties could potentially meet these conditions. In fiscal year 1983-84, two of the eight counties received state CCS funds to pay for emergency medical services for children under this provision.

In addition, Section 265 of the California Health and Safety Code obligates all counties to fund the county CCS up to an amount equal to one-fourtieth mill of the assessed valuation of taxable property in the county. For example, in fiscal year 1983-84, San Francisco County was obligated to fund its CCS up to $640,000, although its budget for the CCS was only $364,000. Therefore, if the San Francisco County CCS needed additional funds to pay for children's medical services, state law required the county to supply the necessary funds up to the limit of its obligation.

Further, the state CCS can request an additional appropriation from the Legislature when the state CCS expends available funds, and each county CCS can request additional funding from the county's board of supervisors. In May 1983, the state CCS requested an additional appropriation, and the Legislature subsequently provided additional funds.

COUNTY CCS STAFF CONDUCT VARYING TYPES OF UTILIZATION REVIEWS

The county medical staff use varying procedures in conducting utilization reviews. The reviews range from a limited review of medical information in some counties to extensive reviews in other

counties. In some larger counties, the CCS staff also visits children and reviews their medical records at hospitals. The Department of Health Services opposes using Medi-Cal personnel to conduct utilization reviews for the CCS.

The CCS conducts "utilization reviews" to ensure that children are receiving an appropriate level of medical care. As a part of a utilization review, the CCS may review a child's medical records and case records. The CCS may also examine medical reports that describe the diagnosis, prognosis, and plan for treatment. Further, the CCS may discuss a child's treatment plan with the treating physicians or the hospital staff. Finally, the CCS staff may visit hospitals to review children's status.

In our survey of county CCS administrators, we asked the administrators to indicate the number of hours per month that the CCS medical staff devotes to CCS cases in their counties and if the CCS staff visits hospitals to review children's cases. The results of our survey show that many independent counties have a medical staff, which includes physicians and nurses, that spends more than 100 hours per month reviewing children's medical records and reports. In most dependent counties, the medical staff devotes less than 100 hours per month to CCS cases. Some dependent counties reported zero hours for medical staff. The CCS staff in only 12 counties--11 independent counties and one dependent county--visits hospitals.

In 24 of the 25 independent counties responding to the survey, the CCS has a physician available to review medical records and reports on children. Physicians spent from 8 hours per month in San Luis Obispo, Solano, and Stanislaus counties to 320 hours in Los Angeles County participating in the medical aspects of the CCS. The CCS in only one independent county, Napa County, reported zero hours for physicians. Eight independent counties reported zero hours for nursing staff, while the remaining 17 counties reported hours for nurses ranging from 14 hours per month in Santa Barbara County to over 1,920 hours per month in Los Angeles County.

In 11 independent counties, the CCS staff visits hospitals to review the children's status. Contra Costa, Los Angeles, Marin, Monterey, Orange, Sacramento, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura counties reported that the CCS staff visits hospitals. The number of children for whom the CCS staff in these 11 counties reviewed hospital records per month ranged from one to 200. Sonoma County did not respond to our survey. (Appendix B presents the results of our survey of independent counties.)

Thirty of the State's 32 dependent counties responded to our survey. The CCS in 18 dependent counties reported zero hours for physicians. The number of hours per month reported for physicians in the remaining 12 dependent counties ranged from one to 16. The CCS in 22 counties reported time for nurses ranging from 6 hours to 220 hours per month. Only the Santa Cruz County CCS reported that the staff

conducts hospital visits; the county staff visits five children per month in hospitals. In addition to county staff, the department's regional offices have two part-time physicians and two part-time nurses to assist in the administration of the CCS independent counties. Two dependent counties, Lake and Trinity counties, did not respond to our survey. (Appendix C presents the results of our survey of dependent counties.)

In the following four sections, we provide information on utilization reviews that the CCS conducts in the four counties we visited.

Utilization Reviews by the Los Angeles County CCS

The Los Angeles County CCS employs a medical staff consisting of 2 physicians and 12 nurses. The medical staff is responsible for monitoring the medical treatment of over 24,000 children. The Los Angeles County CCS conducts most of its reviews of children's medical conditions in the CCS office; various CCS personnel conduct the reviews. The responsibilities of the nurses include reviewing medical records and reports of children receiving treatment. In the most complex medical cases, the nurses refer children's medical records and reports to the CCS physicians. The physicians review these complex cases and determine appropriate action.

Of the four counties we visited, Los Angeles County is the only county in which the CCS uses a committee to review the cases of children who are hospitalized for extended periods. This committee reviews from two to ten children's cases per month. The committee consists of the medical director, the assistant medical director, the supervising medical services coordinator, the public health nurse, the supervising medical social worker, and the home health coordinator.

Further, the Los Angeles County CCS conducts utilization reviews at hospitals for children whose medical conditions warrant hospital visits. The primary objective of these hospital visits is to ensure that children requiring long-term hospitalization are appropriately managed. Also, the hospital visits ensure that the hospital develops "discharge plans" for the children during the early stages of hospitalization. During these hospital visits, CCS physicians, nurses, medical social workers, or home health coordinators may review the children's medical conditions with appropriate hospital staff. The CCS staff reviews cases of from two to eight children each month at the hospitals.

Utilization Reviews by the Sacramento County CCS

The Sacramento County CCS employs a part-time physician and a part-time nurse to review the medical treatment of approximately 2,800 children receiving CCS care. The physician devotes 32 hours per month to the CCS program.

As in Los Angeles County, the Sacramento County CCS medical staff reviews the medical records and reports of children at the CCS office. The physician reviews the more complex medical cases. However, the Sacramento County CCS seldom conducts hospital reviews of children. The CCS administrator stated utilization reviews at hospitals for more complex medical conditions would be beneficial, but the small staff precludes such activities.

Utilization Reviews by the San Diego County CCS

The San Diego County CCS employs one physician and two nurses to review the medical treatment of 4,300 children. The CCS medical staff reviews children's medical reports and records in the CCS office in a manner similar to that used by the CCS in Los Angeles County. However, the San Diego County CCS conducts weekly case reviews of children at the three hospitals that provide the majority of care.

The CCS staff reviews the cases of from 35 to 50 children weekly at the three hospitals. For each hospital visit, the hospital staff provides a list of children who are hospitalized and brief summary of each child's medical condition. The CCS staff may discuss with the hospital staff the children's medical condition, diagnosis, prognosis, discharge plans, and other information. The CCS physician may visit some patients and review their medical records. Also, the CCS physician may contact the treating physician to discuss a particular child's medical condition.

Utilization Reviews by the San Francisco County CCS

The medical staff at the San Francisco County CCS consists of a part-time physician and one nurse to monitor the medical treatment of 1,500 children. The physician, who devotes 16 hours per month to the CCS, reviews medical records and reports on children's medical conditions. The nurse, who also is the administrator for the program, devotes approximately 40 percent of her time to reviewing treatment reports and authorizing treatments.

The medical staff reviews most medical reports and records at the CCS office. However, the physician visits hospitals to review medical records and to visit one to two children per month. Also, the CCS physician may contact the treating physician or hospital staff to discuss a particular child's medical condition.

Department Opposition To Using Medi-Cal Personnel To Conduct Utilization Reviews for the CCS

The Department of Health Services is strongly opposed to using Medi-Cal personnel to conduct utilization reviews of CCS children. Item 4260-001-001 of the Supplemental Report of the 1984 Budget Act requires the department to study the feasibility of using Medi-Cal personnel for hospital reviews for the CCS. In a report to the Legislature in October 1984, the department concluded that transferring responsibility for hospital reviews from the CCS to the Medi-Cal

program would be "counterproductive" to the department's efforts to increase administrative efficiency in the CCS program.

The department believes that dividing responsibilities between the CCS and the Medi-Cal program would be disruptive and require duplicate recordkeeping. Also, the department believes that transferring the responsibility for reviews would not result in savings to the State.

THE CALIFORNIA MEDICAL ASSISTANCE COMMISSION RECOMMENDS THAT THE CCS NOT CONTRACT FOR HOSPITAL CARE

Before February 1983, both the Medi-Cal program and the CCS paid hospitals on a "percent of charges basis." In February 1983, the Medi-Cal program began contracting with hospitals for a per diem rate for hospital care. However, the CCS continued to reimburse hospitals on a "percent of charges basis."

In the Supplemental Report of the 1984 Budget Act, the Legislature required the California Medical Assistance Commission (commission) to examine and report to the Legislature on whether the CCS should contract with selected hospitals for hospital services. To meet this legislative mandate, the commission reviewed CCS data and held public hearings to obtain information on the issue.

In its report to the Legislature dated October 1984, the commission concluded that a full services contracting program for CCS hospital care would not be feasible or desirable at this time because of the potential negative effects of contracting. In addition, the commission reported that the CCS has insufficient data for contracting. The data are insufficient because the CCS does not differentiate between inpatient and outpatient hospital services. Further, the CCS does not maintain records on the type of hospital service provided.

The commission also concluded that contracting for certain types of treatment such as cardiac care should not be pursued at this time. The commission stated that contracting could result in fewer hospitals being available to treat CCS children. Consequently, contracting could create greater logistical and travel problems for children and their families. Also, the commission reported that some doctors might drop out of the CCS, which would disrupt medical care. Further, the commission stated that hospitals may reduce the quality of their care in an attempt to economize in response to reduced CCS fees. Although the commission concluded that contracting could improve some specialized services and result in potential savings of between $.5 million and $1.5 million, the commission reported that the savings would be significantly reduced by increased administrative costs.

A STATEWIDE COMMISSION FOR THE CCS PROGRAM IS NOT NEEDED

We found no demonstrated need to establish a statewide commission to assist the Department of Health Services and the CCS in determining medical conditions eligible for CCS care. Most county CCS administrators do not believe that a commission is necessary. In addition, the department currently has an advisory committee to assist the department and the CCS in formulating CCS policy, and the department can appoint a task force group to study any issue of concern. Finally, a commission would cost the State over $800 per meeting.

In our survey of county CCS administrators, 35 county administrators either indicated that a commission is not needed or stated no opinion on the need for a commission. The CCS administrator in San Francisco County, for example, does not believe that a statewide commission is needed because a commission would duplicate functions of the CCS advisory committee that already exists. The CCS administrator in Los Angeles County, on the other hand, favors an *ad hoc* commission of representatives from academia and at least one county CCS administrator to advise the CCS and the department.

Twenty of the State's county CCS administrators favor establishing a statewide commission for the CCS. Seven of the 20 county administrators believe that the commission should be a policy-making body while 9 county administrators believe the commission

should be advisory only. The remaining 4 administrators who favor a commission expressed no opinion on the type of commission to be established.

We also discussed this issue with the Department of Health Services. The department believes that a statewide commission is not necessary. The department believes that it is able to supply the counties with the information they require to administer the CCS. Currently, the state CCS director obtains advice from medical experts and makes decisions about conditions and treatments that qualify for CCS funds.

In addition, the department has an advisory committee that it established approximately 35 years ago to advise the department in administering the CCS. The ten members of the advisory committee represent physicians, providers of CCS medical services, interested consumers, and CCS administrators. Also, two additional persons serve as consultants to the committee. The committee has met once each year during the last three years to discuss current legislation, subcommittee reports, fiscal matters, and financial and medical eligibility concerns. Since the advisory committee already meets regularly, a statewide commission would be an unnecessary expense for the State. We estimated that travel and room rental for a statewide commission would be approximately $800 per meeting.

Finally, the department can appoint a task force group to study and report on any issue of concern. Recently, in response to a request from the California Conference of Local Health Officers, the department established such a task force to study the relationship between the CCS and other children health service programs. In addition, the eight-member task force will review the relative responsibilities and relationship of the State and the counties in the CCS. The task force represents the medical field, CCS providers of medical services, and interested consumers.

THE STATE CCS IS PAYING THE COUNTY CCS LESS FOR ADMINISTRATION THAN THE MEDI-CAL PROGRAM OR THE COUNTIES PAY

The state CCS is paying the county CCS less for administration than the Medi-Cal program or the counties pay. State law limits the amount that the state CCS can pay for administrative costs to 4.1 percent of the State's total CCS medical costs. Some county CCS administrators stated that county boards of supervisors are reluctant to increase funding for county CCS administration because the primary beneficiary of improved operations is the state CCS, not the county.

In fiscal year 1983-84, counties spent approximately $10.5 million to administer the CCS. Counties paid $5.3 million (50 percent) of these administrative costs, while the Medi-Cal program paid $3.1 million (30 percent). The Medi-Cal program reimburses counties for the administrative duties of authorizing treatment and

payment for CCS children eligible for Medi-Cal benefits. Finally, the state CCS paid the remaining $2.1 million (20 percent) of county administrative costs. (Appendices D and E present the total administrative costs for independent and dependent counties, respectively, and the percentage of costs paid by the counties, the Medi-Cal program, and the state CCS.)

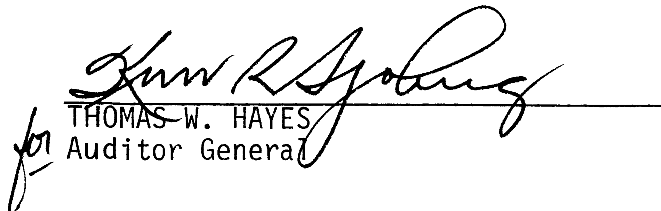
Section 268 of the California Health and Safety Code limits the State's overall payment for administrative costs to 4.1 percent of total CCS medical costs. Medical service costs are costs for diagnosis, medical treatment, and therapy. Independent counties, which administer the CCS locally, receive 4.35 percent of the amount of their medical service costs for administering the program; dependent counties receive 1.37 percent. Dependent counties receive a smaller allowance because these counties rely on the department's regional offices to perform many CCS duties.

Some county CCS administrators stated that the county boards of supervisors are reluctant to increase county contributions for CCS administrative costs because any improvements would primarily benefit the state CCS, not the county. This result occurs because the counties pay 25 percent of county CCS medical service costs but 50 percent of the county CCS administrative costs. In contrast, the state CCS and the federal government pay 75 percent of the county CCS medical costs; the state CCS pays only 20 percent of the county administrative costs. For example, if the county hires additional medical staff to conduct

utilization reviews and thereby reduce medical costs, it receives only 25 percent of the benefit of the reduced costs. The state CCS and the federal government, which pay nothing for the additional medical staff, receive 75 percent of the reduction in medical costs.

We conducted this review under the authority vested in the Auditor General by Section 10500 et seq. of the California Government Code and according to generally accepted governmental auditing standards. We limited our review to those areas specified in the audit scope section of this report.

Respectfully submitted,



for THOMAS W. HAYES
Auditor General

Date: March 1, 1985

Staff: William S. Aldrich, Audit Manager
Dore C. Tanner, CPA
Murray Edwards
Gregg A. Gunderson
Geraldine C. Parks, CPA
Perla M. Netto
Margaret Ann Peters
Patricia Woehrlin

GEORGE DEUKMEJIAN, *Governor*

STATE OF CALIFORNIA

HEALTH and WELFARE AGENCY

OFFICE OF THE SECRETARY
1600 NINTH STREET, ROOM 460
Sacramento, California 95814
(916) 445-6951

February 25, 1985

Thomas W. Hayes
Auditor General
660 J Street, Suite 300
Sacramento, CA 95814

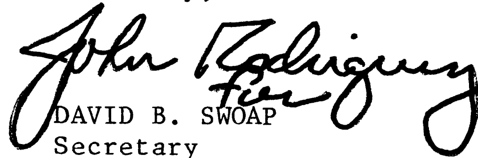
Dear Mr. Hayes:

Thank you for the opportunity to review and comment on the draft of your report on the California Children Services Program.

Some comments and suggestions are enclosed.

Implementation of some of the recommendations in the report has been started. For others, though, statutory and/or regulatory changes would be required, as well as more detailed cost-benefit analysis before they could be adopted.

Sincerely,



DAVID B. SWOAP
Secretary

Enclosure

Department of Health Services

Responses to

Draft Report By the Auditor General Entitled:

"CALIFORNIA CAN REDUCE STATE AND COUNTY CCS EXPENDITURES FOR MEDICAL SERVICES TO CHILDREN"

March 1985

California Children Services (CCS)
Department of Health Services
February 21, 1985

EXECUTIVE SUMMARY

The Department of Health Services generally concurs with the findings and recommendations of this report. However, some of the recommendations will require legislative changes or pilot studies to determine whether they are possible or cost-beneficial.

The Department does take exception to the opening statement in the summary that CCS "could have reduced its expenditures for medical services for children by millions of dollars." Whether such savings are possible, or even desirable, would depend on changes in state laws, and on changes in state and county policies and practices, which may in turn generate other costs and problems.(1)*

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* The Auditor General's comments on specific points contained in the agency's response appear on page 63.

COMMENTS BY THE AUDITOR GENERAL, and
RESPONSES BY THE DEPARTMENT OF HEALTH SERVICES

COMMENT:

The State does not ensure that providers bill insurance companies for medical services.

RESPONSE:

This Department is in agreement with the requirement that maximum utilization of patient insurance be made by the CCS program. Because of delays in determinations by insurance companies, it may not always be feasible to have an absolute requirement that a provider must submit an insurance company denial before being paid by CCS.

State legislation (AB 1261-1981) has pushed CCS in the opposite direction--requiring CCS to submit (Medi-Cal) bills for payment before CCS is allowed to determine if the care was authorized, necessary, appropriate, etc., and without determining if insurance was billed.

While CCS presently requires providers to first bill insurance companies, the study findings identified some areas where this policy is not being carried out as effectively as possible. As the report points out, a provider may receive more money from insurance than CCS will pay for a particular procedure, but there is usually a lengthy delay before insurance pays the provider. Providers are then in the position of having to accept a delay of a few months and then perhaps finding out that the insurance will not pay for a particular service, or that the child is not covered by the policy.

To make maximum utilization of insurance, the State CCS program will monitor county practices more closely and will provide additional training to counties. It should be noted that the CCS program allows a family to deduct part of its insurance premium from its CCS repayment obligation so as to encourage more families to purchase health insurance. As a result, CCS has been able to both learn of more insurance coverage, and to reduce CCS treatment costs. The Auditor General's report recognizes the complexity of insurance policies and the difficulty of CCS staff knowing the coverage of each patient's policy. Coverage under each of the many HMO and PPO insurance contracts is often difficult to ascertain.

In order to continue our cooperative working relations with providers, the Department is exploring alternative arrangements so that providers would not have to wait for the insurance company response when the provider would be hurt by delay, or when it is expected that the reply will be a negative one.

When the CCS case management process is fully computerized, it may be possible to provide CCS case managers with details on major health insurance policies and thereby avoid much of the delay.

COMMENT:

The State does not consider a family's assets when determining a child's eligibility for CCS care.

RESPONSE:

CCS does not agree that the value of a family's assets can be determined easily, or solely by using the State income tax return. If assets are to be included in determining financial eligibility, then CCS recommends that it be done initially or on a pilot basis to determine the most effective and most efficient methods.

Present CCS financial eligibility standards are established by law. Previously, both income and assets were used to determine financial eligibility. Under that prior system, there were many problems, and the system was difficult and costly to administer.

We question the report's statements about the ease and simplicity of determining assets. CCS would require detailed regulations defining assets, regulations that would be comparable to the many Medi-Cal regulations, and which would then require interpretation and application by each county CCS eligibility worker.

Many studies have been made of what CCS financial eligibility criteria ought to be. No single proposal was found that was equitable, cost-effective and productive of much revenue. If assets are to be included, this approach should be tried on a pilot basis in a few counties. A cost benefit analysis should then be done so that the net impact then could be determined. (2)

COMMENT:

The State does not refer to the Medi-Cal program all children potentially eligible for Medi-Cal benefits.

RESPONSE:

We recognize that there is some variation among counties in the application of this CCS requirement.

Both Medi-Cal and CCS use income as one criteria of eligibility. Medi-Cal also considers assets. CCS refers children to Medi-Cal solely on the basis of low income (and regardless of family assets); thus, CCS refers all those who might be eligible. (3)

Statements in the report about Medi-Cal eligibility require some clarification. A person is not eligible for Medi-Cal if his or her assets exceed a specified amount ($1,500 for a single person). If the Medi-Cal applicant does not have such assets, eligibility may be possible with a "share of cost". The monthly "share of cost", the difference between monthly income and the monthly maintenance level ($484 for a single person, $1,320 for a family of four) must be spent for medical care before any assistance is provided by Medi-Cal. (4) As a

result, the monthly Medi-Cal "share of cost" may be much higher than CCS repay requirements. Consequently, the $370,000 in projected savings will be less if families referred to Medi-Cal refuse to pay for their share of medical expenses.(5)

While the pending CCS regulations encourage referral to Medi-Cal and encourage families to pay the Medi-Cal "share of cost" when the amount is relatively low, a person eligible for CCS who is not "potentially eligible for cash grant public assistance" cannot be required to apply for Medi-Cal.

Furthermore, the State must pay approximately $73.27 for processing each Medi-Cal application and, therefore, to require application from a family with an exhorbitant share of cost would be wasteful when that family is not likely to qualify for Medi-Cal.(6) Consequently, the report's contention and projected savings appear to be overestimated.(7)

Overlooked in the report are CCS' successful efforts to utilize Medi-Cal to the maximum extent possible. CCS has shown a continuous increase in the proportion of CCS children covered by Medi-Cal, with significant savings to the State.

COMMENT:

<u>The State does not use the Tax Intercept Program to collect delinquent payments.</u>

RESPONSE:

The Department agrees with the recommendation that the Tax Intercept Program be utilized. The Department is investigating whether this is feasible and cost-effective, and whether this system can be used to collect repayments of both state and county funds.

COMMENT:

<u>A statewide pool of funds is not needed to pay medical costs in catastrophic cases.</u>

RESPONSE:

The Department agrees.

COMMENT:

<u>County CCS staff conduct varying types of utilization review.</u>

RESPONSE:

The utilization review process does vary from county to county. State CCS has strengthened its monitoring of county programs. More intense reviews of hospitalized cases have reduced lengths of stay and saved public funds.

COMMENT:

The California Medical Assistance Commission recommends that CCS not contract for hospital care.

RESPONSE:

The Department is in agreement with these recommendations, and with the Commission's findings that fewer hospitals would be available to treat CCS children, resulting in greater logistical and travel problems, as well as a possible reduction in quality of hospital care and in the number of participating physicians.

COMMENT:

A statewide commission for the CCS program is not needed.

RESPONSE:

The Department agrees and will continue to rely on the CCS Advisory Committee and special task forces for input to the program.

COMMENT:

The State is paying the county CCS less for administration than the Medi-Cal program or the counties pay.

RESPONSE:

State reimbursement of county CCS administrative costs is limited by law to 4.1 percent of medical care costs. The report describes some of the resulting consequences to the counties and to the State.

AUDITOR GENERAL'S COMMENTS ON THE HEALTH AND WELFARE AGENCY'S RESPONSE

(1) Our reasons for concluding that the CCS could have reduced its expenditures by millions of dollars is fully explained in the summary and again in Chapter I of our report. Further, the amount of potential savings is based on data from only 4 of the State's 58 counties. Also, we explained that state law needs to be changed in only one area--financial eligibility for CCS care. The department can reduce expenditures in the remaining areas by taking the administrative actions we recommend on pages 34-36.

(2) On pages 17-22, we state that the process of determining asset values is simple and not time consuming. Further, the southern California CCS administrators' group has developed financial screening procedures that allow county staff to determine easily the value of family assets.

Even though we agree there were problems with the department's previous system, we used a less complicated system to determine assets. As stated on page 22, our system is not time consuming. Since the CCS currently reviews state income tax returns to identify income, the CCS could also review the tax returns to determine a family's assets.

(3) The department did not refer all children potentially eligible for Medi-Cal benefits. As we stated on page 24, at least 10 percent of all children receiving CCS care were potentially eligible for Medi-Cal benefits but were not referred by CCS staff.

(4) On page 24, we state that families who are eligible for Medi-Cal benefits but have income exceeding specified amounts must pay or obligate themselves to pay a share of their medical expenses before they can receive Medi-Cal benefits.

(5) We state this on pages 25-26.

(6) On page 35, we recommend that the state CCS consult with representatives of the Medi-Cal program to insure that the new guidelines are reasonable and effective methods of identifying children who are potentially eligible.

(7) We used a statistical projection formula that produced the most conservative estimate (the lowest amount) of the potential savings.

APPENDIX A

RESULTS OF SURVEY OF COUNTY CCS ADMINISTRATORS ON THE PREFERRED METHOD OF DETERMINING FINANCIAL ELIGIBILITY

The 31 Counties Preferring a System That Considers Income and Assets	The 17 Counties Preferring the Current System That Considers Income Alone
Alameda	Amador
Butte	El Dorado
Calaveras	Inyo
Colusa	Kings
Contra Costa	Marin
Del Norte	Mendocino
Fresno	Napa
Glenn	Nevada
Humboldt	Plumas
Imperial	Sacramento
Kern	San Benito
Lassen	San Joaquin
Los Angeles	Shasta
Madera	Stanislaus
Mariposa	Tulare
Mono	Tuolumne
Orange	Ventura
Placer	
Riverside	
San Bernardino	
San Diego	
San Francisco	
San Luis Obispo	
San Mateo	
Santa Clara	
Santa Cruz	
Siskiyou	
Solano	
Sutter	
Tehama	
Yuba	

NUMBER OF ACTIVE CCS CASES REPORTED BY INDEPENDENT COUNTIES, HOURS PER MONTH FOR MEDICAL PERSONNEL, AND NUMBER OF CHILDREN REVIEWED AT HOSPITALS PER MONTH

Independent Counties	Active CCS Cases	Physician Hours Per Month	Nurse Hours Per Month	Children Reviewed at Hospitals Per Month
Alameda	4,000	48	0	0
Contra Costa	1,519	14	240	4-6
Del Norte/ Humboldt	608	*	80	0
Fresno	1,991	32	0	0
Kern	1,995	126	0	0
Los Angeles	24,960	320	1,920	2-8
Marin	251	55	16	5
Monterey	2,645	30	160	10
Napa	331	0	80	0
Orange	4,630	170	640	100
Riverside	2,082	160	160	0
Sacramento	2,848	32	32	1
San Bernardino	3,181	64	83	0
San Diego	4,300	144	300	140-200
San Francisco	1,500	16	160	1-2
San Joaquin	1,422	91	0	0
San Luis Obispo	630	8	0	0
San Mateo	670	140	0	20-30
Santa Barbara	896	30	14	0
Santa Clara	2,755	112	140	50
Solano	467	8	80	0
Sonoma**				
Stanislaus	962	8	0	0
Tulare	846	35	0	0
Ventura	1,710	28	160	10-15

*County did not report data.

**County did not respond to survey.

NUMBER OF ACTIVE CCS CASES REPORTED BY DEPENDENT COUNTIES, HOURS PER MONTH FOR MEDICAL PERSONNEL, AND NUMBER OF CHILDREN REVIEWED AT HOSPITALS PER MONTH

Dependent Counties	Active CCS Cases	Physician Hours Per Month	Nurse Hours Per Month	Children Reviewed at Hospitals Per Month
Alpine	3	0	6	0
Amador	65	0	45	0
Butte	549	0	0	0
Calaveras	50	2	32	0
Colusa	98	2	80	0
El Dorado	451	0	0	0
Glenn	118	2	143	0
Imperial	682	0	160	0
Inyo	50	0	0	0
Kings	323	1	20	0
Lake**				
Lassen	108	0	0	0
Madera	201	5	6	0
Mariposa	35	0	0	0
Mendocino	300	5	32	0
Merced	623	0	80	0
Modoc	22	0	0	0
Mono	40	0	48	0
Nevada	240	1	30	0
Placer	375	0	188	0
Plumas	58	0	34	0
San Benito	107	2	60	*
Santa Cruz	521	8	220	5
Shasta	409	0	30	0
Sierra	8	0	0	0
Siskiyou	166	5	0	0
Sutter	539	16	160	0
Tehama	187	0	160	0
Trinity**				
Tuolumne	126	0	16	0
Yolo	383	0	163	0
Yuba	358	4	50	0

*County did not report data.

**County did not respond to survey.

ADMINISTRATIVE COSTS OF INDEPENDENT COUNTIES PAID BY THE STATE CCS, THE MEDI-CAL PROGRAM, AND THE COUNTIES FISCAL YEAR 1983-84 (Source: The State CCS)

Independent Counties	Total County Administrative Costs	Percent Paid by the State CCS	Percent Paid by the Medi-Cal Program	Percent Paid by the County
Alameda	$ 331,591	30	38	32
Contra Costa	401,123	18	16	66
Del Norte	15,816	5	30	65
Fresno	249,917	24	21	55
Humboldt	72,467	15	22	63
Kern	258,355	19	26	55
Los Angeles	2,734,918	21	40	39
Marin	109,029	7	8	85
Monterey	182,094	42	27	31
Napa	74,119	9	21	70
Orange	1,064,835	24	16	60
Riverside	309,267	28	36	36
Sacramento	366,734	21	41	38
San Bernardino	288,241	28	42	30
San Diego	668,856	21	44	35
San Francisco	256,595	25	25	50
San Joaquin	289,589	10	32	58
San Luis Obispo	104,309	18	20	62
San Mateo	262,395	11	9	80
Santa Barbara	129,166	20	19	61
Santa Clara	710,749	15	16	69
Solano	88,506	14	29	57
Sonoma	163,977	15	13	72
Stanislaus	140,710	17	24	59
Tulare	150,817	15	29	56
Ventura	175,466	34	32	34
Total	$9,599,641			
Average Percent Paid		21	30	49

ADMINISTRATIVE COSTS OF DEPENDENT COUNTIES
PAID BY THE STATE CCS, THE MEDI-CAL PROGRAM, AND THE COUNTIES
FISCAL YEAR 1983-84
(Source: The State CCS)

Dependent Counties	Total County Administrative Costs	Percent Paid by the State CCS	Percent Paid by the Medi-Cal Program	Percent Paid by the County
Alpine	$ 776	65	10	25
Amador	6,958	15	28	57
Butte	70,812	8	29	63
Calaveras	2,609	19	33	48
Colusa	25,113	4	17	79
El Dorado	47,160	10	20	70
Glenn	11,468	9	40	51
Imperial	80,626	5	32	63
Inyo	31,531	3	8	89
Kings	26,512	6	24	70
Lake	6,560	23	45	32
Lassen	5,593	18	22	60
Madera	34,173	7	19	74
Mariposa	1,061	47	28	25
Mendocino	24,798	15	17	68
Merced	45,332	14	33	53
Modoc	7,934	6	25	69
Mono	3,599	14	12	74
Nevada	21,992	9	24	67
Placer	47,391	10	20	70
Plumas	16,941	6	16	78
San Benito	12,822	8	43	49
Santa Cruz	75,187	13	29	58
Shasta	32,798	19	56	25
Sierra	1,119	45	19	36
Siskiyou	32,857	17	16	67
Sutter	66,917	8	25	67
Tehama	11,700	20	31	49
Trinity	4,161	39	39	22
Tuolumne	33,894	6	14	80
Yolo	52,364	7	40	53
Yuba	26,098	9	50	41
Total	$868,856			
Average Percent Paid		10	27	63

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
State Controller
Legislative Analyst
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
Capitol Press Corps