

*Reprint*

from *The 1992-93 Budget: Perspectives and Issues*

**The 1991-92  
State and Local  
Program Realignment  
*Overview and Current Issues***

Elizabeth G. Hill  
*Legislative Analyst*

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# *The 1991-92 State and Local Program Realignment Overview and Current Issues*

## ***What Steps Should the Legislature Take to Ensure the Effective Implementation of Realignment?***

### **Summary**

*The 1991 realignment legislation represents a fundamental change in the state and county fiscal relationship. This legislation included three major components: (1) program transfers from the state to the counties, (2) changes in state/county cost-sharing ratios for nine social services and health programs, including AFDC, and (3) an increase in the state sales tax and the vehicle license fee earmarked for support of the programs. Thus, the legislation did not give counties discretion to use these revenues for any local purpose, nor did it make the realigned programs discretionary.*

*The legislation includes a number of programmatic and fiscal reforms. It also addressed the state's budget gap to some extent. In the near term, this was due primarily to the revenue increase to support the county's share of realigned program costs. In the longer term, the legislation's reforms could result in a more significant contribution to closing the state's structural budget gap than would have been achieved through a tax increase alone.*

*The Legislature will face several significant issues related to realignment in the current legislative session and in later years. These include (1) a net \$130 million revenue shortfall for the counties in the current year, (2) pending court cases that could trigger the legislation's "poison pill" provisions, (3) the implementation of performance-based contracts for county mental health programs, (4) the state's role with regard to IHSS service reductions, (5) the need to establish a fund reserve to ensure the long-term viability of realignment, and (6) the state's future oversight role for the realigned programs.*

*Finally, we believe the Legislature should consider extending some of the concepts that underlie this legislation to other program areas as one strategy to address the state's current budget gap.*

## INTRODUCTION

The state and local program realignment legislation enacted in 1991 represents a fundamental change in the state and county fiscal relationship. In this piece, we (1) provide background on the evolution of the legislation, (2) review its primary components, (3) assess its likely programmatic and fiscal effects, and (4) identify realignment-related implementation and policy issues we believe the Legislature will face in the current legislative session and in later years. Finally, we identify program areas where we believe the Legislature might effectively extend some of the legislation's features to enact further reforms.

## BACKGROUND

In January 1991, the Governor proposed a transfer of responsibility for community-based mental health programs and the AB 8 county health services program from the state to counties as part of a "realignment" of state and local programs. The administration proposed to eliminate a total of about \$900 million in General Fund support for these services, and to provide counties with roughly equivalent additional revenues from an increase in the alcohol tax and the vehicle license fee (VLF). This proposal was a major component of the administration's initial plan to address the significant funding gap that faced the state for 1991-92.

The administration's rationale for its proposal to transfer program responsibility included the following:

- Authorizing legislation did not require extensive state oversight of the two programs as compared to most others in the health and welfare area.
- Funding for mental health local assistance had historically been considered "discretionary" expenditures, and had been reduced significantly in years where the state faced a major budget shortfall.
- Allowing local governments greater flexibility in determining program structure and ultimate funding levels would improve program services and their responsiveness to local concerns.
- The specified funding sources would provide a stable and growing revenue base to support the programs over the long term.

In responding to the administration's initial proposal, the Legislature endorsed a number of these principles, but raised several concerns:

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- Providing counties complete discretion over mental health expenditures could have jeopardized over \$300 million in federal funding for substance abuse and mental health treatment services annually, due to certain federal requirements.
- The administration's proposal for mental health would have potentially shifted significant costs to other, primarily state-funded programs (such as AFDC-Foster Care and the state hospitals) that were generally more costly and less consistent with the programmatic goal of mental health legislation (that is, that persons should receive services in the least restrictive settings).
- There were other health and welfare programs administered as a "partnership" between the state and the counties that could be incorporated into a realignment package to give counties more flexibility and a greater fiscal stake in the programs. Incorporating such programs would recognize programmatic linkages among various health and welfare programs, thereby adopting a "system-building" approach to programmatic reform.
- Realignment legislation needed to be structured in such a way as to limit intercounty migration — the movement of individuals to counties that provide relatively higher levels of services. Such migration could become more severe to the extent that service level variations became more extreme.

#### **LEGISLATIVE ACTION: THE 1991-92 REALIGNMENT**

Based on the concerns raised in the realignment hearings (including those noted above), the Legislature saw advantages in a modified and significantly expanded version of the administration's original proposal. Through a task force, the Legislature and the administration jointly developed three pieces of legislation — Ch 87/91 (AB 758, Bates), Ch 89/91 (AB 1288, Bronzan), and Ch 91/91 (AB 948, Bronzan),<sup>a</sup> which affected a total of 18 programs (16 in the health and welfare area).

This legislation included three major components: (1) program transfers from the state to the counties, (2) changes in state/county cost-sharing ratios for certain social services and health programs, and (3) an increase in the state sales tax and the VLF earmarked for supporting the increased financial obligations of counties. Figure 1 summarizes the major components of the 1991-92 realignment, as

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<sup>a</sup> Subsequent to the passage of the 1991-92 budget plan, Chapter 89 was amended by "technical cleanup" legislation, Ch 611/91 (AB 1491, Bronzan).

well as the amount of 1991-92 General Fund expenditures transferred to counties and funded by the revenue increases.<sup>b</sup>

The realignment measures eliminated a total of \$1.7 billion in projected General Fund expenditures for the transferred programs, and increased net county sharing ratio costs by approximately \$469 million. As Figure 1 indicates, these actions increased county expenditure requirements by a total of \$2.2 billion for the current year. The Legislature also enacted an increase in the VLF (through a modified depreciation schedule) and state sales tax (1/2 cent) that was projected to raise \$2.2 billion in revenues for 1991-92, and additional amounts in future years to cover caseload and other costs in the realigned programs.

### Program Transfers

The realignment legislation transferred some degree of additional responsibility to counties for:

- **Community-Based Mental Health Services.** These services, which are administered by county departments of mental health, include short- and long-term treatment, case management, and other services to seriously mentally ill children and adults. Previously, these services were funded 90 percent state, 10 percent counties and, in most cases, by additional county funds.
- **State Hospital Services for County Patients.** The state hospitals, administered by the state Department of Mental Health, provide inpatient care to seriously mentally ill persons placed by counties, the courts, and other state departments. They were previously funded 85 percent state, 15 percent counties.
- **Institutions for Mental Diseases (IMDs).** IMDs, administered by independent contractors, generally provide short-term nursing level care to the seriously mentally ill. They were previously funded by the state and, in some cases, by additional payments from counties.
- **AB 8 County Health Programs.** Under this program, counties carry out public and indigent health services. Indigent health services include direct patient care services, such as clinic visits or inpatient care. Public health activities include services that are generally preventive in nature or that limit the spread of disease, although they may also encompass certain services provided directly to patients, such as immunizations.

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<sup>b</sup> A portion of expenditures displayed in Figure 1 for the Medically Indigent Services Program reflects the earmarking of \$116 million in revenues to replace funding that was anticipated to be lost in 1992-93 due to the expiration of funding under the federal Immigration Reform and Control Act.

**Figure 1**

**Components of State and Local Program Realignment  
1991-92**

(in millions)

<b>Transferred Programs</b>		1991-92 COSTS SHIFTED TO COUNTIES				
<i>Mental Health</i>		<b>\$750</b>				
• Community-based Mental Health Programs		452				
• State Hospital Services for County Patients		210				
• Institutions for Mental Diseases (IMDs)		88				
<i>Public Health</i>		<b>\$506</b>				
• AB 8 County Health Services		503				
• Local Health Services (LHS)		3				
<i>Indigent Health</i>		<b>\$435</b>				
• Medically Indigent Services Program (MISP)		348				
• County Medical Services Program (CMSP)		87				
<i>Local Block Grants</i>		<b>\$52</b>				
• County Stabilization Subventions		15				
• County Juvenile Justice Subventions		37				
<b>County Cost-Sharing Ratio Changes</b>		STATE/COUNTY SHARES OF NONFEDERAL PROGRAM COSTS		1991-92 COSTS SHIFTED TO COUNTIES		
		PRIOR LAW		REALIGNMENT		
<i>Health</i>						
• California Childrens' Services		75 / 25		50 / 50		<b>\$30</b>
<i>Social Services</i>						<b>\$441</b>
• AFDC - Foster Care (AFDC-FC)		95 / 5		40 / 60		363
• Child Welfare Services (CWS)		76 / 24		70 / 30		42
• In-Home Supportive Services (IHSS)		97 / 3		65 / 35		235
• County Services Block Grant (CSBG)		84 / 16		70 / 30		13
• Adoption Assistance Program		100 / 0		75 / 25		12
• Greater Avenues for Independence (GAIN) Program		100 / 0		70 / 30		26
• AFDC - Family Group and Unemployed Parent (AFDC FG & U)		89 / 11		95 / 5		-155
• County Administration (AFDC-FC, FG, U, foodstamps)		50 / 50		70 / 30		-95
<b>Additional County Expenditures (Net)</b>						<b>\$2,212</b>
<b>Additional County Revenues</b>		ORIGINAL ESTIMATE		JAN '92 ESTIMATE		
• State Sales Tax		\$1,422		\$1,350		
• Vehicle License Fee (VLF)		769		712		
		<b>\$2,191</b>		<b>\$2,062</b>		

- ***The Medically Indigent Services Program (MISP).*** Under the MISP, larger counties provide indigent patient care to persons not eligible for the state Medi-Cal Program.
- ***County Medical Services Program (CMSP).*** Under the CMSP, the state generally provides indigent patient care to persons in smaller counties who are not eligible for the state Medi-Cal Program.
- ***Local Health Services (LHS) Program.*** This program provides public health staff to small rural counties.

In addition, the realignment package included revenues to offset the Budget Act elimination of two block grants: These were the County Justice Subvention Program (CJSP), which provided assistance to counties for local juvenile justice programs, and the County Revenue Stabilization Program (CRSP), which provided assistance to stabilize the fiscal condition of smaller counties. The legislation provided funding equal to the block grant amounts proposed in the Governor's Budget and gave counties discretion to use these funds for juvenile justice, health, mental health, or social services programs.

#### **County Cost-Sharing Ratio Changes**

Realignment increased the county share of nonfederal costs for certain health and social services programs, and reduced the county share for others, as detailed in Figure 1. Specifically, the legislation increased the counties' share of the following programs:

- ***California Children's Services (CCS) Program.*** The CCS Program provides medical diagnosis, treatment, and therapy to financially eligible children with specific disabilities.
  - ***AFDC-Foster Care.*** This program pays for the care provided to (1) dependent children who are removed from their homes due to child abuse and neglect and (2) wards of the court who have committed offenses.
  - ***Child Welfare Services (CWS) Program.*** The CWS Program investigates allegations of child abuse and neglect, and provides services to abused and neglected children in foster care and their families.
  - ***In-Home Supportive Services (IHSS).*** This program provides assistance to eligible aged, blind, and disabled persons who are unable to remain safely in their own homes without assistance.
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- **County Services Block Grant (CSBG).** CSBG funds can be used for various social services, including adult protective services and programs to provide information and referrals.
- **Adoption Assistance Program.** This program provides monthly grants to parents who adopt "difficult-to-place" children.
- **Greater Avenues for Independence (GAIN) Program.** Under the GAIN Program, AFDC (Family Group and Unemployed Parent) recipients receive education and job training services in order to help them find jobs and become financially independent.

The legislation also *reduced* the county share of grant costs in the AFDC Family Group and Unemployed Parent Programs, and for county administration of social services programs.

#### Revenue and Transfer Provisions

The legislation established a Local Revenue Fund, into which the additional revenues attributable to the increase in the sales tax are deposited, and established several provisions to govern their expenditure. The State Constitution requires that VLF proceeds be subvended directly to counties and does not allow them to be earmarked for specific purposes. In order to expend the realignment sales tax revenues, however, the legislation requires counties to deposit into the health accounts of the Local Revenue Fund an amount equal to the increase in VLF funds they receive. Accordingly, counties will use the VLF funding to support health programs.

The legislation allocates both VLF and state sales tax funds among the counties, generally according to the amount of funding counties would have received in 1991-92 had prior law for the various programs continued. The flow of revenues to the programs encompassed in the legislation is shown in Figure 2.

As the figure shows, the legislation authorizes counties to transfer up to (1) 10 percent of funding from one major program area to another (for example, from mental health programs to social services programs) and (2) an additional 10 percent from health programs to the entitlement-driven programs if increased caseload costs exceed the amount of revenues available in the social services account.

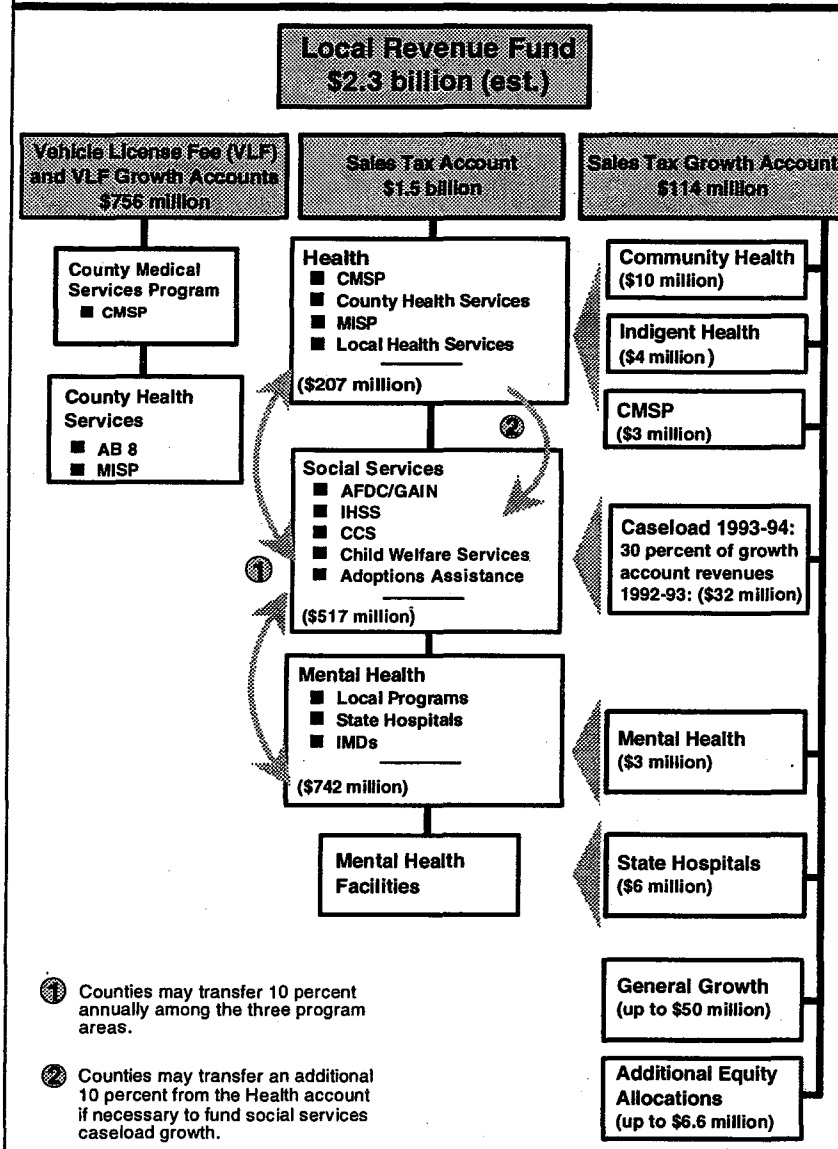
Finally, the legislation establishes a schedule for allocating future increases in revenue collections attributable to the VLF and sales tax increases among the programs and across counties. For

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Figure 2

**Proposed Allocation of Realignment Funds  
1992-93**



this purpose, the legislation anticipates approximately \$114 million in additional sales tax revenue in 1992-93, and allocates it for specified purposes, as shown in Figure 2. In general, however, the legislation does not establish priorities for these allocations if actual revenue growth is below the amount anticipated. (This issue is discussed further below.)

### **“Poison Pill” Provisions**

In addition to the various fiscal and programmatic provisions described above, the individual realignment statutes each contain “poison pill” provisions that would render them inoperative under specified circumstances. These provisions fall into three categories:

**Reimbursable Mandate Claims.** If, as a result of the provisions of the realignment legislation itself, (1) the Commission on State Mandates adopts a statewide cost estimate or (2) an appellate court makes a final determination that upholds a reimbursable mandate, the general provisions governing realignment would become inoperative.

**Constitutional Issues.** If a final appellate court decision finds that the provisions of realignment requiring counties to deposit funds equal to their share of the VLF increase into the realignment funding accounts violate the constitutional requirement that VLF proceeds be subvended directly to counties, the VLF increase would be repealed.

Similarly, if a final appellate court decision finds that revenues raised pursuant to the realignment portion of the 1991-92 sales tax increase (1/2 cent out of the 1-1/4 cent increase) count against the Proposition 98 funding guarantee, the realignment portion of the sales tax increase would be repealed.

**Court Cases Related to Medically Indigent Adults.** If a final appellate court decision finds that the 1982 legislation that transferred responsibility from the state to the counties for providing services to medically indigent adults constitutes a reimbursable mandate, the VLF increase, which supports the realigned health programs, would become inoperative.

If any of these provisions take effect, the affected statute would become inoperative within 30 to 90 days, depending on the provision.

### **IMPACT OF THE REALIGNMENT**

The realignment legislation encompasses a number of policy changes that were intended to achieve various programmatic and

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fiscal reforms. The legislation's major fiscal and policy features are summarized in Figure 3.

In this section, we review the specific policy changes in health, mental health, and social services programs and the potential programmatic effects of the legislation's revenue and transfer provisions. In addition, we discuss the short- and long-term implications of the legislation's fiscal provisions on state and county governments. Our review is based in part on our field visits to 10 counties and discussions with staff in several other counties.

### **Policy Changes to Expand County Flexibility and Service Coordination**

***Indigent and Public Health.*** For the indigent and public health programs, the legislation makes limited programmatic changes. The AB 8 program originally was established by Ch 282/79 (Leroy Greene) to provide block grants to counties for funding inpatient and outpatient services and public health programs. This legislation was one part of the state's response to the passage of Proposition 13. Previously, these services had been funded at the county level. Thus, the state's oversight and policy direction has historically been limited.

Under the realignment legislation, both the AB 8 and MISP statutes were eliminated, allowing counties to use funding previously allocated for these programs for indigent and public health generally. The near-term effect of this change is not as dramatic as it may appear, for the following reasons:

- Counties that wish to receive Proposition 99 funds must continue to maintain specified expenditure and service levels, or "maintenance of effort." (We discuss this issue in more detail below.)
- Counties had previously been able to use AB 8 funds for either public or indigent health purposes. Furthermore, based on our field visits, it does not appear that counties will use MISP funds (which were previously restricted to indigent health services) for public health to any significant degree in the near term. However, this could change in future years.

For the CMSP, specific statutes defining the program were retained and/or modified; and the state continues to have fiscal responsibility for the program's costs, to the extent these costs exceed limits specified in the legislation. (These dollar limits are based on the projected revenue growth for the CMSP counties.) Accordingly, the state continues to have funding responsibility to

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**Figure 3**

**Major Fiscal and Policy Changes in the 1991-92 Realignment**

**Reflects a "System-Building" Approach**

- Establishes incentives for programmatic coordination among 16 health and welfare programs by (1) authorizing funding transfers across programs and (2) changes in cost-sharing ratios for some programs.
- Establishes incentives for innovation by (1) authorizing funding transfers across programs and (2) providing a fixed amount for realigned entitlement programs.

**Establishes Mechanisms for Cost Control in Major Entitlement Programs**

- Increases county share of costs for California Children's Services (CCS), AFDC-Foster Care, Child Welfare Services, In-Home Supportive Services (IHSS), and other social services entitlement programs.
- Establishes new county administration funding structure for CCS that provides incentives for case management and cost control.

**Provides Greater Flexibility to Counties**

- Gives counties authority to make resource-allocation decisions in mental health by determining state hospital and IMD usage.
- Authorizes funding transfers across programs.
- Authorizes counties to reduce IHSS expenditures through 1993-94.

**Emphasizes Performance-Based Oversight**

- Directs the DMH to develop "outcome measures" and requires "performance-based contracts" for local mental health programs.
- Establishes data task force to recommend future reporting requirements for both health and mental health programs.

**Contributes to Addressing State's Budget Gap**

- Provides \$2 billion in revenues for existing health and welfare programs.
- Establishes two fiscal incentives to reduce long-term growth in entitlement program expenditures:
  - (1) Increases county share of costs for entitlement services.
  - (2) Provides incentives for case management in CCS.

meet increases in the need for indigent health services in smaller counties. (We discuss CMSP costs further in our *Analysis of the 1992-93 Budget Bill*, Department of Health Services, Item 4260.)

**Mental Health.** For mental health programs, the legislation made a number of major policy changes. First, the legislation provided counties additional flexibility regarding the use of funds that support services for county patients. These include services provided through the state hospitals, IMDs, and community-based programs. The legislation authorizes counties, beginning in 1992-93, to increase or decrease their use of state hospital beds by up to 10 percent annually. In addition, the legislation authorizes counties to use funds previously budgeted for the purchase of IMD services for any mental health purpose, again beginning in 1992-93.

These changes provide counties with the authority to make resource allocation decisions regarding mental health services based on counties' assessments of programmatic effectiveness. Previously, counties were required to use state hospital and IMD services whether or not they considered these services to be more valuable than community-based alternatives.

Finally, the legislation expressed intent that the most seriously mentally ill be given priority for receiving mental health services provided by counties. Under prior law, the legislative mandate was quite broad and could be interpreted to cover less seriously ill persons.

### Changes in State Administration

The legislation also made changes in the responsibilities of the state Department of Mental Health (DMH) and, to a much lesser extent, the Department of Health Services (DHS). We discuss these changes below.

**Department of Mental Health.** Under the legislation, the department is charged with the development (in collaboration with counties and others) of performance outcome measures and with integrating those measures into its current data system. The legislation directs the department to negotiate performance-based contracts with counties in future years on the basis of these outcome measures.

The DMH also continues to have responsibility to:

- Review county expenditure plans (though in less detail).
  - Provide technical assistance to counties.
  - Ensure compliance with federal ADAMH and Medicaid requirements.
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- Manage the state hospital system, which serves county and judicially committed clients and clients of the Departments of Corrections and the Youth Authority.
- Administer additional programs, including the Conditional Release Program, local assistance for services to special education pupils, the Primary Intervention Program, and pilot projects for coordinated service delivery for children and adults (more commonly known as the AB 377 and AB 3777 programs, respectively).

In other areas, the department's responsibility for oversight of county programs generally is limited to aspects that involve compliance with federal law.

It is difficult to assess the ultimate effect of these changes on the DMH's role in the state's mental health system. However, the legislation clearly continues a state/county partnership regarding mental health programs and, as a result of the provisions regarding outcome measures and performance-based contracts, may potentially result in oversight of local mental health programs similar to that for the existing AB 377 and AB 3777 pilot programs. In these pilot programs, the department's responsibility is to monitor counties' successes in achieving specified outcomes for clients receiving mental health services (such as the extent to which state hospital and AFDC-Foster Care group home placements for children are avoided). The realignment legislation does not, however, authorize the department to implement specific sanctions if county performance falls short of the specified performance objectives.

***Department of Health Services.*** With certain minor exceptions, the realignment legislation did not explicitly change the department's responsibilities regarding oversight of public and indigent health programs. The department, however, has consolidated its public and indigent health units and eliminated several monitoring and technical assistance positions as part of its allocation of various budget reductions, stating that these changes are "due to realignment." The DHS realignment-related workload will depend in large part on its eventual data monitoring duties, which are one subject of the Health and Welfare Agency data task force meetings we discuss later. (Also, please see the *Analysis of the 1992-93 Budget Bill*, Item 4260.)

The realignment legislation increased DHS responsibilities related to the administration of the CCS Program. This is because the legislation requires the department to (1) implement and maintain oversight over a new county administration system

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(which we discuss below) and (2) develop program changes that would expand eligibility or benefits through consultation with the counties.

### **Policy Changes to Facilitate Cost Control**

**AFDC-Foster Care.** The Legislature increased county cost-sharing ratios for AFDC-Foster Care to provide an incentive to contain rapid expenditure growth in the program, and in recognition of the link between the program and children's mental health services. The Legislature sought to avoid placements of seriously emotionally disturbed children in AFDC-Foster Care group homes who could be more appropriately served through community mental health programs. Without a change in the AFDC-Foster Care county sharing ratio, counties' own costs for foster care group home placements would in many cases have been significantly less than the costs counties would incur to provide services through their mental health programs, even though the total costs (state and local) for group home placements frequently would have been higher.

**AFDC-Family Group and Unemployed Persons (FG&U) Program.** The legislation reduced county costs for the AFDC-FG&U Program in recognition of the fact that the ability of counties to control expenditures in this program is limited because the program's costs generally are driven by changes in the state's economy and population.

Accordingly, through increased sharing ratios for AFDC-Foster Care, the legislation gives counties a relatively higher fiscal stake in the cost of services that they may be able to control and, with regard to AFDC-FG&U, attempts to reduce their costs for services that are largely driven by forces beyond their control.

**California Children's Services.** The legislation establishes a new system for funding CCS county administrative costs beginning in 1992-93 that is designed to provide incentives for reducing program costs through (1) improved case management and (2) improved collections of federal and third-party payor funds. The previous system effectively *discouraged* such activities. This new system, in combination with increased county cost-sharing ratios, provides incentives for containing expenditure growth in the program.

**In-Home Supportive Services.** The legislation changed the entitlement nature of the IHSS Program by limiting costs to the Budget Act appropriation and authorizing counties to reduce IHSS services through 1993-94. The legislation also significantly increased the county share of costs for IHSS services. While the

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primary effect of these changes will be service reductions, they may also provide a strong incentive for counties to provide IHSS services more efficiently.

### **Revenue and Transfer Provisions**

The legislation establishes a number of requirements on counties regarding the use of funds deposited into the Local Revenue Fund, including that they may only be used for the activities provided under the various indigent and public health, mental health, juvenile justice, and caseload-driven social services programs that were the subject of realignment. Accordingly, the realignment ultimately enacted did not give counties discretion to use these additional revenues for any local purpose, nor did it make the programs encompassed in the legislation discretionary.

The legislation established three separate accounts for program funding and established limits on transfers, to ensure that (1) entitlement program cost increases would not result in cuts to health and mental health programs beyond the specified transfer percentages in any given year, (2) state and federal maintenance-of-effort provisions for health and mental health programs could be tracked to ensure compliance, and (3) some level of service for each of the program areas would be provided in every county.

Finally, the Legislature sought to provide counties with a fiscal incentive to manage costs in entitlement programs. The legislation does so by establishing a defined revenue source to fund the counties' share of entitlement costs, and by effectively requiring either (1) transfers of funding from health and mental health programs or (2) additional county expenditures, if costs in the entitlement programs exceed the amount of revenues allocated to fund them.

### **Implications for the State's Budget Gap**

The realignment legislation was a major component of the solution to the \$14 billion budget funding gap the state faced in 1991-92. Of the approximately \$7 billion in additional tax revenue increases enacted as part of the state's spending plan for the year, approximately \$2 billion was for additional revenues to support the programs encompassed in the realignment legislation. In the shorter term, this increase, dedicated to offset the county's additional share of realigned program costs, was the primary contribution of the legislation in addressing the 1991-92 funding gap.

In the longer term, however, the legislation's cost-sharing ratio changes could have an additional effect on addressing the state's underlying structural funding gap. First, to the extent that service

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costs in the realigned programs continue to grow at a rate in excess of the state's revenue growth, a significantly higher portion of these costs will be absorbed by the counties. Second, the ratio changes may result in improved efficiencies and greater effectiveness in delivering and managing entitlement program services. As discussed above, the provisions that may have this "behavioral" effect include:

- Strong fiscal incentives to better coordinate service delivery for individuals whose need for more expensive entitlement services (such as AFDC-Foster Care) may be reduced through other services included in the legislation (such as community mental health). For many counties, such "targeting" will be critical.
- Strong fiscal incentives for counties to engage in case management and be innovative in structuring their programs, potentially reducing long-term costs for both the state and the counties.

Thus, as a result of county sharing ratio changes, the realignment legislation could result in a more significant contribution to closing the state's budget gap than would have been achieved through a tax increase alone.

#### **Fiscal Impact on Counties: Fund Condition**

As we discussed earlier, the VLF and sales tax increases were projected to raise approximately \$2.2 billion in additional revenues, which would fully offset anticipated county costs under realignment for 1991-92. Due to the lingering recession, however, counties face a major shortfall in the current year:

- **Revenues.** Actual revenue collections to date have been significantly less than the administration's original projections. The administration currently anticipates revenue collections of \$2,062 million in the current year, or about \$150 million (7 percent) less than the amount originally estimated.
  - **Expenditures.** The administration's latest estimates of county expenditure requirements for entitlement programs during the current year, however, have decreased only slightly, by \$18 million (or 1 percent).
  - **Shortfall.** We estimate that the resulting shortfall for counties in 1991-92 is slightly over \$130 million. (Note, however, that the administration's expenditure estimate assumes a March 1 enactment of the Governor's welfare
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reform initiative. If the initiative's proposed AFDC cost reductions are not implemented or are implemented later in the year, the county shortfall would increase slightly.)

For 1992-93, the budget projects that total realignment revenues will increase by \$274 million (or 13 percent) to a total of \$2.3 billion, which would fully restore the originally anticipated current-year funding level and provide \$114 million to fund the legislation's growth allocation provisions. However, given current estimates of economic recovery, these estimates appear to be somewhat optimistic.

Whatever the ultimate growth in realignment revenues, we estimate the counties will need to spend an additional \$200 million in 1992-93 simply to offset current-year reductions due to the revenue shortfall and fund their share of projected caseload and state hospital rate increases for 1992-93. Thus, counties will have, to the extent the administration's revenue forecast proves accurate, up to \$74 million in additional funds during 1992-93 to make "discretionary" cost adjustments, such as for indigent and mental health services.

***Current-Year Implications for Counties.*** For the counties, a shortfall of the magnitude estimated for the current year (\$130 million) has serious implications: the need for most counties to make up the shortfall through use of their general purpose revenues and service reductions.

The realignment legislation provided counties with various options for dealing with shortfalls. Under the legislation, counties may:

- Transfer up to 10 percent of funding from the health or mental health accounts that could be used to offset entitlement caseload costs.
- If necessary, transfer sales tax revenue growth allocated to other programs to fund caseload costs.
- If necessary, transfer up to an additional 10 percent of funding from health programs to fund caseload costs.
- Reduce IHSS expenditures.
- Reduce indigent health, public health, and mental health expenditures.

However, a Proposition 99 maintenance-of-effort requirement significantly constrains county options. Proposition 99, passed by voters in 1988, established a surtax on cigarettes and tobacco products and specified that the surtax funds "shall be used to

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supplement existing levels of service” for indigent and mental health programs, “and not to fund existing levels of service” based on 1988-89 expenditure amounts.

Chapter 1170, Statutes of 1991 (SB 99, Watson), defined “existing levels of service” for these programs to be the amount each county was *projected to receive* from the realignment revenue sources. Although Chapter 1170 adjusts these amounts for future revenue *increases*, it did not adjust required health expenditures in the event of a revenue *shortfall*. Thus, the maintenance-of-effort level required by Chapter 1170 effectively requires counties to make up the full amount of the current-year shortfall in the health account (projected at \$70 million) from their general purpose revenues if they wish to continue receiving Proposition 99 funds. The major Proposition 99 funds at stake are \$215 million in 1991-92 for the larger counties for the California Healthcare for Indigents Program.

For the remaining \$60 million current-year shortfall in the Local Revenue Fund, counties must either (1) “backfill” from their general purpose revenues to maintain services or (2) implement service reductions in health, community mental health, and IHSS programs. During our county visits, almost all the counties mentioned that they plan to transfer funds from the health account to the social services account for caseload costs, if necessary. It was unclear, however, how many of the counties would actually choose to make such transfers given the Proposition 99 implications discussed above. Thus, it is too soon to tell what changes in indigent and public health services might occur as a result.

In the long run, however, a number of the smaller counties we visited indicated that they might choose to forego Proposition 99 funds in order to gain additional flexibility to transfer their health account funds to social services programs.

#### **IMPLEMENTATION: LEGISLATIVE OVERSIGHT ISSUES FOR 1991-92 AND 1992-93**

The realignment legislation established a number of implementation steps, reporting requirements, and evaluations of programmatic impacts that will occur in 1991-92 and in subsequent years. The more significant implementation steps and reporting requirements are summarized in Figure 4, and the evaluation requirements are shown in Figure 5.

In this section, we review issues related to these implementation steps that are of particular importance from a legislative

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**Figure 4**

**What Happens Next?  
Implementation Steps and Reporting  
Requirements Through 1992-93**

Date	Responsible Organization	Implementation Step or Reporting Requirement
(January 10, 1992)	Department of Mental Health	Report on realignment legislation's impact on departmental responsibilities and duties
(January 15, 1992)	Department of the Youth Authority Task Force	Present recommendations for improving coordination of, and achieving savings in, services for youthful offenders
(January 31, 1992)	Health and Welfare Agency IHSS Task Force	Recommend alternatives to targeted IHSS Program reductions ("A through E cuts") in case of funding deficiency
April 1, 1992	Health and Welfare Agency Data Task Force	Recommend county data reporting requirements for all programs subject to realignment
July 1, 1992	Department of Health Services	Implement revised state/county funding match system for California Children's Services Program county administration
July 1, 1992	Department of Mental Health	Develop plan for statewide data system to include performance outcome measures for mental health services
July 1, 1992 and annually thereafter	County Departments of Mental Health	Assume responsibility for management and reimbursement of Institutions for Mental Diseases, and implement negotiated contracts for state hospital services
April 1, 1993	Department of Health Services and Local Health Officers	Present review of all public health statutes and recommend appropriate changes

<b>Figure 5</b>		
<b>What Happens Next? Realignment Evaluation Requirements</b>		
<b>Date</b>	<b>Responsible Organization</b>	<b>Requirement</b>
<b>Health</b>		
February 1992	Legislative Analyst	Report on realignment legislation's impact on California Children's Services Program
May 15, 1992; April 1, 1993; and April 1994	Legislative Analyst	Present report summarizing county health service plans and site visits
April 15, 1992 and annually thereafter	Department of Health Services	Report on county health services, including fiscal and programmatic impact of realignment
<b>Mental Health</b>		
March 15, 1992	Organization of Mental Health Advisory Boards	Report on realignment's impact on local mental health programs and recommend future role and structure of advisory boards
January 15, 1993	California Council on Mental Health	Report on impact of realignment on local mental health services, and review budgets of various departments providing mental health and related services
<b>All Programs</b>		
April 1, 1992	Health and Welfare Agency Data Task Force	Recommend plan for evaluation of realignment legislation and identify necessary county data reporting requirements
June 30, 1992	Legislative Analyst Auditor General	Present plan for evaluation of various issues, including the programmatic impact of realignment

oversight perspective. Specifically, we discuss (1) future data reporting requirements, (2) alternatives to the proposed IHSS "A through E" cuts, (3) county authority over state hospitals and IMDs, and (4) the status of the legislation's "poison pill" provisions.

### **County Data Reporting Requirements**

Prior to the 1991-92 realignment, counties were subject to a number of data reporting requirements to assist the state in its oversight of county mental health, indigent health, and public health programs. The realignment legislation generally continued these requirements for 1991-92, and directed the Health and Welfare Agency to convene a task force of administration, county, advocacy group, and legislative staff representatives to identify reporting requirements that should be retained or modified, and those which should be repealed.

In addition, the Legislature expressed its intent that (1) the state implement a data system for mental health programs that will measure performance outcomes and (2) any new requirements, such as those which would focus on performance outcomes, should not result in increased county costs as compared to current law. Thus, modifications to, or repeal of, existing requirements will be necessary if both goals are to be realized. The task force is due to report its findings to the Legislature in April, and the Department of Mental Health (DMH) is to present a plan for incorporating performance outcome measures into its data system in July. (Because the legislation generally made only cost-sharing ratio changes for social services programs, related data reporting requirements were not addressed in the legislation.)

***State/County Responsibilities.*** In our view, decisions regarding the types of data counties will be required to collect and provide to the state reflect the inherent tensions of programs administered through a state/county partnership, such as the desire for both state oversight and local flexibility. We believe the Legislature's actions regarding data requirements are important because they (1) affect both the focus and the scope of the state's oversight capacity and (2) will structure policy debates for years to come. The Legislature may elect to make changes in any of the programs encompassed in the legislation. Below, we discuss the two program areas — health and mental health — that are the specific charge of the Health and Welfare Agency task force.

***Mental Health.*** Many of the existing data requirements for mental health programs are linked to federal conditions for

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participation in the Short-Doyle/Medi-Cal Program. Accordingly, if the Legislature continues to believe that both a performance-driven data collection system and the principle of no additional reporting costs are important, it will have few options and may find that the two goals are mutually exclusive.

However, it is also important to note that federal requirements for data reporting are fairly broad. Thus, from our perspective, one option for the state to implement a performance-driven data system without imposing additional costs on counties is to identify opportunities to revise existing data collection and reporting procedures that are linked to federal requirements so that federal objectives can be met more simply and less expensively. To do so will, in many cases, require federal approval through the state plan review process. (Note, however, that it is difficult to determine the degree of flexibility the state actually has in revising federally related reporting requirements without actually seeking approval to implement changes.)

To assist the Legislature in determining whether the task force recommendations take full advantage of whatever flexibility the state may have to modify procedures for federally linked data requirements, we have suggested in task force meetings that the task force include in its findings a review of reporting requirements in other states. We believe this review should focus on areas where (1) other states have developed satisfactory data procedures from a federal perspective and (2) modifications to California's procedures along similar lines would result in reduced state and county costs for data collection and reporting. Even significant changes in existing requirements, however, may not be sufficient to offset the cost of establishing a performance-driven system. Accordingly, it is possible that the Legislature will face a choice between its two objectives.

***Indigent and Public Health.*** Generally, the Legislature has greater freedom to restructure indigent and public health data requirements, with the exception of certain federally mandated disease monitoring. Our review indicates that some data — particularly in the indigent health area — could be collected and monitored in a more efficient manner. We also believe, however, that it will be important for the Legislature to maintain the state's ability to monitor trends in county expenditure and service delivery decisions for public and indigent health. In particular, we believe the state needs to continue its ability to ensure an adequate degree of public health activities and services which may have significant long-term fiscal and health consequences if they are not maintained. As an example, if counties fail to ensure adequate immunizations, measles or other epidemics could occur.

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### The IHSS "A through E" Program Reductions

The realignment legislation authorized a departure from the IHSS Program's entitlement status and specified the manner in which potential service level reductions can be made.

**Background.** The IHSS Program provides assistance to eligible aged, blind, and disabled persons who are unable to remain safely in their homes without assistance. While this implies that the program prevents institutionalization (such as in nursing facilities), eligibility for the program is not based on the individual's risk of institutionalization. Instead, an individual is eligible for IHSS if he or she lives in his or her own home — or is capable of safely doing so — if IHSS is provided, and meets specific criteria related to eligibility for the Supplemental Security Income/State Supplementary Program (SSI/SSP) for the aged, blind, and disabled.

The types of services available through the IHSS Program are domestic and related services, such as meal preparation and cleanup; nonmedical personal services, such as bathing and dressing; essential transportation; protective supervision, such as observing the recipient's behavior to safeguard against injury; and paramedical services, which are performed under the direction of a licensed health care professional and are necessary to maintain the recipient's health.

The Governor's Budget proposes \$744 million (\$150 million General Fund, \$338 million federal funds, and \$256 million county funds) for the IHSS Program in 1992-93. According to the Department of Social Services (DSS), the proposed expenditures for the IHSS Program are \$82 million (\$47 million General Fund and \$36 million county funds) *less than* the amount needed to fully fund the projected increases in caseload and the average number of service hours per case.

The realignment legislation limits the state's share of IHSS costs to the annual Budget Act appropriations in 1992-93 and 1993-94. The measure also permits counties to reduce services (on the basis of an assessment of each recipient) to stay within their annual IHSS budget allocations in these years. The act further provides that any such reductions must be made according to the following priorities (known as the "A through E" program reductions):

- A. Reduce the frequency of nonessential (that is, domestic and related) services.
  - B. Eliminate these services.
  - C. Terminate or deny eligibility to individuals requiring only domestic services.
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- D. Terminate or deny eligibility to persons who would not require institutionalization in the absence of services.
- E. Reduce, on a per capita basis, the cost of services authorized.

If the Legislature approves the budget-year funding reflected in the Governor's Budget, counties will be required to either (1) make significant service reductions in the program according to the "A through E" criteria or (2) transfer funds from their realignment revenues (health or mental health subaccounts) or from their general purpose funds to maintain the IHSS Program.

The realignment legislation also established a task force to recommend IHSS program efficiencies and improvements. The task force explored alternatives to the "A through E" criteria for implementing service reductions, and recently submitted a required report to the Legislature.

In the report, the task force concludes that the "A through E" program reductions are not a practical option because (1) to implement service level reductions would require a case-by-case review of current IHSS recipients and (2) such a review would be administratively difficult and expensive. As an alternative, the task force recommends replacing the "A through E" program reductions with unallocated (across-the-board) reductions.

**Comments.** We believe that the Legislature should reevaluate the task force's conclusion to determine whether specific groups or services should in fact be targeted in order to reduce program costs. For instance, targeted reductions would be preferable to unallocated across-the-board reductions to the extent that they resulted in fewer institutionalizations of program recipients.

This is because long-term care services (typically Medi-Cal nursing facility services) can be significantly more expensive than those provided through the IHSS Program. Counties, however, do not currently have a fiscal stake in the funding of long-term care services, as these costs are covered entirely by state and federal funds. A strategy that targets IHSS reductions to avoid, wherever possible, the placement of recipients in nursing facilities could improve the quality of life for those patients and prevent cost shifts from the IHSS Program to the Medi-Cal long-term care program. We note, in this respect, that the "A through E" priorities, although they may be administratively burdensome, are structured to avoid institutionalization.

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In order to assist the Legislature in considering the proposed service level reductions, we identify several options to control program costs in our companion document to this publication, the *Analysis of the 1992-93 Budget Bill* (Item 5180).

### State Hospitals and IMDs

As noted above, realignment provides county departments of mental health with significant additional flexibility regarding their use of state hospitals and IMDs beginning in 1992-93. Under the legislation, counties are specifically authorized to determine both the number of state hospital bed-days they wish to purchase, and the types of units (acute, subacute, etc.) in which their patients are to be placed.<sup>c</sup> Counties are required to reimburse the state for these services according to rates set by the department. Under the legislation, the department and the counties may negotiate other issues related to state hospital services, including procedures for admissions and discharges, pooled beds for a group of counties, potentially collaborative agreements for a unique type of treatment program (such as one featuring an expanded emphasis on vocational rehabilitation), or the number of treatment hours to be provided to patients.

**Comment.** We believe these features of the realignment legislation have the potential to improve services for patients and provide counties with the opportunity to determine an effective and efficient allocation of treatment resources for their patients. To ensure that the Legislature's intent in enacting these provisions is realized, we also believe it will be important for the Legislature to review the department's performance in negotiating the contracts to ensure responsiveness to the needs of counties, particularly regarding the types of treatment services the counties believe their patients require.

### Related Issues

In addition to the implementation steps and reporting requirements discussed above, there are additional issues that, in general, are the subject of proposals in the Governor's Budget and that have implications for realignment. Please see the *Analysis of the 1992-93 Budget Bill* for a discussion of the following issues:

- Public and indigent health budget for the Department of Health Services (DHS) and the CCS Program (Item 4260).
- Support budget for the DMH (Item 4440).

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<sup>c</sup> The legislation specifies that if county bed-day requests would, on net, reduce the total of number of beds (a) in any given state hospital or (b) statewide by more than 10 percent, the requests are subject to the approval of the department. Counties with a population of less than 125,000 are exempt from this provision.

- Implementation of Child Welfare Services case management data system (Item 5180).
- Department of the Youth Authority report on integrating services to youthful offenders (Item 5460).

### Status of "Poison Pills"

As we discussed earlier, the realignment legislation contains several "poison pills," including a provision that would render the VLF increase inoperative if an appellate court decision determines that the state must reimburse counties for the cost of providing services to medically indigent adults (MIAs). Currently, there are three lawsuits before the courts that are related to this provision.

First, there are two cases, *County of Los Angeles and County of San Bernardino v. State of California et al.* and *County of San Diego v. State of California et al.*, which seek a mandate claim against the state for the cost of providing care to MIAs pursuant to the 1982 statutes, which transferred the responsibility of providing MIA care from the state to the counties. As of February 1992, the San Diego case was being heard in superior court, which has made an interim ruling indicating that it may ultimately find in favor of the county. The Los Angeles/San Bernardino case is under appeal by the state after a superior court found in favor of the counties. A final appellate court ruling in favor of the counties in either case would trigger the poison pill provision of the realignment legislation.

In addition to these two cases, San Bernardino County recently filed a separate action in an appellate court against the state (*County of San Bernardino v. State of California et al.*) claiming that the realignment legislation's mandate-related poison pill provisions are themselves unconstitutional. San Bernardino notes that under the State Constitution, the counties are entitled to claim reimbursement for the cost of implementing a state mandate. In its brief, the county argues that these poison pill provisions serve as "punitive financial disincentives" that would force the abandonment of the Los Angeles/San Bernardino mandate claim. A decision in favor of the county in this case would not trigger the poison pill provisions of the realignment legislation. Rather, it would invalidate them. (At the time of this analysis, an appellate court had rejected the claim not on its merits but because it must first go to a superior court. Apparently, the claim will be filed shortly in a superior court.)

Of the three cases, the Los Angeles/San Bernardino case alleging a mandate for indigent health services appears closest to resolution, and could conceivably be scheduled for oral arguments

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before the California Court of Appeals this spring, though requests by either party for postponement could easily delay a resolution of the case beyond the current legislative session. If the case is decided in favor of the counties, the Legislature would be faced with decisions regarding (1) the expiration of the realignment statutes and (2) how to fund a likely General Fund obligation for MIA-related mandate costs in the range of \$3 billion.

### **ADDITIONAL POLICY ISSUES FOR THE LEGISLATURE**

The 1991-92 realignment represents a fundamental change in the state/county partnership. The impact of this legislation presents a number of issues that warrant further consideration by the Legislature. In this section, we discuss issues related to (1) the Local Revenue Fund condition, (2) the issue of varied funding allocations among counties, and (3) the future role of the state in overseeing programs encompassed in the legislation.

#### **Issues Related to the Local Revenue Fund Condition**

As a result of the precarious condition of the Local Revenue Fund for 1991-92 and potentially in 1992-93, the Legislature should address three issues: (1) the need for a Local Revenue Fund reserve, (2) the definition of each county's "base" allocation, and (3) county match requirements. We discuss these issues below.

***Need for a Reserve.*** The funding shortfall in the current and budget years is causing numerous problems for counties, raising the issue of whether counties need a reserve for "economic uncertainties" similar to the state's reserve. While counties already have general purpose revenue reserves, realignment transferred a substantial amount of increased expenditure requirements to counties. In addition, the need for services provided through the "realigned" programs generally increases during periods when economic conditions are poor and, therefore, when available revenues are most constrained.

Accordingly, we believe that action by the Legislature to provide counties a reserve for economic uncertainties within the Local Revenue Fund would mitigate the need for both (1) significant reductions in service levels in the realigned programs and (2) demands on county general purpose revenues in future years when realignment revenues may again fall short. Accordingly, we believe a reserve would improve the prospects for the long-term viability of realignment.

One approach to establishing a reserve would be to earmark a share of realignment revenue growth over a period of several years,

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to build a reserve of some level, potentially in the range of \$100 million (or 5 percent of revenues). Were a reserve of this level available during 1991-92, the need for counties to make significant service reductions in the realigned programs and to backfill from their general purpose revenues would be greatly reduced. Under any approach, the Legislature could specify that access to the reserve would be dependent on a specific level of weakness in the performance of realignment revenues.

**Definition of County "Base" Allocations.** The legislation establishes each county's share of the amount of revenues collected in the current year as the county's "base" allocation. All revenue in excess of this amount will be allocated in 1992-93 according to the legislation's growth allocation provisions. Given the current-year shortfall, however, some counties have expressed concern that the existing base definition is defined according to actual collections during the current year, rather than the amounts that were *anticipated* (which more closely relate to each county's anticipated additional costs under the legislation). They note that as a result of this definition and the legislation's growth allocation provisions, a significant share of the 1992-93 revenue increase will be allocated only to certain counties (those whose share of resources is less than their relative need) before all counties have received at least the amounts necessary to cover their current-year costs.

As with the "equity" issue we discuss shortly, this issue presents the Legislature with a choice between (1) providing funding stability for all counties or (2) equalizing individual county shares of total resources relative to each county's need.

**County Match Requirements for Health Programs.** As a condition for receiving funding under realignment, counties must provide a match according to a schedule specified in the legislation. This requirement continues the approach of prior law, which required counties to provide some amount of locally generated revenues to support health and mental health programs. This amount was defined according to a percentage of state funding provided. For example, counties generally were required to spend on local mental health programs an amount equal to 10 percent of the state funding they received.

In the realignment legislation, the match amounts for health programs were specified in *dollar* terms, based on June 1991 Department of Finance estimates of anticipated sales tax and VLF revenue collections. More recent estimates indicate that total revenues for both the sales tax and VLF for 1991-92 are expected to fall substantially below those projections. Because the legislation specifies the matching requirements as a fixed dollar amount,

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rather than as a percentage of actual revenue collections, counties are required to spend in the current year an amount that is significantly higher than their share would have been under prior law.

Because the current-year shortfall was not anticipated, the dollar amounts that define health program matching requirements under the legislation may not reflect the Legislature's intent. If the Legislature wishes to continue the approach of prior law (which determined county expenditure obligations for *both* health and mental health programs based on the amount of funding provided by the state), it would need to amend the realignment legislation to specify matching requirements for health programs in percentage terms. The Legislature may also need to establish a "floor" for the matching requirements to ensure compliance with Proposition 99.

#### Issues Related to "Equity"

Prior to the enactment of realignment, "equity" in funding health and mental health allocations was generally defined as the point at which each county's share of funds equaled the share they would have received according to their population and the degree of poverty in their county. Progress toward equity prior to realignment was limited by constraints on available funding for the programs. Accordingly, the realignment legislation continues this approach by (1) allocating a portion of growth in Local Revenue Fund revenues above the amount collected in 1991-92 to those counties whose 1991-92 share of funding is "under-equity" and (2) ensuring that no county's allocation will be reduced below the amount of revenues collected in 1991-92.

Based on the administration's revenue projections for 1992-93, it appears that approximately \$54 million, or about 35 percent, of the anticipated growth in revenues will be used for equity purposes for both mental health and the AB 8 programs. Due to the extremely wide variation in actual funding allocations as compared to the amount counties would receive according to the equity definition, this amount will not result in significant change. Over the longer term, the realignment legislation's current formulas are unlikely to result in equity within the next several decades.

To illustrate this point, achieving equity for mental health programs alone would require roughly \$800 million (or at least 50 times the amount of funding that is earmarked for distribution according to the equity formula) to raise all counties to the funding level of the county with the highest allocation according to the equity definition. Equity could be achieved more quickly if the "benchmark" were less than the amount allocated to the highest

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county. This approach, however, would require a reallocation of base allocations among the counties, which is not provided for in the realignment legislation.

The equity issue presents the Legislature with a trade-off. The Legislature's choice is to (1) make more rapid progress toward equity by reallocating base funding levels in mental health and health programs or (2) provide stability in funding for individual counties, with equity adjustments occurring slowly over a period of many, many years.

### **Future Role of the State**

Although the realignment legislation "transferred" authority for implementing indigent health, public health, and mental health programs to counties, it continued a significant oversight and administrative role for the DHS and DMH. (Because the legislation's effect on social services programs generally was confined to changes in county cost-sharing ratios, the legislation did not significantly affect the role of the Department of Social Services.)

The Legislature will consider three reports this spring that will have major implications for the future role of the DMH and DHS. These reports are:

- The plan completed in October 1991 by the AB 904 Task Force regarding the governance and structure of California's mental health system.
- The Health and Welfare Data Task Force report (due this April).
- A report by the DMH regarding the impact of realignment on its responsibilities and workload (currently in draft form).

As the Legislature considers various requests for changes, including those which will be proposed in these reports, we believe the principles we presented in response to the administration's original realignment proposal in January 1991 continue to provide a useful framework for the Legislature's deliberations regarding the future role of the counties and the state and, more specifically, of these two departments. Among these earlier principles are the following:

- ***Make it Clear.*** The Legislature should ensure that its emphasis on clear system goals and specific target populations is maintained.
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- **Ensure Accountability.** The realignment legislation places greater responsibility for resource allocation decisions with the counties in both the health and mental health areas, but continues certain state responsibilities. The state can play an important role in ensuring program effectiveness by holding counties accountable for results. For instance, strengthening the role of the DMH and DHS by giving them the authority to contract with regional service providers or other organizations when counties do not achieve performance outcomes would help ensure accountability for results while preserving opportunities for local innovation and flexibility.
  - **Allow Flexibility.** The realignment legislation removed many barriers to innovation and efficiency, particularly in the mental health and social services areas. For example, the legislation allows counties to “buy” more community mental health services and fewer state hospital services if they wish. We believe the Legislature should ensure that future proposals do not dilute this approach of focusing on outcomes rather than on prescriptions for specific methods of service delivery.
  - **Expect People to Work Together.** The realignment legislation does not generally require formal interagency collaboration between state departments or within counties. However, due to the fiscal interactions between the three program accounts and the state’s continued role in expanding the AB 377 and AB 3777 pilot projects in mental health (which require formal interagency agreements), we believe the legislation made significant progress at the county level in this area. We believe that the Legislature should continue to identify opportunities where interagency collaborations at the state and county level might be strengthened, consistent with the state’s fiscal stake in improved programmatic outcomes.
  - **Get Results.** Again, the focus on outcome measures, their eventual integration into the existing data system, and the implementation of performance-based contracts are, from our perspective, among the more significant reforms that were included in the 1991-92 realignment. We believe the Legislature should, in its oversight capacity, ensure that implementation of these management approaches continue.
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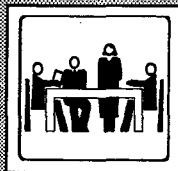
The realignment legislation continues some measure of shared responsibility for the effectiveness of all programs encompassed within it. As the Legislature reviews the administration's implementation of the legislation and makes decisions regarding those issues which will come before it this spring and in later years, it will continue to face the inherent tensions of implementing programs through a state/county partnership. From our perspective, the bottom line is that the state must strike a balance between maintaining enough state-level accountability and oversight to ensure that its key programmatic objectives are achieved, without stifling innovation at the local level.

### EXPANDING THE CONCEPT

We believe that some of the policy changes reflected in the 1991-92 realignment collectively provide a blueprint for restructuring state health programs, social services programs, and potentially those in other areas. We believe the Legislature should consider extending some of the concepts that underlie this legislation to other program areas, with an eye toward opportunities to more effectively and efficiently deliver services. The key features of the legislation that could be applied in other programs are shown in Figure 6.

Figure 6

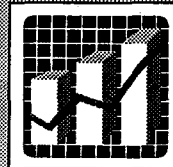
### Realignment Features That Provide a Blueprint for Health and Welfare Reform



The establishment of clearly defined target populations.

The use of mechanisms to facilitate coordinated service delivery.

The creation of fiscal incentives that (1) match program objectives and (2) assist the state in achieving cost containment for the most expensive services.



The development of management and oversight that is driven by performance outcomes, rather than through regulatory detail.

We believe the Legislature could productively apply these principles to achieve meaningful long-term policy reform and potentially significant expenditure reductions for services that are currently provided to many groups, including the following:

- Families who require a number of health, education, and welfare services in order to reduce their dependence on long-term state assistance ("multi-problem families").
- Correctional institution parolees.
- Probationary youths.
- Substance abusers.
- Pregnant teens and teenage parents.
- Persons at risk of placement in long-term care facilities.
- High school drop-outs.

Given the need for further responses to the state's structural budget gap, we recommend that the Legislature draw on the elements of the 1991-92 legislation identified in Figure 6 to reform services that are provided to these and other appropriate groups.

## **CONCLUSION**

In this review, we have described the major features of the 1991-92 realignment, presented some of the more significant fiscal and policy implications of the legislation, highlighted major issues that the Legislature will face in this legislative session and in later years, and suggested those features of the 1991-92 realignment which could be productively applied to other program areas. We summarize our principal findings and recommendations in Figure 7.

In our view, the realignment legislation demonstrates the potential for achieving fiscal solutions that enhance the Legislature's policy objectives. It does so by combining program restructuring with budget balancing measures. While the major fiscal impact of the legislation in the near term was to provide new revenues dedicated for health, mental health, and social services programs, the legislation may, in the long run, succeed in bringing down the *rate* of expenditure growth in a major policy area of the state's budget. Thus, some elements of the legislation may provide a road map for the Legislature as it attempts to navigate the fiscal challenges of 1992-93.

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**Figure 7**

**The 1991-92 Realignment:  
Summary of Findings and Recommendations**

**Legislation Reflects a "System-Building" Approach**

- Recognizes programmatic links between 16 health and welfare programs.
- Provides programmatic and funding flexibility.
- Establishes incentives for innovation.

**Calls for Performance-Based Oversight**

- Places resource allocation decisions at local level for mental health and health programs.
- Scales back some regulatory functions of Departments of Health Services and Mental Health.
- Seeks development of performance outcome measures and performance-based contracts for mental health and indigent health programs.

**Legislation is Still Evolving**

- Legislative oversight of implementation steps is vital to legislation's ultimate success.
- State and federal maintenance-of-effort requirements will determine real funding flexibility.
- Some significant decisions have yet to occur, such as which data reporting requirements will be continued.

**Key Actions for the Legislature**

- Providing greater financial stability, such as through a reserve, would strengthen the long-term viability of realignment.
- Expanding requirements for formal interagency collaboration at the state and local levels could enhance effectiveness.

**Some Elements of the Legislation Provide a Blueprint for 1992-93**

- Uses program restructuring to achieve fiscal benefits, including a greater fiscal stake at the service delivery level.
- Includes major *policy changes* (especially in mental health area) that improve local flexibility and may result in more efficient service delivery.

This analysis was prepared by Bill Wehrle, under the direction of Donna Watkins Olsson, and with assistance from Anna Carr, Charles Lieberman, Sheila Manalo, and Peter Schaafsma. Secretarial support was provided by Kelly Zavas. For information concerning this analysis, please contact the author at (916) 445-6061.