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STATE OF CALIFORNIA

EDMUND G. BROWN JR., *Governor*

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

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Sacramento 95814

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L. H. HALCOMB
Executive Director

ADMINISTRATION OF THE MEDI-CAL PROGRAM

SECOND SUPPLEMENTARY REPORT

STATE OF

CALIFORNIA

February 1979

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February 1979

Honorable Edmund G. Brown Jr.
Governor, State of California

Honorable James R. Mills
President pro Tempore, and to Members of the Senate

Honorable Leo T. McCarthy
Speaker, and to Members of the Assembly

For the past three years, this Commission has been advocating major revisions in the Medi-Cal program which can save hundreds of millions of dollars each year.

Testimony provided at our latest hearing January 18 gives us reason for cautious optimism, as the attached supplemental report indicates. The new Director of Health Services expressed concurrence with most of the Commission's past findings and recommendations, and stated her intention to implement most of them. Although this is indeed refreshing news, the magnitude of the task is overwhelming.

The current estimate for Medi-Cal expenditures during fiscal 1978-79 is $4 billion. In the last four years, the cost of this program has more than doubled. Without containment of costs, Medi-Cal will consume 25% of the entire state budget by 1984, thereby threatening other essential state programs.

Lax administration of the Medi-Cal program has permitted pervasive scandal, fraud and abuse. Time and again, audits and investigations reveal misuse of millions of dollars of public funds by unscrupulous providers.

Review of fee providers presently amounts to only two percent of the total of those participating, yet this generates more referrals of abusers than can be handled by the department's investigation and surveillance units.

The department has been unable to develop much needed statistical studies of patterns of provision of services so that it can measure the justification for services being performed, and institute more effective program controls.

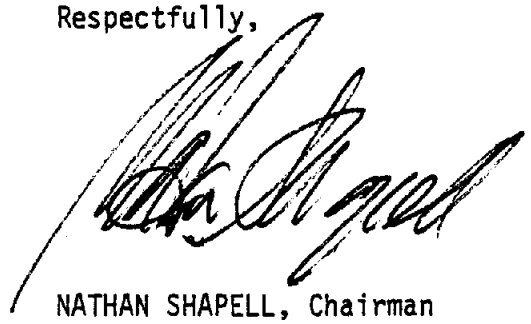
Prepaid health plans have been sharply reduced in number, after recurrent scandals forced revisions in regulation to assure fiscal integrity and quality of care.

County hospitals, the last resort for the poor who are unable to qualify for Medi-Cal, are facing severe fiscal constraints which seriously impair their ability to meet their legal responsibilities. While their continued existence is threatened, many private hospitals exploit Medi-Cal and government continues to subsidize an excess acute bed capacity of 25,000 beds at a cost estimated to be $1 billion dollars a year.

The gravity of this situation can no longer be ignored by the Administration or the Legislature.

The Commission urges that the Director of Health Services be given the full support of the Governor to bring Medi-Cal expenditures into line. She will also need strong Legislative action much of which will bring stiff opposition from segments of the health industry. We urge both the Governor and the Legislature to support the Director vigorously in these long overdue reforms so that control of this huge program can be attained quickly.

Respectfully,



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February 1979

ADMINISTRATION OF THE MEDI-CAL PROGRAM
SECOND SUPPLEMENTARY REPORT

BACKGROUND

This is the Commission's third Medi-Cal report in as many years. The first major analysis of this complex and critical program was contained in the Commission's comprehensive January 1976 report entitled 'A Study of the Administration of State Health Programs.' A follow-up supplemental report was released in September 1977, evaluating the limited progress which had been made concerning the first report's recommendations. This third report is based on supplemental staff work and testimony presented at a hearing January 18, 1979 to assess the progress being made by the Department of Health Services in implementing the Commission's recommendations. For the record, we reiterate the major Medi-Cal revisions which the Commission has repeatedly urged in the past:

1) Simplification of standards, methods of determining and recording of eligibility, and revision of the central identification to make daily updates through an on-line system.

2) Studies of the eligible population with a goal of reducing numbers of categories and awarding longer periods of eligibility at lower administrative costs. The validity of these studies, however, depends on a more accurate eligibility file.

3) Direct departmental control of standards and criteria for Medi-Cal policy and procedures for reviewing performance in the claims processing system. Stronger on-site monitoring of fiscal intermediary operations. The criteria for review by Professional Standard Review Organizations should be set by the department, not by program providers.

4) Initiation of a system to select providers through contracts which require adherence to professional standards, developed by the department with clinical consultation, as a condition of continued participation in Medi-Cal. Permanent exclusion of providers unwilling or unable to conform to such contracts.

5) Preservation, in the competitive bid for a new fiscal intermediary contract, of the department's option to assume the claims review and payment function within five years.

6) Computerized review of patterns of providing services to trigger more targeted audits, referrals of suspect providers to investigations for fraud, and enforcement against program abuse.

7) Encouragement of testing new methods of reimbursement on a prospectively budgeted basis to organizations capable of providing a full range of comprehensive and continuous service in a more organized fashion. Factors stressed are prevention, integrated and accessible primary ambulatory services, controlled referral to specialized care, and planned reduction in unnecessary admissions to hospitals and long-term care facilities by development of alternatives to institutional care.

8) Adoption of a case management system for Medi-Cal recipients whose condition requires prolonged and expensive long-term care or rehabilitation.

9) Systematic study of providing maximum benefits permitted by the U.S. Department of Health, Education and Welfare to the Medi-Cal population in order to reduce state costs by taking full advantage of federal financial participation.

10) Expansion of capitation contracts with organizations which have the potential to provide better organized, more efficient and hence less costly services. A high priority should be assigned to stronger and more equitable support of county institutions, reputable prepaid health plans, and university operated or affiliated county hospitals.

11) Development of an organized capacity, within the Medi-Cal Division for program planning evaluation and policy development. This unit should integrate systems of information, inventory and refine reports to eliminate those of questionable validity or use, and conduct studies of importance to the continuous refinement of management policy.

CURRENT STATUS OF MEDI-CAL REFORMS

In July 1978, Beverlee Myers became the director of the new Department of Health Services, created by SB 363 (Gregorio), in which the Medi-Cal program is presently lodged.

She is the third Medi-Cal administrator in as many years. She has extensive prior experience as Medicaid Director for the State of New York and familiarity with reports of the Commission. At the Commission's January 18 hearing she was able to provide detailed and informed responses to the Commission's major concerns.

In her testimony, the Director provided the current status on most of these initiatives. She reported that the state is in the process of developing a revised eligibility system capable of providing on-line current eligibility status to local welfare departments, various providers and the fiscal intermediary. The system will be tested in several counties in the fall of 1979 and will be installed statewide by 1981. It will improve accuracy and permit studies to determine characteristics of the eligible population, its fluctuations, and pave the way for simplified administration, such as elimination of the sticker system. The file can also be coordinated with the paid claims file of the fiscal intermediary in order to develop profiles of both providers and beneficiaries' use of services.

The department has placed the highest priority on phasing in the new fiscal intermediary, Computer Sciences Corporation. Medical manuals are being developed for departmental approval to set audits, edits, standards and criteria for reviewing the professional performance of various providers. An advanced surveillance and utilization component is being designed which will afford the department flexibility in performing analyses of patterns of provision of service and detection of fraud and abuse.

Many recommendations of the Commission have been followed in the administrative organization of the new department:

- A Medi-Cal Standards Division is responsible for program planning, policy development and evaluation on matters related to eligibility, benefits, rates, utilization and organization of services.

- A Medi-Cal Operations Division is responsible for implementing policies approved by the Director and for monitoring activities of the fiscal intermediary. This division is no longer responsible for development of program policies.

- A Division of Audits and Investigations consolidates such control activities as institutional audits, surveillance and utilization review, and investigations. It operates as an autonomous unit responsible for applying its functions to all department programs. This Division reports directly to the Director.

- An Alternative Health Systems Division is responsible for developing, maintaining and evaluating alternatives to the traditional fee for service system in the form of prepaid health plans or pilot projects.

The Director indicates her intention to emphasize primary care oriented more to prevention, and expansion of prepayment plans and health maintenance concepts so that Medi-Cal will influence how services are delivered, their cost and their accessibility. Providers will be selected, placed on contract, and required to meet standards of professional performance.

Priority will be given to health services outside institutions, such as multiple service centers, day care programs, in-home services and hospices.

Public health institutions will be given higher priority to strengthen their ability to offer comprehensive services in an orderly fashion. Capitation and prospective budgeting will be promoted in place of fee for service.

In its relationship to the new fiscal intermediary, the department's contract assures allocation of financial risk by using firm, fixed prices for claims processing, liability for costs of payment errors, penalties for tardiness in meeting performance criteria, and incentives to reward innovations which result in greater efficiency. The state will have ownership rights of the system and the option to take over its operations at the end of the contract period.

The history of the procurement project for the new fiscal intermediary was reviewed and a detailed presentation was made by Computer Sciences Corporation of system characteristics and capabilities. (Excerpts of their presentation are attached.)

The Director summarized current program problems. Resources in California are not unlimited, but the implications of this reality are not fully accepted by either the providers or beneficiaries. To do an adequate job of management, the department needs adequate staff resources. Holding to a 10 percent vacancy factor leaves the department now with 500 vacancies. In many instances, less staff now means the loss of dollars. Some examples are auditors, investigators, liability recoverers and utilization controllers--all types of staff capable of recovering dollars far in excess of their salaries.

Kenneth Cory, the State Controller, pointed to the foolish economy of such staff constraints and submitted a letter (attached) calling for increases in department staffing for certain control functions. He noted that the new fiscal intermediary operation shows great promise in improving program controls and management. He pledged his continuing cooperation with the department and stated that his independent authority to audit would be used in auditing providers as well as departmental operations. He predicted that this authority would have a cleansing effect throughout the whole system. When the possibility of independent audits exists, administrators and providers will exert care that they are always prepared to defend what they are doing.

Nicholas Krikes, M.D., President of the California Medical Association informed the Commission that his organization will be reviewing its existing policy position on Medi-Cal in light of limited funds in the future. The results of this policy review will be forwarded to the Commission after the mid-March annual House of Delegates meeting of the California Medical Association.

Dr. Krikes listed factors which, in his opinion, have caused changes in health care costs in general. For Medi-Cal, he listed the following factors:

1) Increased eligibility.
2) Broader benefit structure.
3) Administrative complexity.
4) Fraud and abuse by providers and beneficiaries.
5) Inappropriate location for receipt of service.
6) No restraints on frivolous utilization.
7) Lack of attention to prevention.
8) Poverty and ill health.

He pointed out that, although physicians can control some utilization patterns, many cost factors are out of their control. He noted 18% of Medi-Cal expenditures go to physicians, whose reimbursement rate has risen only 20% in 13 years.

Alternatives to be considered in California Medical Association policy review are:

1) Reduce number of beneficiaries:
   --Eliminate some entirely.
   --Introduce copayments for others.
   --Care for undocumented aliens only in emergencies.

2) Reduce scope of benefits.
3) Stress prevention and health education.
4) Introduce incentives to use of physician's offices rather than emergency rooms.
5) Prosecute fraud by both providers and beneficiaries.
6) Put certain beneficiaries on prior authorization.
7) Consider total prepayment.
8) Consider state catastrophic plan to avoid medical indigency.

To control costs, California Medical Association is urging its members to monitor utilization, participate in Professional Standard Review Organizations, limit fee increases, develop independent physicians associations and provide educational materials on prevention.

In regard to fraud and abuse, Dr. Krikes feels there is a need not to create new programs of detection, but better ways to deal with those already identified.

He pointed to the increasing efficiency of Professional Standard Review Organizations and to the present operations of both the Surveillance and Utilization Review System of the Department and the Board of Medical Quality Assurance in their control of bad providers. He criticized proliferation of parallel efforts by other state agencies.

Paul Ward, representing the California Hospital Association, opposed the policy initiatives of the new director of health services. He expressed fear that they will take the state back to the two-tiered system of care in which the poor are treated only in county hospitals, and others only in private hospitals.

He alleged that, prior to 1965 passage of Medi-Cal, county hospitals took care of only emergency illnesses, were seriously overcrowded, were under-financed and were unable to offer quality care. Reduction in the Medi-Cal budget, he asserted, will reduce access now being provided in the private sector.

He pointed to the relatively short length of stay in California hospitals compared to other states. He claimed that the problem of excess beds is mythology and suggested that if the cost of care is to be reduced, entire institutions should be closed, creating waiting lines for care. He defended the rising cost of hospital care by claiming it is more related to expanded provision of care than rises in the unit cost of services. He presented some statistics he said show no excessive rise in the cost of medical care when compared to food, homes, gas, electricity and similar consumer services.

Mr. Ward's analysis was challenged vigorously by several Commissioners and the staff. They asked to be sent the statistics upon which Mr. Ward's conclusions were drawn. At the heart of the challenge is the issue of providing a large volume of hospital services which are not medically justified.

In this exchange, hospitals were accused of variations in charges made for the same medication, varying from $10 in one hospital to over $100 in another.

Mr. Ward was urged to defend only those hospitals which can demonstrate efficiency, integrity and quality of professional performance, and to dis-associate from those shown to be guilty of exploitation.

This is not the function of his association, he replied, but the job of the Licensing and Certification Division of the State Department of Health Services.

In a statement submitted for the record by Jerrold L. Wheaton, M.D., Chairman of the Conference of Local Health Officers, the following major revisions in Medi-Cal policy were recommended:

1) That Medi-Cal and other programs of the department consider all county owned, operated or brokered health services to be considered a single county system, and be permitted by law and regulation to be operated as an enterprise fund.

2) That such systems be funded by reimbursement policies which utilize capitation, prospective budgeting and inclusive rates, in order to eliminate the need for fiscal intermediary processing of bills for itemized services.

3) Reduce eligibility determination to an annual process, and conduct state audits to assure that clients receive services of the quality and quantity set forth in the contract.

4) Lift the salary freeze imposed by Proposition 13 to keep county systems competitive and to enable them to produce the revenue which is dependent upon retention of health professionals and technical personnel.

5) Flexibility should be permitted in the law to accommodate the wide ranging discrepancies in need and capacity which characterize the 58 rural, suburban and urban counties.

6) The state should use a subvention system to finance those services which are not covered in a prospectively budgeted comprehensive health care delivery system.

7) The state should standardize reporting requirements and collection of data relating to administration, fiscal accounting, eligibility criteria and utilization of services. This will lead to greater efficiency and accountability.

8) A capital investment fund should be established at state level from which counties could obtain low or interest free loans for capital improvement, any acquisition of buildings and equipment when approved by the Local Health Systems Agency.

9) Community and free clinics dependent on county and state funds, should respond to the needs of patients in accordance with a county wide plan, and operate under contracts with counties that assure control of quality of care, accessibility, availability and reporting of service statistics.

The Commission is encouraged that the new administration of the Medi-Cal program is taking forthright steps to finally bring this program under control so it provides the best possible quality of care in the most cost-effective way possible. Although the revisions certainly appear to be moving in the right direction, it will take a renewed spirit of commitment and cooperation on the part of the Administration, the Legislature the providers and representatives of beneficiaries to put Medi-Cal on a solid foundation at last.

A P P E N D I X

A. Kenneth Cory's letter to the Commission

B. Computer Sciences Corporation presentation (Excerpts)

C. Statement of Jerrold L. Wheaton, M.D., Chairman, Conference of Local Health Officers.

APPENDIX A

KENNETH CORY

Controller of the State of California

SACRAMENTO, CALIFORNIA 95805

January 16, 1979

Mr. Nathan Shapell
Commission on California State
Government Organization and Economy
11th and L Building
Suite 550
Sacramento, California 95814

Dear Mr. Shapell:

The growing concern over the rapidly escalating cost of the Medi-Cal program caused the Legislature last year to establish, at my request, in the Office of the Controller a special project to oversee Medi-Cal fiscal program operations.

As Controller, I am constitutionally responsible for $3.5 billion in disbursements of taxpayer funds for Medi-Cal. I was - and I remain - concerned that we have insufficient controls on the program to manage it properly.

Furthermore, I am concerned that during this period of Federal and State austerity, that we make sure that in cutting budgets we do not inadvertently reduce the strength of the very systems upon which we must rely for efficient and economic program management.

It is as a result of this concern that I would like to call to your attention the results of one of the reviews of the Medi-Cal Audit Project by the Controller's Office. It has to do with manpower resources devoted to the investigation of the Medi-Cal program.

Since July of last year, there has been a 27 per cent decrease in the number of health program investigative staff. From a high of 108, the State now has a total of 79 investigative positions in two agencies -- there are 31 in the Medi-Cal Fraud Control Unit of the Department of Justice and 48 in the Health Services Department.

In February 1976, the Governor directed that there be an immediate increase in the number of expert manpower engaged in health program fraud and abuse detection activities. Utilizing 100 per cent Federal funds, 33 positions were created in the Health Department's Office of Investigations increasing from 75 to 108 the total number of persons dedicated to such investigations. The increase was the largest augmentation of fraud and abuse manpower the State has experienced.

The Federal funding expired at the end of June 1978 and a permanent plan was submitted to State budget authorities for continued funding of the 33 member investigative group. Because the Federal government pays 50 per cent of the cost of Medi-Cal administration and investigative staff is part of program management, the State taxpayers' share of this cost would have been half of the total.

However, two events took place with severe impact on the investigative unit: Proposition 13 and State Department of Justice plans to avail itself of 90 per cent federal funds to establish a Fraud Control unit under provisions of H.R. 3.

Of the 108 positions in the Health Department's investigative unit, 27 were moved to the Department of Justice which added 4 more positions on its own. A total of 33 positions formerly funded by the Federal grant were dropped from the Health Services Department. The number of investigative staff now in the Health Services Department is 48. The combined number of investigative positions in the Health Department and the Department of Justice is now 29 fewer than the number of just a year ago.

The creation of the Medi-Cal Fraud Control Unit in the Department of Justice, the net overall reduction of investigators and a Federal regulation may combine to cause even further problems.

When the Medi-Cal Fraud Control Unit was created, Health Services Department investigators were relieved of their pre-trial fraud investigative responsibilities. When fraud is suspected in one of their cases, the matter is referred to the Department of Justice. The regulations under which the Department of Justice receives 90 per cent Federal funds provide that those funds cannot be spent on detection activities. Therefore, detection and preliminary inquiries are the responsibility of the reduced number of investigators in the Health Services Department.

In the fiscal year ended June 30, 1978, the Health Services Department Investigative Unit received a total of 11,415 complaints. After preliminary inquiries, a total of 1,693 cases were opened. During the fiscal year, there were 72 convictions, 38 other proceedings and recoveries of $1,083,310.

In the first six months of the current fiscal year, a total of 5,782 complaints were received. At an annual rate, the total number of complaints are running slightly ahead of last year with fewer members of the investigative staff to deal with them.

Nonetheless, this reduced staff in the first six months has referred to the recovery unit for collection $1,127,995. This figure at an annual rate is $2,255,990 which would be 108 per cent greater than the amount for referrals for recovery in the previous fiscal year.

The total cost of operating the Health Services Department investigative unit is $1,288,000 which is substantially less than the amount that it can be expected to recover. This figure does not take into account the numerous convictions and other disciplinary actions which the staff will help to accomplish. The deterrent effect of the presence of an effective investigative unit is impossible to quantify.

But the presence of that deterrent is gone from five major cities in the State where investigative field offices had to be closed because of the reduction in staff. Now there are only four field offices. The reduction of the staff has caused an explosion in the case load for each person in the unit, which now amounts to an impossibly burdensome case load in excess of 125 per staff member.

There is little question that we must continue to bring our Medi-Cal program costs under control. But we must be especially careful not to cut in the process the very personnel and systems which give us the capability to improve the efficiency of our management and the economy of our program. The need for investigative staff was recognized by the Health Services Department and the Health and Welfare Agency in its October budget proposal. The Department and the Agency requested 12 more investigative unit positions. These positions, however, were eliminated from the budget by the Department of Finance.

The 27 per cent reduction in investigative staff was a false economy. Investigative staff do not simply contribute to prosecutions and recoveries. They provide to government a most important insight into the abusive acts and practices of providers, which may not be illegal, but which may, nonetheless, be unreasonable and cause unnecessary program expenditures. Such information can lead and has in the past led to important changes in law, regulations and program management. In short, investigators offer to us the ability to respond to issues that will save money without, at the same time, reducing necessary services to the poor and the elderly.

Cordially,

Kenneth Cory

APPENDIX B

EXCERPTS FROM PRESENTATION OF CALIFORNIA MMIS

TO

COMMISSION ON CALIFORNIA
STATE GOVERNMENT
ORGANIZATION AND ECONOMY

BY

COMPUTER SCIENCES CORPORATION
January 18, 1979

SURVEILLANCE AND UTILIZATION REVIEW SUBSYSTEM (S/URS) — MAJOR FUNCTIONS

- DEVELOPS OVER TIME A STATISTICAL PROFILE OF DELIVERY AND UTILIZATION PATTERNS OF PROVIDERS AND RECIPIENTS
- IDENTIFIES POTENTIAL MISUTILIZATION
- PROVIDES INFORMATION WHICH WILL REVEAL AND FACILITATE EXAMINATION OF POTENTIAL DEFECTS IN THE LEVEL OF CARE OR QUALITY OF SERVICES
- MINIMIZES THE LEVEL OF ADMINISTRATIVE EFFORT REQUIRED TO MEET FEDERAL AND STATE REGULATIONS

HIGHLIGHTS

- MEDICAL JUDGMENT CAN BE USED TO COMPLEMENT STATISTICAL CRITERIA OF STANDARD MEDICAL PRACTICE
- UNDER-UTILIZATION IS DETECTED, AS WELL AS OVER-UTILIZATION
- PROVIDES FOR FLEXIBLE DEFINITION OF PEER GROUPS AND FOR USER-CONTROLLED INCLUSION OR EXCLUSION OF MEASUREMENT ITEMS
- PRODUCES HIERARCHICAL LEVELS OF REPORTS RANGING FROM MANAGEMENT SUMMARIES TO SUMMARY PROFILES TO CLAIM DETAIL REPORTS

ADVANCED S/URS

- EMPHASIS ON FLEXIBILITY
- DIRECT USER CONTROL OF THE S/UR PROCESS
  - — RUN-TIME DEFINITION OF PEER (CLASS) GROUPS
  - — REPORT CONTENTS
- PROVIDES THE STATE'S S/UR STAFF WITH THE TOOLS REQUIRED TO ACCOMPLISH THE SURVEILLANCE AND UTILIZATION REVIEW FUNCTION
  - — S/UR STAFF MAKES DECISIONS THAT GOVERN DATA ANALYSIS

8133-25A

MEDICAL REVIEW — MAJOR FUNCTIONS*

- LEVEL II REVIEW
  - — CLAIMS REQUIRING INDIVIDUAL PRICING CONSIDERATIONS
  - — RESOLUTION OF CLAIMS FAILING ANY OF THE COMPREHENSIVE AUDITS FOR EXCESSIVE PROCEDURES, DUPLICATE BILLINGS, OR QUESTIONABLE COMBINATIONS OF SERVICES
  - — RESOLUTION OF CLAIMS EXCEEDING PROGRAM LIMITS FOR CHARGES
- HIGHLIGHTS
  - — REVIEW BY PARAMEDICAL PERSONNEL UNDER DIRECTION OF THE MEDICAL REVIEW DIRECTOR
  - — ONLINE ACCESS TO SELECTED HISTORY AND PENDED CLAIMS FILES
  - — DISPOSITION OF CLAIMS WILL BE MADE ACCORDING TO THE RULES AND REGULATIONS OF THE DEPARTMENT OF HEALTH AND TITLE 22
  - — MEDICAL REVIEW EXAMINERS SPECIALIZED BY AREAS OF EXPERTISE

*Data Control Center

MEDICAL REVIEW — MAJOR FUNCTIONS*

- LEVEL III REVIEW
  - — CLAIMS RESOLUTION PERFORMED BY PROFESSIONALS WITHIN THE FIELD OF THE CLAIM IN QUESTION
  - — DETERMINE MEDICAL NECESSITY AND APPROPRIATENESS OF SERVICES PERFORMED
  - — PRICING OF CLAIMS FOR SERVICES FOR WHICH NO PRICE HAS BEEN ESTABLISHED
- HIGHLIGHTS
  - — PRACTICING MEDICAL PROFESSIONALS
  - — UNITED FOUNDATIONS FOR MEDICAL CARE, INC.

8133-39A

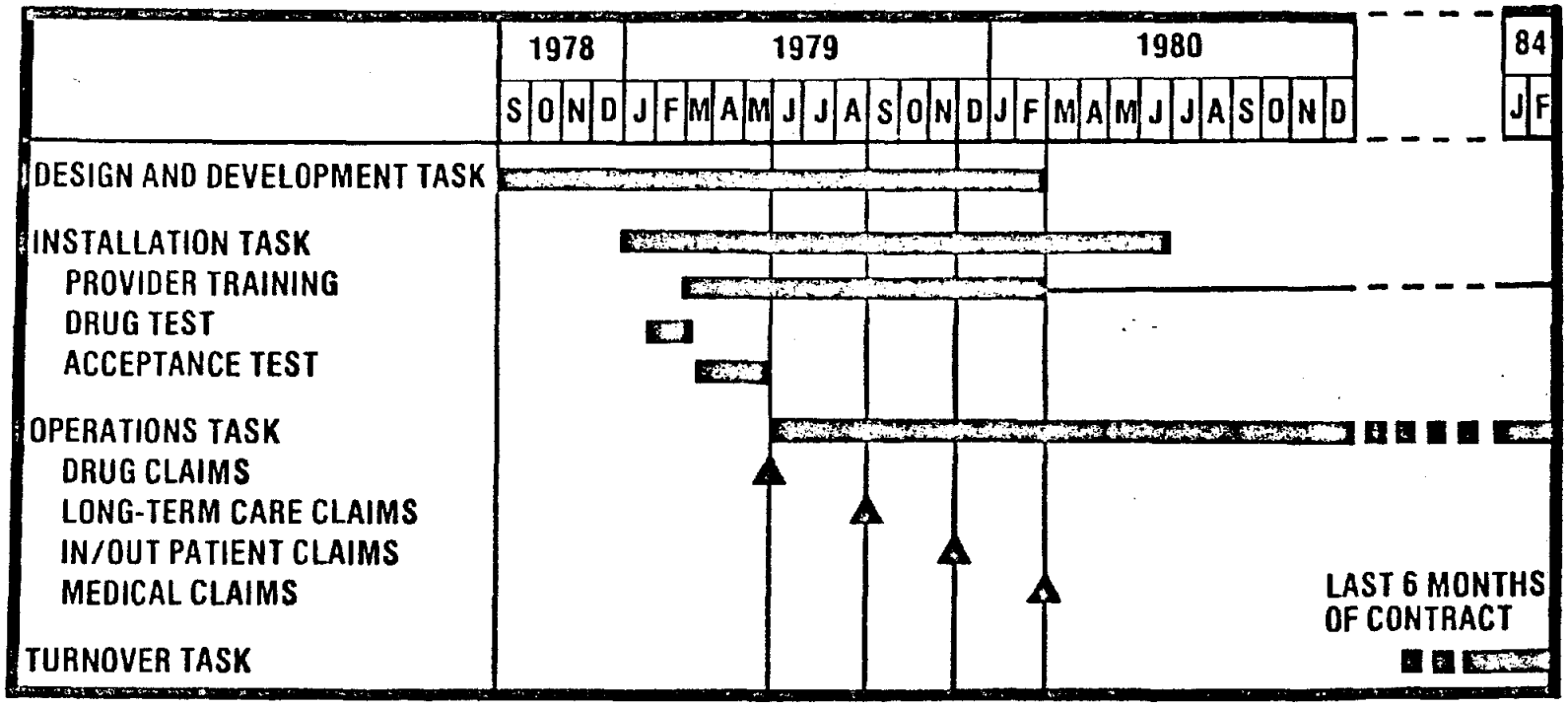
*Data Control Center

PROVIDER TRAINING AND COMMUNICATIONS

- FIELD REPRESENTATIVES TRAIN STAFF OR TROUBLE-SHOOT PROVIDER PROBLEMS IN PROVIDER'S OFFICE — MOBILE VAN PROGRAM
- TOLL-FREE "HOT-LINE" TO ASSIST PROVIDERS OR ANSWER INQUIRIES — ON-LINE RESEARCH CAPABILITY
- PROVIDER TAILORED DISSEMINATION OF PROVIDER MANUALS
- PROMPT NOTIFICATION OF CLAIMS DISPOSITION
- AUTOMATED CORRESPONDENCE CONTROL SYSTEM
- VIDEO COURSE MATERIAL

8133-27A

IMPLEMENTATION SCHEDULE



9070-7

STATEMENT OF JERROLD L. WHEATON, M.D., CHAIRMAN
CONFERENCE OF LOCAL HEALTH OFFICERS TO
SENATE HEALTH & WELFARE COMMITTEE
January 26, 1979

The California Conference of Local Health Officers (CCLHO) was asked for representation at your 17 January 1979 hearing on the complex issues of containing health costs in the public and private sectors. As President of CCLHO, I realize how difficult it is to adequately represent the spectrum of county needs from Alpine to Los Angeles, but will attempt to transmit some sense of consensus, using what I know best--my experience in Riverside--to illustrate points.

The disparate needs of California counties cannot be answered except by a system that recognizes local differences. I recommend that any action taken rely heavily on the concept of a county plan, supported by budget, reviewed and approved by the State Department of Health Services, that speaks to the service needs of a particular county and the level of those services required which may vary from 0 to 100% depending on the local situation. To ensure that small counties are not placed at a disadvantage in this process, the requirement should be levied on the State Department of Health Services (SDOHS) to provide technical assistance in the preparation of an appropriate county plan. Concurrently, the reimbursement, subvention, or other funding mechanisms should make it feasible for small counties to develop Joint Powers Agreements for the provision of appropriate health services in the public sector. This would remove SDOHS from the difficult position of establishing policy on one hand while participating in operations based on that policy on the other.

I would also suggest that all county owned, operated, or brokered health services be considered as one system and that incentives be introduced to encouraged creating a "county system" where the component parts already exist, such as hospital, health department, clinics and environmental services. Basic to this would be expansion of Title II, Article 3, Section 926(b)-Administration, to allow a "county health service system" in addition to "hospitals which have been formally declared general hospitals by the supervisors" to be operated under an Enterprise Fund.

The restriction to a general hospital prevents counties from economies that would be possible under an Enterprise Fund.

The program description of county hospitals and clinics in California provided by your staff is accurate and expresses succinctly a mass of written material. The following responses are numbered to match the "key Issues/ Questions" on page 4.

1. Refining the Welfare and Institutions Code Section 17000 to include specific services and statewide eligibility standards would prevent differences in local interpretation, but still leave the mechanism for the State to shift costs to the counties. The Medically Indigent (MI) category could be expanded, but this would increase Medi-Cal costs unless eligibility is determined for a specific period of time according to a county plan contracted for by the State under a prospective budgeting system. Reducing eligibility determination to an annual process would reduce the administrative cost, and substituting a capitation or prospective budgeting method of funding would eliminate the administrative costs of single procedure billing for the provider and the reactive audit response of the State. In place, State audits would be functional rather than compliance and address whether clients received services of the quality and in the quantity determined by the contract.

2. There are alternative methods of financing and organizing county health service operations that would increase efficiency, cost effectiveness and produce high quality care. The methodology depends on the county taking all of the owned, operated, or brokered health care facilities, elements, and services and restructuring them into one comprehensive system. A first step toward this has been taken by Contra Costa County, and the Riverside Comprehensive Health Service plan could be the basis of another such system that would address hospital, health department, environmental health, etc. as a system perhaps organized as in-patient, ambulatory care, and personal protective and environmental services.

It is not, in my opinion, feasible for all counties to operate health plans any more than it is feasible for all of them to operate rapid transit systems. It depends on the needs of that particular county and should be expressed by a county plan with a supporting budget, approved by the State, that justifies whatever methodology is proposed.

3. The State should definitely lift the salary freeze placed on local employees in SB 154. As an illustration, Riverside County has a 443-bed acute general hospital affiliated with Loma Linda Medical Center for teaching purposes. The "breakeven" point for bed occupancy is 220. Last year, the hospital averaged 229 paid

patients per day. In July, sufficient nurses and allied health personnel quit to force the operating level to 185 beds. Services were consolidated and a new "breakeven" point established at 206. Since July, we have not been able to staff to allow that occupancy and have been operating at a loss. The hospital is under the enterprise system of accounting. In 1975/76, the general fund of the county subsidized the operation by 1.2 million; in 1976/77, by 1.6 million; in 1977/78, by 2.1 million; and since the decrease in revenue due to personnel losses following the wage freeze, the amount needed from the general fund will probably exceed 3 million. From 1 July to 15 November, there were actual losses of about $300,000.00. Many nurses, laboratory technicians, respiratory therapists and other allied health personnel are now working for the V. A. and other hospitals. I do not understand the question, "If so, will this assist the counties in retaining high quality health personnel?" -- since, in my opinion, quality is a direct result of adequate supervision under good management coupled with remedial and continued in-service education.

4. This series of questions is county-specific in that the answers would vary from county to county. There should be the flexibility to create a prospectively budged system. This system should have a built in economy incentive in the form of savings retention with the provision for capital accumulation for future facility improvements and equipment expenditures. Another option would be a State funded "Capitalization Account" from which counties could borrow, without interest, to maintain public facilities at Joint Commission on Hospital Accreditation standards.

5. The State should provide another block grant with the same restrictions on disproportionate reductions as a bridging mechanism while the legislature attacks the problem of creating a new comprehensive California Health Code that would allow local option flexibility, restructuring of the Medi-Cal system to allow diversification from the fee for service system to prospective budgeting, where possible, to limit providers, and give public sector providers true cost reimbursement. Currently, the average private, non-profit or propriatary hospital collects 82 to 85% of every in-patient dollar billed, while the public sector reimbursement, on the average, is at or less than 80%.

The next section deals with Public Health and lists 16 services. One way to consider basic services is to categorize them according to those that apply to the community as a whole, those that are directed toward special populations or problems, those that concern our environment, and those that affect individuals at their work. Such a list could be:

APPENDIX C

BASIC SERVICES

I. Community as a Whole

A. Surveillance of the community for disease:

1. T.B., V.D., other communicable diseases

2. Epidemiology -- the process of disease detection and identification in a population

3. Data collection and analysis

B. Emergency Medical Services/Injury Control

C. Primary Health Services

D. Nutrition Services

E. Preventive Dentistry

F. Health Education

G. Institutional Services

H. Public Health Laboratory Services

II. Special Populations

A. Maternal Health

B. Family Planning

C. Genetic Disease Control

D. Childrens Services

1. (CHDP) Child Health Disability Prevention

2. (CCS) California Children's Services

3. (EPSDT) Early and Periodic Screening, Diagnosis and Treatment

E. Geriatric Services

F. Chronic Disease Control

III. Environmental Factors

A. Air, water and food quality

B. Waste Disposal

C. Housing Quality

D. Noise Control

E. Radiologic/Nuclear Safety

F. Vector and Animal Control

G. Sanitation & Safety of Public Buildings & Places

IV. Occupational Health

That list does not differ significantly from the listing on page 5. It does, however, group these services. In Riverside County, the costs of more than 90% of all environmental services provided are recovered under an ordinance that sets fees on a cost recovery basis under Section 510 of the Health and Safety Code. In fact, the current year actual revenue and expenditures indicate that we may be at 98.2% of actual costs for a 1.3 million dollar program. Operating cost recovery is based on the philosophy that the individual who profits from an endeavor requiring inspection for the protection of some of the "public" should pay the costs of that inspection and recover those costs from the portion of the "public" that patronizes the business. This differs from the philosophy that everyone in the county should be taxed to pay inspection costs of all businesses requiring surveillance for public protection regardless of whether the individual taxed patronizes those businesses or not.

Riverside County has recently created an occupational health service with funds advanced by the Board of Supervisors from the general fund. There is every indication (this service fills a vacuum--there are no credentialed occupational health professionals in the private sector) that this service will completely recover operating costs.

Those services listed for special populations could be absorbed into an inclusive negotiated rate or prospectively budgeted county health delivery system. The same is true of most of the services that apply to the community as a whole. This does not speak to two other aspects of "basic services" which are:

1. level of service, and
2. standards & evaluation of service.

The level of service should be stated, justified and supported by a line item budget in the "county plan" approved by the SDOHS. Standards exist

in draft form and are being refined by the California Conference of Local Health Officers. I would suggest that a "California Health Code" should retain the mandate that created the Conference of Local Health Officers, establish funding, and provide for review and approval authority of any SDOHS regulation purported to implement the intent of legislature.

Answers to the "Key Issues/Questions" on page 7 are indicated by corresponding numbers:

1. The State should mandate the entire list of "basic services". However, the level of any service could vary from zero to one hundred percent according to local needs as expressed and approved in a county plan.

2. The State should finance through a subvention system, services to those not covered under a prospectively budgeted comprehensive health delivery system by increasing the subvention percentage and the levels of service desired up to 50% of the cost of those services. At that level, the county must meet the agreed upon level of service in the county plan.

3. Evaluation criteria are built into the standards now in draft form that cover everything from administration to direct services and stipulate a measurable service level. The California Conference of Local Health Officers will pursue this development and present the product in draft form to the committee for their consideration.

4. In my opinion, the State should not mandate fees or prohibit them. Local option should be preserved as now under Section 510 of the Health and Safety Code. Incentives for cost recovery should be built into the system and encouraged through the county plan.

5. The State can and should standardize reporting requirements and data collection. This would allow the State to satisfy federal reporting requirements and provide the data not now available to determine the major health needs by area in California. The significant federal categorical funding to the State could then be used as discretionary funding to answer indentified needs and begin to upgrade health services on an objective priority basis. For example, the State now receives more than 11 million in Title V federal funds. About 5 million of that sum finds its way to the local operational level by two methods. First is a per capita allocation according to a formula decided on in 1958, and the other is a competitive proposal process that gives each county or non-profit coporation a hunting license for funds without consideration for need or overall plan. Eligibility criteria can be and should be standardized so that one measurement is used for all. Program flexibility and availability to small counties is restrained by requirements for separate administration. An attempt should be made to negotiate flexibility between State and Federal levels, since local operations could be budgeted, described and justified under a county plan system.

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6. The Riverside County Comprehensive Health Delivery System plans to integrate all categorical programs into one community oriented general service system. Where necessary, categoricals would be handled as a bookkeeping procedure. Any prepayment system should include categoricals and account for them by the data collection system and described in the county plan. In my opinion, this system would be more cost effective. Attached is a flow chart of the Riverside Comprehensive Health Plan which indicates preventive service integration and illustrates a system of primary through tertiary care.

The section and questions dealing with community clinics should also be addressed from the standpoint that the State cannot afford duplication of services unless those services are provided to different and distinct populations. Since the Medi-Cal population is the county public health population is the community clinic population, etc., redundancy is very easy to create inadvertently. In my opinion, community clinics and the county operated health service elements of the public sector should be adjunctive, not competitive or duplicative. For example, Title V (Maternal and Child Health) Federal funds available from the State are awarded on a competitive proposal basis without establishing and prioritizing California needs by area. Instead, they are awarded for a "good proposal" on a three year basis. At the end of three years, another entity from the area, such as a non-profit corporation or community clinic, could apply to perform the same services in the same way for another 3 years. In my opinion, federal funds should be used to correct known deficiencies and then made self-supporting under the county plan by fee recovery, prospective budgeting or as part of the subvention.

The State cannot only encourage linkages, but could require them through the county plan. The cash flow problems of community clinics could be addressed by prospective budgeting according to a service delivery plan tied to sanctions for non-compliance or performance.

The section on Medi-Cal has three options. The limiting of eligibility would decrease federal funding unless this limit was applied only to the non-categorical linked medically indigent or MI category. Benefits could be cut back to the minimum specified in federal law. However, this would have adverse consequences and a considerable political impact considering the number (about 300 K) of persons that would be affected. This third option is my unequivocal choice. The State of California should request a waiver from the Federal Government to Section 1115 of the 1976 Health Maintenance Organization Amendments. This waiver has been repeatedly requested by Riverside County with results varying from completely ignoring the correspondence to a flat refusal. This waiver would allow prospective reimbursement with Title XIX funds. The request should address public sector prospectively budgeted systems for low income persons since the California track record for effective prepayment plans in the private sector would have to improve to be even cursory! The federal level bias against creating comprehensive delivery systems in the public sector should be recognized and dealt with appropriately.

In summary, the "county plan" should address all county owned, operated or brokered health services. Funding of mental health services for Medi-Cal recipients should all be accomplished through the county "Short-Doyle system, to eliminate duplication and reverse the known fact that expenditure levels for mental health are in direct proportion to the number of providers in an area, not the population at risk. The current quality assurance system of professional standards review would be more effective in controlling utilization from a cost containment standpoint if the physician and the institution were put at financial risk for unnecessary procedures rather than the current system where only the patient and the reimbursement system is at risk.

1. County government answers to an electorate and is accountable to that electorate as well as the SDOHS.

2. Health services provided on a cost recovery basis are less expensive than those provided on a cost plus basis.

3. Existing county health delivery system fragments should be preserved and encouraged to become systems under budgeted plans developed specifically for those counties with SDOHS review and approval.

4. A County Health Delivery System should be added to Title II, Article 3, Section 925, to allow counties to create a system.

5. All health services in the public sector should compliment each other. The California Conference of Local Health Officers will have standards for those services that can be used for any level of service planned for any county.

6. Health services in the public sector cannot be discussed without considering Medi-Cal since the population requiring health services from the county is larger than, but contains, the Medi-Cal population. Diversification from a straight fee-for-service to a capitation, negotiated rate or prospectively budgeted system would provide the public sector with the flexibility to provide service to low income people of better quality than I can now buy in the open marketplace for myself.

7. Federal funds coming in to SDOHS should be used as "risk capital" in a discretionary manner to bring local delivery system elements up to the level needed to answer service needs. These levels should then be maintained by subvention from the State at a funding level of about 50% with sanctions to ensure service delivery as planned.

8. A capital investment fund should be established at State level from which counties could obtain low or no interest loans for capital improvements, acquisition of buildings, or

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equipment when approved by the Health Systems Agency planning methodology. This should be accomplished through a simplified certificate of need process to eliminate high certificate of need costs for the public sector.

Sincerely,

Jerrold L. Wheaton, M.D.
Director of Health
County of Riverside

JLW:sl
Attachment

cc: Dale Wagerman
Eileen Eastman
Howard Robinson
Little Hoover Commission ✓