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SUPPLEMENTAL REPORT

ADMINISTRATION OF THE MEDI-CAL PROGRAM OF THE STATE DEPARTMENT OF HEALTH

STATE OF CALIFORNIA

SUPPLEMENTARY REPORT ON THE ADMINISTRATION OF THE STATE MEDI-CAL PROGRAM

SEPTEMBER 1977

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September 1977

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

The Commission respectfully submits its supplementary report on the administration of the State's Medi-Cal Program. This report is the third in a series of supplemental reports issued by this Commission since the release in January 1976 of the "Administration of State Health Programs."

The Commission received detailed written response and oral testimony from departmental and Medi-Cal Division officials indicating almost full agreement with the findings contained in our 1976 report. Until recently, however, the Division has not shown much interest in our findings nor has there been much tangible evidence of a plan to implement our recommendations. Instead the Division has been overly preoccupied with eligibility rules, rates and fees, program regulations, and treatment authorizations. It has paid far too little attention to the needs for improving the organization of services, streamlining methods of reimbursement, and increasing the access of low income patients to a comprehensive scope of services.

The newly appointed Deputy Director in charge of the Medi-Cal Program has suggested that the Commission conduct a completely new review of the Division operations, rather than to rely upon the Division's previous written response, or upon the testimony presented at two public hearings. In view of apparent sincere desire to correct organizational and operational deficiencies, the Commission concurred with this request. Accordingly, the analysis and additional review was conducted in June and July of this year.

We are pleased to report that this review led the Commission to conclude that under new leadership the Division is in the process of implementing ninety percent of the Commission's recommendations. We believe that more conservative management, when fully implemented, should result in a ten to fifteen percent reduction in program costs. Based on current budget projections for Fiscal Year 1977-78, this

saving will range from $300 to $450 million annually. This range of savings is only possible if the department pursues a vigorous program of enforcement against fraud and abuse and implements strong management controls.

The great potential for both savings and loss is demonstrated by the recent allegation of a Medi-Cal overrun of approximately $200 million. This Commission has warned of the catastrophic consequences which could result from the State's huge medical budget being out of control. The safeguards and management controls recommended will greatly aid the reduction of these types of problems and the great potential for loss.

A well organized, efficient operation of the Medi-Cal Program has a strong impact on the operations of other health programs. The extensive network of crossover funding may be more difficult to administer efficiently if the department is broken up into several separate and autonomous organization units.

It is anticipated that a fourth and final supplemental report dealing with the review of state hospital programs and community services for the developmentally disabled will be released in October. In the Fall of 1978, the Commission will review the progress that has been made in the provision of health services to the State of California. Accordingly, the Commission will schedule additional public hearings at that time to assure that the intended program reforms have actually been implemented.

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SUPPLEMENTARY REPORT ON THE ADMINISTRATION

OF THE STATE MEDI-CAL PROGRAM

SEPTEMBER 1977

I. NINETEEN MONTHS OF PROGRESS--AN OVERVIEW

The Commission issued its first report on the Medi-Cal Program in January 1976 as part of a report entitled, "The Administration of State Health Programs." The Commission concluded that this huge program (budgeted for $2.6 billion in Fiscal 1975-76, and for $3.1 billion in Fiscal 1977-78) could not be properly administered by the Department of Health or anyone else, due to the obstacles to proper management which had become ingrained in the program. The Commission recommended extensive, specific changes to bring Medi-Cal under a semblance of managerial control.

A written response was not made by the Department for one full year. Subsequently, the Commission held two public hearings: March 16, 1977 in Sacramento to hear testimony from representatives of the Department and the fiscal intermediary, and April 20 in Los Angeles to hear the comments of Medi-Cal providers and users.

In opening the supplemental hearings, Commission Chairman Nathan Shapell noted the "alarming rate of growth" in the budget for Medi-Cal, the largest human service in state government. He summarized the main points of the Commission's January 1976 report: "A crisis of major proportion is imminent...an eligibility process which is overly complex and expensive to administer... fiscal intermediaries whose system is totally inadequate for detection of questionable provision of services...apparent widespread fraud and abuse by private providers...prepaid health plans under Medi-Cal have become a national embarassment for California, tainted with widespread scandal...county institutions, the traditional vehicle for public services for the poor, are facing collapse..."

At the March 16 hearing, representatives of the Department of Health and its Medi-Cal Division acknowledged many serious shortcomings in the program. They described numerous steps which are being taken--many of them recommended by the Commission--to bring Medi-Cal under tighter fiscal and administrative control.

As Raymond Procunier, the Department's chief deputy director, put it: "There are going to be a lot of rocky roads, a lot of problems, but I think that together we can do it." Also testifying on details of the fiscal operations was the executive director of Medi-Cal Intermediary Operations, the private venture which has held the contract since the program began 11 years ago.

Witnesses at the April 20 hearing included Medi-Cal providers, recipients, and organizations representing them. Their testimony in large part concerned the red-tape involved in the Medi-Cal treatment.

The Department's written response and oral testimony indicated almost full agreement with the findings of the Commission, but little tangible evidence of a coherent plan to implement its recommendations. Shortly after completion of Commission hearings, a new Department deputy director was appointed to head the Medi-Cal Division. He suggested that the Commission conduct a complete new review of the program, rather than base this supplementary report entirely on the response of the Department and the hearing record. Such a review was carried out in June and July of 1977, consisting of extensive interviews with senior staff in the Medi-Cal Division, together with a study of current policy statements and administrative practices.

This review leads the Commission to conclude that, under new leadership, the division is in the process of implementing more than 90 percent of the Commission's original recommendations. The division is ready to assume direct control of policy for determining criteria and standards for medical policy and methods for review of these standards. Certain parts of the claims processing system will be placed under direct control of the department. Other information systems will be revised to enable the department to evaluate the characteristics of the eligible population and to make comparisons in the patterns of services offered by a wide variety of providers.

These policy initiatives are reflected in the development of two important "requests for proposals." One will revise the eligibility information file to increase its accuracy; the second will make fundamental revisions in the claims processing system and fiscal intermediary contract. These proposals concentrate on the accomplishment of eleven policy initiatives either recommended or endorsed by the Commission:

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 procedures and methods for reviewing performance in the claims processing system. Stronger on-site monitoring of fiscal intermediary operations. The criteria for review by the Professional Standard Review Organization should be set by the Department.

4) Initiation of a system of selecting 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.

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 entirely 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 primary ambulatory services, controlled referral to specialized care, and planned reduction in unnecessary admissions to hospitals and long-term care facilities.

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 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, foundations for medical care, and university operated or affiliated county hospitals.

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

II. SUMMARY OF JANUARY 1976 REPORT

The growth of the Medi-Cal Program has consistently exceeded estimates. Its growth now threatens to financially encroach upon other essential state services.

The Commission's 1976 report criticized Medi-Cal's excessive administrative costs, reported approaching 40 percent of the total program cost. The eligibility system for determining whether a person is eligible for Medi-Cal was found unduly complex and expensive to administer. Although the state requires the counties to provide medical services to the indigent, the definition of indigency varies from county to county so some counties are paying a disproportionate amount to serve indigents.

Because the state Medi-Cal Division receives its basic eligibility data from various state, county and federal sources--often unverified for accuracy--the eligibility file is vulnerable to a large degree of error. This results in unwise use of state money by providing services to some who are not eligible and denying care for others who are eligible. A severe scarcity of resources persists in low-income urban and rural communities despite the staggering expenditures made over the past 10 years for the care of the Medi-Cal eligible population.

Lack of an accurate, up-to-date eligibility file also precludes eligibility and utilization analyses which are essential to good management. To add to the confusion, inconsistency was found in eligibility standards for Medi-Cal and other health programs administered by the Department. The report also addressed the need for maximizing legitimate benefits for recipients while eliminating services which are not medically necessary. Concern was expressed over Medi-Cal's heavy use of hospital and other long-term care, and relatively little emphasis on preventive services. Providers of lesser integrity perform unnecessary services in an effort to make up for the rates which Medi-Cal pays, widely declared to be too low.

When the report was prepared, about 80 percent of the payments to providers were made on a fee-for-service basis at "reasonable" rates. However, the Department had not undertaken a cost-benefit study of this method as compared to providing services through foundations for medical care, prepaid health plans, university hospitals or county institutions.

The report noted that the prepaid health plans under Medi-Cal have been plagued by mismanagement; foundations have not proven to be more cost-effective; university medical centers have problems uncompensated losses and providing basic services, due to their primary mission as teaching hospitals; and the heavy financial burdens which the state placed on county hospitals

forced some to close, and seriously eroded the quality of care which others provide to patients who have no other resources.

The data acquisition and processing system is largely controlled by the fiscal intermediaries who, in turn, are controlled by providers. Defective information systems enable providers to abuse the program without detection. The Commission criticized the fragmentation of auditing, investigations and quality control among two state agencies and the fiscal intermediary, instead of having them all under the control of the Department of Health. Also cited was the notable lack of a formal planning and evaluation program within the Division.

In summary, Medi-Cal has been overly preoccupied with eligibility rules, rates and fees, program regulations, and treatment authorizations. At the same time it has paid far too little attention to the need for improving the organization of services, streamlining methods of reimbursement, and increasing the access of low-income patients to a comprehensive scope of services.

* * *

The Commission's complete, 420-page January 1976 report, entitled, "A Study of the Administration of State Health Programs," may be obtained by writing the Department of General Services, Publications Section, P. O. Box 1015, North Highlands, Ca., 95660, and enclosing a check or money order for $6.00 payable to "State of California, Documents Section."

III. RESPONSE TO RECOMMENDATIONS

Following are the major recommendations of the Commission's January 1976 report on the Medi-Cal program (with page references.) They are followed by an analysis of steps the Department has taken in response to those recommendations, as determined by Commission hearings and staff investigation.

A. Administrative Costs

> "The Department of Health should commission a study of administrative costs in Medi-Cal, taking into consideration the costs generated by the Administrative processes listed in the findings of this report." (pg. 156)

As yet, the Department has not seen fit to call upon outside consultants to perform an objective, professional assessment of the administrative costs of the Medi-Cal program. However, in developing a proposal to call for bids for a new fiscal intermediary operations contract, there is a refreshing acknowledgement by the staff that improved information systems--and the department's assuming direct control over some of them--holds the promise for ending wasteful administration and uncontrolled provision of services. The Commission will elaborate on the Medi-Cal intermediary operations procedurement project later in this report.

B. Fees and Quality of Care

> "The Department should study alternatives to its present vulnerability to paying for the excesses which prevail in the private sector. A reduction in the number of fee providers, expansion of quality prepaid plans, expanded support to county institutions, and preferential treatment to Foundations for Medical Care could substantially reduce cost and enhance quality of care." (pg. 157)

> "The principle of selection of providers should be applied to the Medi-Cal program as is now done under Crippled Children Services. The installation of a Professional Standard Review Organization capacity in the Department of Health would enable the Department to identify patterns of practice which are substandard

> and eliminate those providers from participation. The quality review process should deal with all types of providers, individual and institutional. Reimbursements from Medi-Cal should be conditioned on a satisfactory review record. Incompetence and exploitation must be added to fraud as grounds for removal from the program." (pg. 158)
>
> "The Department, in its dealings with organized providers, should move in the direction of prospective budgeting and reimbursements, composite rate reimbursements and prepayment, and move away from procedural billing. The cost of processing fees for every service provided is high and inherently wasteful." (pg. 158)
>
> "The auditing and recovery functions now lodged in the Department of Benefit Payments should be transferred into the Medi-Cal Division in such a position that both functions articulate with the services review operation, as described above and with investigations." (pg. 161)

Methods of reimbursement constitute a powerful tool for containing Medi-Cal costs. Every opportunity should be employed to reduce the program's vulnerability to fee-for-service reimbursements and payments to institutional providers for "reasonable costs." Fee and reasonable cost reimbursements place no incentives on the providers to control their costs. By contrast, prospective rates, fixed budgets, capitation payments and audited composite rates all convey the concept of the providers sharing the risk of cost over-runs. They force providers to pay close attention to cost, management and utilization controls, and to seek ways of attaining greater operational efficiency.

This principle is best illustrated by a recent study by the Prepaid Health Plan Research and Development Project. It showed a 17 percent cost reduction in well managed prepaid health plans, compared with fee-for-service costs for the same scope of coverage.

Because of its critical importance to program management, the control of fees paid to Medi-Cal providers must be moved from the Division of Administration to the Medi-Cal Division. The management of the program cannot otherwise be held accountable if such a highly charged, complex and critical aspect of

program management is outside control of the division. The Commission urges that this action be taken immediately as part of a reorganization of the Division, as detailed in the supplemental recommendations at the end of this report.

The Commission's recent review reveals that fee-for-service providers are still discouraged by low rates of reimbursement and by the Governor's recent veto of a budget item to grant rate increases to professional providers.

The impact of malpractice insurance premium increases is now more clear. Rural communities have lost ground, especially in access to obstetrics, anesthesia and elective surgery. The availability of practitioners willing to do obstetrics under Medi-Cal has diminished since the malpractice crisis. There is a serious problem in access to care by Medi-Cal recipients in rural areas and in other parts of the state with professional manpower shortages.

The Department has taken steps to control the soaring costs of institutional care under Medi-Cal, but most of those major efforts have been thwarted.

The Department instituted a 10 percent limit on increases of reimbursements for hospital providers, but the providers won a federal court suit which blocked the new limit. The Department has appealed, but in the interim the court ordered that hospitals continue to be paid "reasonable costs" no matter how much they increase.

Later, the Department was offered a contract with the U. S. Social Security Administration to undertake a pilot project for prospective rate reimbursement for hospitals. The Department submitted a budget augmentation request to pay the state's 25 percent share of the project funding, but the legislature turned down the proposed contract earlier this year.

Despite these setbacks, the Medi-Cal administrator concurs with the Commission on the continued importance of expanded demonstrations of such controls as prospective budgeting, composite rate reimbursement and capitation payments to organized providers of services.

Currently, the Department is in the process of developing a "prudent buyer" project, in which selection of hospital providers with lower rates and assured quality of care will be made. Services will be performed in selected hospitals which serve certain geographical areas in the state. This project awaits further development and approval of the U.S. Department of

Health, Education and Welfare. It is based on the assumption that the state will save money by optimizing the occupancy of well-run hospitals and securing a higher level of quality of care.

In March, the Department organized a Surveillance and Utilization Review unit to intervene with providers identified by the fiscal intermediary (or by direct complaints) as displaying an aberrant profile in providing services, usually in the form of grossly excessive practice patterns. At present, the SUR unit is of limited size, spends 40 percent of its time in the field and 60 percent in performing desk reviews.

When the unit starts removing offending providers from participation in Medi-Cal, the professional staff feels the word will spread and this will tend to diminish abuses. The attitude of the new Medi-Cal administrator is that the department intends to be more aggressive in its control of Medi-Cal standards and in its review of questionable patterns of provision. The ultimate goal is removing the problem providers from the program, while adhering to due process of law.

Another development pertinent to fiscal and quality control is a major demonstration contract, now in its final year, involving the California Dental Service. CDS is the prime contractor in an $87 million contract for fiscal 1976-77 for providing dental services to all Medi-Cal indigents.

CDS performs these functions:

1. Computerized review of claims for payment, with prepayment audits and edits to assure compliance with standards of quality and pricing.

2. Exception reporting for adjudicated claims which do not pass audit and are settled on the basis of criteria set by the dental service.

3. Maintenance of information services to providers and responses to their inquiries and complaints.

4. Claims processing and payments for approved services.

5. Professional review of treatment authorizations for services which require prior approval.

6. Disciplinary action against dentists with questionable standards of performance is recommended both to the Department of Health and to the Board of Dental Examiners.

Although problems prevail in the definitions of "norms of service," a less than optimal percentage of population being served, and restrictions in benefits covered, nonetheless the demonstration has increased access by expanding the number of participating providers. CDS also has developed a computerized claims review and control system which appears to be sophisticated and efficient.

C. Eligibility Standards

> "The Department of Health should collect, analyze and report the standards of eligibility in use in each county to the Legislature." (pg. 155)
>
> "The Legislature should define and make uniform the standard of eligibility for public assistance medical care under W & I Code 17000." (pg. 155)
>
> "The Department, with federal waivers, should undertake, in a large county institution, a study of the fiscal implications of elimination of prior eligibility processing for non-cash grant recipients, (MI, MN, County indigent) and the substitution of sample post-treatment audits to determine eligibility status. If a relatively insignificant number of patients in such a study proves to be marginally ineligible for care in a county institution, the simplification of eligibility should be employed in all county institutions to reduce costs of processing every patient. (This experiment is consistent with the intent of Section 222 of PL 93 603.)" (pg. 156)
>
> "A second study should be undertaken to explore the feasibility of reducing the number of standards used in the determination of eligibility in all programs of the Department including Medi-Cal. The nature of medical indigency is such that multiple standards may be more costly to apply than a single standard at the maximum level." (pg. 157)

Senate Bill 660, authored by Senator David Roberti and supported by the Administration, would provide grants to counties to test eligibility simplification in county institutions.

Staff of the Medi-Cal Division report that attempts to interest counties in experiments with simplified eligibility systems have not been very productive so far. The Commission finds this difficult to understand, in view of bitter complaints from county health administrators concerning the high cost of compliance with complex rules and regulations for administering eligibility. These officials point to county losses due to failure to establish eligibility in a timely fashion for purposes of reimbursement by the State. The need for simplification of eligibility throughout the program should not be ignored. The immediate opportunities which prevail in county institutions should be pursued further without delay.

Concerning reduction in the number of categories of eligibility, SB 660 would authorize a study of benefits which may be derived by eliminating the category MI (medical indigent) within Medi-Cal. There should be a companion study of the median length of eligibility for Medi-Cal for other classes of recipients to determine the feasibility of annual or semi-annual eligibility status for certain classes of indigent. The accuracy of such studies will be augmented by use of an on-line eligibility system.

Such an extended eligibility policy, if proven feasible, would do much to cut costs of frequent processing and could stabilize the enrollment in prepaid plans.

D. Benefit Structure

> "The benefit structure in Medi-Cal should be systematically reviewed in those programs which are involved in 'crossover' funding. The purpose of such a review is to study with care the dynamics of the fifty percent federal share and the losses being incurred to the state budget by failure to cover services under Medi-Cal which are therefore covered in other programs with less advantageous matching formulas or which are funded entirely by the state." (Pg. 157)

> "Preventive medical services should become a covered benefit in the provision of care by organized providers...in a position to build a program of prevention into their system of delivery of services." (pg. 157)

The Medi-Cal administrator agrees with the Commission on the need for systematic review of the Medi-Cal benefit structure to maximize federal matching participation in other state funded health programs which serve the Medi-Cal population.

Crossover funding for programs outside of the direct administrative control of Medi-Cal constitutes a complex and frustrating situation. Historically, Medi-Cal administrators have not been especially helpful to other health administrators who attempt to make legitimate demands on Medi-Cal funding. Many chronic disputes prevail in the Department, mostly related to the lack of understanding within the Medi-Cal Division of the potential benefits of a rational and more systematic approach to crossover funding procedures and eligibility criteria. The new director of Medi-Cal acknowledges the advisability of creating a unit in this Division to make the funding of programs in other divisions more efficient and rational.

E. Fiscal Intermediary

> "...the Department should assume direct responsibility for the fiscal intermediary function. The Medi-Cal Management System should be reinstated as the first step toward development of a standard review capability in the Department. To accomplish this capacity, the central eligibility file should be tied into the paid claims file, as discussed under Data Processing." (pg. 158-159)

> "The Department, in assuming fiscal intermediary operations, should plan to install a data system capable of performing analysis of characteristics of recipients as well as patterns of provision of services... . Lack of control over information makes it literally impossible to control any program." (pg. 161)

The Medi-Cal administrator has expressed agreement with the Commission on the importance of keeping open the eventual complete assumption of fiscal intermediary operations by the state. In fact, the proposal for a bid request for a new fiscal intermediary contract provides the state with an option to take over and operate the fiscal intermediary contract, if this is deemed desirable and cost effective.

But in the interim, the department has taken perhaps the most significant step forward in the Medi-Cal Program in the past two years--implementation of the Medi-Cal Intermediary Operations (MIO) procurement project. This project was initiated, in part, because of criticisms made in the Commission's 1976 report. The Commission emphasized that successful

management of the Medi-Cal program requires control of basic policy decisions and those information systems which contain the basic details of the program.

The MIO procurement staff, for the first time, gathered a complete description of the entire information system--the purpose of each component, its location and control, the types of data and reports produced and the uses to which information was put. They described the relationships which were intended among the information sub-systems and the deficiencies which exist, primarily lack of departmental control over design, coordination and operation of information systems essential to program evaluation and management control. In addition, a review of the current MIO contract revealed that through the years the state simply had not monitored or audited the fiscal intermediary contract to protect against excessive profits.

The Medi-Cal administrator agrees with the Commission on the need to revise the eligibility information system immediately, with outside consultant assistance, so that its development can coincide with the Medi-Cal intermediary operations procurement project. This will make more accurate on-line eligibility information available to the Department and to the fiscal intermediary. Errors would be reduced and the intermediary could develop profiles of the provision of services to detect abuse by both beneficiaries and providers. Such studies would be far more accurate with an improved eligibility file.

However, the Department of Finance has expressed reluctance to permit such a consultant contract without a prior six-month feasibility study to test whether the Department has an independent capability to develop an on-line system. The Commission strongly believes that the Department requires outside consultation, and that there is much to be gained in the concurrent development of the on-line system with the redesign of the claims processing system. The new contractor for claims processing is being asked to assume risks relating to erroneous payments. He cannot assume such a risk as long as he is dependent on an error-ridden eligibility file controlled and supplied by the state.

Concern continues over the fragmentation of Medi-Cal program controls. The Commission is encouraged that the Medi-Cal administrator agrees with the need to consolidate basic control functions within the Medi-Cal Division. As indicated in the supplemental recommendations in this report, the Commission urge that this reorganization be accomplished as soon as possible. Following are the control functions and where the authority over them currently lies--the Department

of Benefit Payments (DBP), the Medi-Cal Intermediary Operation (MIO), the Medi-Cal Division (MD), or the Division of Administration (DA):

Medical policy standards and criteria (MIO)
Criteria and enforcement of quality standards (MIO)
Utilization review standards (MIO)
Treatment authorization review (MD)
On-site case review (MD)
Surveillance and utilization enforcement (DA)
Fiscal intermediary monitoring--on site (MD)
Prepayment audits/edits for medical procedures (MIO)
Claims adjudication (MIO)
Post-payment audits and analyses of statistical norms (Not Done)
Program audits and appeals (DBP)
Program investigations (DA)
Third party recovery (DBP)

Some of these control functions shifts are addressed in the Department's request for proposal for the new fiscal intermediary contract. These moves, together with other improvements either recommended or endorsed by the Commission, include:

1. The Department's immediate assumption of control over medical policy and criteria, prepayment audits, criteria and supervision of adjudication of claims, and systematic audits of post-payment claims. These controls would facilitate development of statistical norms for providing services, ordering of timely audits of suspect providers and prompt referrals for investigation to fraud and abuse units.

2. Development of criteria for a new contract to move away from the no-profit, no-loss payment arrangement which invites inefficiency. Instead, it would move toward fixed prices for claims defined in clear language, with contract features that place the intermediary at risk for errors which are attributed to his operational deficiencies.

3. State ownership of all systems developed by the contractor, and assurance of audit access to all subcontractors.

4. A stipulation that the state will share financially in the cost savings related to advances in technology in the operation of the fiscal intermediary function.

At last, Medi-Cal administrators appear to be moving some of the basic controls of the program into the Medi-Cal Division. The fiscal intermediary role is being properly redefined as fiscal agent for the state with a contract designed to implement basic program policies developed by the state.

F. Prepaid Health Plans

> "The prepaid approach to Medi-Cal should be preserved and strengthened." (pg. 159)
>
> "The Alternative Health Division should be abolished and the program be moved into the Medi-Cal Division." (pg. 159)

As recommended by the Commission, the administration of prepaid health plans and demonstrations has been moved into the Medi-Cal Division. If Senate Bill 660 relating to county health programs is signed into law, the administration of that program will also be placed in the division.

At the time of this review, 13 prepaid health plans in the state continue to serve about 120,000 enrollees. The same number of contracts have been cancelled since the Commission's last review, partly as a result of recommendations made by the Commission. The plans in force are much more closely monitored in regard to financial integrity and professional standards.

Manuals describing prepaid health plan performance criteria are in draft form. The department staff has developed a thorough and commendable set of standards and methods of review which appear to be equitable, reasonable and efficient.

Although many fewer Medi-Cal recipients are currently enrolled in prepaid health plans, the quality of care provided to them is deemed to be acceptable and the financial affairs of the plans are aboveboard and in order.

This accomplishment, significant in light of the agonizing history of prepaid health plans, has occurred through cancellation of contracts with providers who do not meet standards sufficient to qualify as federal health maintenance organizations.

An Assembly Bill is moving in the Legislature which further delineates the State's determination to strengthen the standards and performance of prepaid health contractors in the Medi-Cal program. A federally funded program, the Prepaid Health Research, Evaluation and Development Project, is currently under way in the Department of Health supported by funds from the U.S. Department of Health, Education and Welfare. This project is performing crucial studies of great potential value to both the State and federal programs by developing valuable data and information as follows:

1. A study of the rational basis for actuarial calculation of premium rates for all classes of recipients under prepaid plans.

2. A study of the characteristics and needs of those in the various programs and to explore better methods of marketing, enrollment and retention.

3. A study to develop methods of quality assurance and utilization reporting through the development of encounter data systems for recording and analysis.

4. A study of alternative models of organization for prepaid health providers and the pattern of services which they provide.

Contra Costa County's 'key' plan continues to be the pacesetter for significant progress in the organization, financing and delivery of county health services. This plan is now in the process of application for qualification by Health, Education and Welfare as a health maintenance organization.

To comply with federal law the creation of a community health commission is under consideration by the county board of supervisors to provide public, consumer and provider guidance to the operation and further development of the plan.

The plan is presently negotiating with the State Health Department to test the validity of enrollment of families and individuals not on the welfare roles, and to convey eligibility in the plan on an annual basis. The board has been asked to approve of enrollment of county employees.

Integration of preventive and primary mental health services is in progress on a decentralized basis in various parts of the county. They are being given first priority.

G. Foundations for Medical Care

> "The Department should show preference to Foundations for Medical Care in the selection of private fee providers on the basis of their record of claims review and hospital utilization control, to improve the quality of care..." (pg. 159)

As predicted in the Commission's 1976 report, the viability of prepayment contracts with Foundations for Medical Care for Medi-Cal recipients has proven to be marginal. Only one contract is still in force, the one with the Redwood Foundation in Sonoma County. All other contracts have been terminated. A recently completed analysis of the now defunct Sacramento County Foundation Prepaid Plan, the state's largest, reveals that no

savings were realized by the state compared to the cost of fee-for-service provision of care. However, the state should study the probability that quality of care and control of utilization was improved in the foundation plans, even though administrative costs may have been higher. If this proves to be the case, prepaid contracts for Medi-Cal recipients may be worth pursuing to assure quality of care at costs which are not higher than uncontrolled fee-for-service practice.

H. County Institutions

> "The traditional partnership should be restored between the State Department of Health and county institutions by removal of regulations designed for private providers which are inappropriate to public institutions." (pg. 159)
>
> "Formulas which determine county share of the cost of Medi-Cal should be revised to reflect variations in the proportion of indigents in the county population eligibility standards, the assessed valuation of the county, and growth of population." (pg. 156)

If enacted, SB 660 will provide a start toward implementing the Commission's 1976 recommendations concerning county institutions. This legislation would:

a. Provide financial assistance to counties to enable them to maintain present levels of service to medical indigents not eligible under Medi-Cal.

b. Provide grants to counties to develop alternative methods of paying for medical services (capitation, prospective budgeting, composite rates) and to expand and refine the prepaid approach to the delivery of comprehensive county health services.

c. Create a task force of state and county health administrators to develop major revisions in Medi-Cal for consideration by the Legislature two years hence. They would be authorized to define county responsibilities under Welfare and Institutions Code Section 17000 for levels of eligibility, service and county financial participation, based on assessed valuation and the size of the county's indigent population. The goal is to ensure that all Californians will receive equal access to health services they need, without regard to their county of residence, and that county contributions to the cost of services are made on an equitable basis.

d. Create a county health services information system to be operated on an ongoing basis.

e. Establish a conference of county health administrators.

f. Award planning grants to counties to encourage a wide variety of innovations in the way that ambulatory and preventive services are provided.

At this writing, the Administration is opposing stipulations in SB 660 which would require that counties which participate in new financial assistance under this bill must provide services to persons not legally resident in the county. This opposition represents denial of essential services to such groups as migrant health workers and undocumented aliens. The great majority of these individuals make significant economic contributions to the state through menial labor at marginal wages. California has an obligation to provide these workers with essential health services which they are unable to purchase for themselves. County institutions should not be forced to discriminate against patients in need simply because they do not meet a test of residence. The state, not local property taxpayers, should finance this humane obligation.

In the overview, though, SB 660 holds the prospect of restoring the traditional partnership between state and county government in providing health services to the poor--a partnership which was virtually destroyed by passage of the Medi-Cal reform program in the Reagan Administration.

I. University Medical Centers

> "The State should enter into contract negotiations between University of California and county institutions for provision of care to medical indigents. Contracts should be written to assure no loss of access to care by medical indigents not eligible under Medi-Cal reimbursement. The care of such indigents is both a state and county obligation. Contracts should also demand that a system of family oriented primary care be developed and preserved to coordinate care and referrals to specialty clinics. Such family oriented clinics should be located in the neighborhoods close to recipients and not only at the hospital site." (pg. 160)

A rational, equitable, long-term solution has not been devised for the perennial problems which mark relationships among the poor, the county governments and the state in relationship to providing health services in university-affiliated and operated hospitals.

The recent tentative agreement on renewal of the contract between the University of California at Davis and Sacramento County must be viewed as a signal accomplishment. But it is not accompanied by any basic solutions of the prominent disputes which characterized those contract negotiations. Similar problems prevail in Orange and San Diego counties where the University of California operates county facilities. These questions remain:

> "Who is responsible for payment of uncompensated losses which occur in the operation of a county-university facility intended to serve a predominantly poor population?"
>
> "How can universities be persuaded to develop effective primary care services to poor families, rather than subjecting them to the confusing complexity of a departmentalized and specialized care lacking in supervision and continuity for the family?"
>
> "How can universities modify the excessive costs of services they provide to individuals and families who have marginal ability to pay to counties responsible for paying the bills of medical indigents?"
>
> "What can be done to prevent university-county hospitals from developing highly expensive technological services which duplicate services already available in the community?"

These problems prove to be highly recalcitrant and resistant to solution, except for the temporary accommodations reached in a tense atmosphere of an emergency negotiation.

For the Medi-Cal program, the primary concern should be the welfare of recipients and the pursuit of more orderly and rational approaches to reimbursement policy. The facilities should provide Medi-Cal recipients with services which are well organized, sensitive to their needs, continuous in supervision and fairly priced--especially for those numerous families who are expected to pay part of the cost of the services.

J. Planning and Evaluation

> "The system of collection, organization and analysis of data in Medi-Cal should be premised in the future on these changes in policy:
>
> " -Selection, and hence reduction, of the numbers of providers in Medi-Cal." (pg. 162)

" -Selection of providers on the basis of systematic review in all treatment settings, of compliance with a very specific statement of professional performance standards developed by the Department of Health. (pg. 162)

" -Assumption by the state of the fiscal intermediary function, in phases, on the basis of a planned reduction in the volume of procedural billings. (pg. 162)

" -Much expanded investment by the state in organized, comprehensive prepaid health delivery systems and in prospectively budgeted contracts with county institutions, Institutes for Medical Care, consumer-sponsored, federally assisted programs ... and with State Health Department-sponsored innovative demonstration programs." (pg. 162)

The new director of the Medi-Cal program is prepared to establish an independent unit, reporting directly to him, with the responsibility of evaluating on a continuing basis the information being generated within the Medi-Cal program. The unit would review and catalogue reports, examine their accuracy and potential value, and eliminate those of marginal value in order to improve management practices and to increase the flow of crucial information to the general public.

This unit would conduct studies critical to the efficient performance of the program. As a result of these studies and evaluations, the unit would draft policies to improve the program and integrate the systems of information in such a way that comparisons can be made in the performance of various providers.

IV. AUGUST 1977 SUPPLEMENTAL RECOMMENDATIONS

1. The Department of Health, the Legislature and the State Administration should take steps to carry out those 1976 Commission recommendations which have not been implemented, particularly those referring to state assumption of fiscal intermediary operations, maximizing benefits, comparative performance studies of types of providers, more timely audits of major providers and conversion to reimbursement methods which do not require claims processing.

2. The Department should move into the Medi-Cal Division all program activities deemed necessary for effective management, specifically the central eligibility identification information file, all authority for setting rates and fees, and program controls which are now located in the fiscal intermediary operations, with the Department of Benefit Payments, or in the Division of Administration.

3. A unit should be created in the Medi-Cal Division which reports directly to the Medi-Cal Director and performs these functions: Program planning and evaluation, special studies, maintaining effective, consolidated information systems, design and updating of reporting formats, and policy development.

4. Three operating sections of equal status should be organized within the Division: Alternative health systems, fee-for-service program management and administrative support services.

(The attached organization chart illustrates the administrative reorganization proposals enumerated in recommendations 2, 3 and 4 above.)

5. Department staff should be trained in the application of computerized controls on the quality of payment systems and medical services. Experience has proven the hazards of a failure to monitor fiscal intermediary operations more closely.

6. Department personnel should be placed on site in sufficient numbers to ensure that contractors comply with fiscal and medical care standards.

7. The Department should immediately initiate steps to revise the eligibility information system, with the assistance of an outside consultant, to provide the Department and the fiscal intermediary with more accurate eligibility information and permit daily updates of status.

8. The Department should be more vigorous in requesting federal waivers in order to perform tests of simplification of eligibility. The Department also should study lengthening the eligibility period and methods to provide improved control of eligibility.

9. The contract with the California Dental Service should be extended, with the requirement that treatment norms be redefined and that providers who demonstrate questionable standards of performance shall be removed entirely from the program.

September 20, 1977

A D D E N D U M

Following completion of field work on this report, the State Health Department notified the Governor and the Legislature of a projected overrun of $200 million in the Medi-Cal Program (for Fiscal Year 1977-78). The tentative explanation was a sharp increase in the numbers of individuals qualifying as medical indigents under a simplified standard of eligibility.

Validation of this projected deficit was not feasible, due to the press of other business in the closing days of this session of the Legislature.

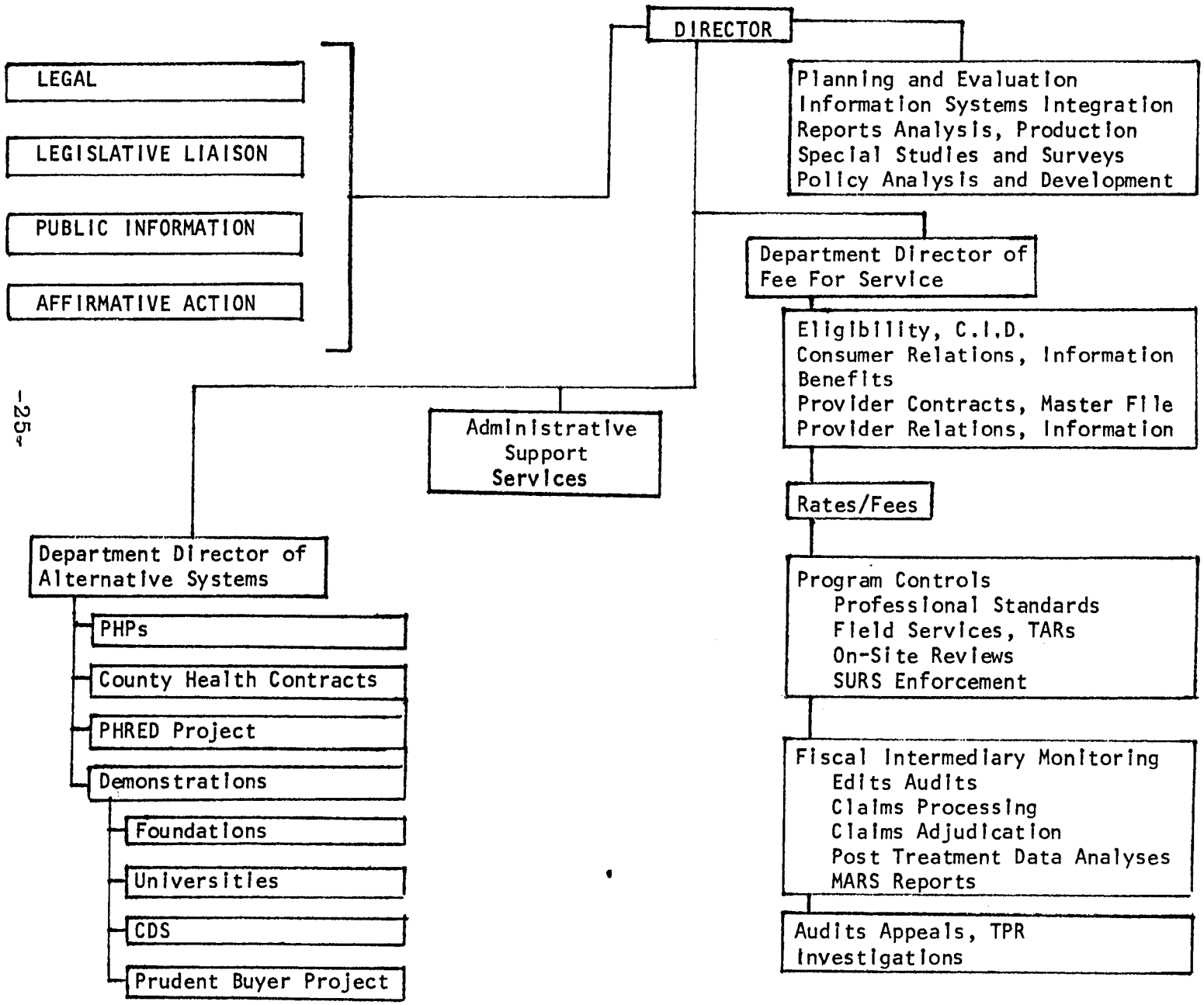
The Ways and Means Committee of the Assembly took the following actions which bear upon the substance of this report:

1) SB 660 on financing of county services was placed in its suspense file to be reactivated in January 1978.

2) Action on the projected $200 million deficit in the Medi-Cal Program was deferred until January, pending the provision of credible documentation of the projected deficit by the State Health Department, in face of the existence of a large surplus in the General Fund.

3) No change in Medi-Cal law was considered to be necessary in regard to services covered, standards of eligibility or rates of payment until January 1978.

The Commission is convinced that costs attributable to provision of unnecessary services by unscrupulous providers must be dealt with on an urgent basis in order to prevent cutbacks either in eligibility or in health services essential to the poor.

The staff of the Commission will provide further reports on the Medi-Cal crisis and the progress in the implementation of its recommendations by the State Health Department.

MEDI-CAL DIVISION