STATE OF CALIFORNIA GEORGE DEUKMEJIAN, *Governor*

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

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May 18, 1987

The Honorable George Deukmejian
Governor of California

The Honorable David A. Roberti
President pro Tempore of the Senate
and Members of the Senate

The Honorable Kenneth L. Maddy
Senate Minority Floor Leader

The Honorable Willie L. Brown, Jr.
Speaker of the Assembly
and Members of the Assembly

The Honorable Patrick Nolan
Assembly Minority Floor Leader

Dear Governor and Members of the Legislature:

The Commission on California State Government Organization and Economy, also known as the Little Hoover Commission, has had an on-going interest in the State's management and operation of its health care programs. Since 1975, the Commission has conducted numerous hearings and issued several reports presenting recommendations to improve the efficiency of the Medi-Cal program. The Commission was one of the first bodies to recommend the prudent buyers approach to the purchase of hospital care under Medi-Cal and was very pleased when, in 1982, major reforms to control the cost of the Medi-Cal program were enacted.

In the past five years, numerous changes have been undertaken to implement the 1982 Medi-Cal reforms. Considering the magnitude of the changes that have occurred, the Commission determined that it was an appropriate time to assess the impact of the Medi-Cal reforms and determine if any further changes and improvements are warranted in the Medi-Cal program. To do this, the Commission held a fact-finding hearing in December 1986 and studied additional information on the impact of Medi-Cal reforms.

The Commission found that the Medi-Cal reforms have resulted in significant cost savings to the State and have encouraged hospitals to be more cost conscious. However, the Medi-Cal reforms have had a severe fiscal impact on county hospitals, which serve a disproportionately higher share of Medi-Cal and medically indigent patients. In addition, the Commission found that the Medi-Cal reforms may have encouraged patient "dumping" and may have resulted in poorer health for some medically indigent adults.

The remainder of this letter provides background on the Commission's previous involvement in reviewing the Medi-Cal program, presents an overview of the State's current Medi-Cal financial problems, describes the effects of the Medi-Cal reforms, and presents our Commission's recommendations.

COMMISSION'S PRIOR INVOLVEMENT REVIEWING MEDI-CAL

The Medi-Cal program in California has undergone continuous change during the last twenty years. As part of its independent oversight of the Executive Branch of State government, the Little Hoover Commission participated in the public policy dialogue which led to many of the Medi-Cal reforms. For example, the Little Hoover Commission began a series of public hearings in 1977 that spanned a five-year period. These hearings examined a variety of issues that were having an impact on the operation of Medi-Cal, including annual increases in program costs, the passage of Proposition 13, and the economic recession of the late 1970s and early 1980s.

In June 1982, the Legislature implemented major Medi-Cal reforms through the passage of a series of bills designed to control the rapidly increasing costs of the program. These bills shifted certain funding responsibilities from the State to the county level and provided fiscal incentives to reduce costs. These reforms included competitive bidding for services through the Selective Provider Contracting Program. This program authorized a special negotiator, or Medi-Cal "Czar", whose responsibilities were later assigned to the California Medical Assistance Commission, to negotiate contracts on a competitive basis with hospitals which provided the most cost-effective bids for the provision of specified in-patient hospital services. Hospitals that were not awarded contracts were precluded from serving Medi-Cal recipients except in medical emergencies. This replaced the old "fee-for-service" system based upon "reasonable cost" in which all hospitals who wished to provide services to Medi-Cal recipients were permitted to do so and subsequently billed the State for those services.

Another feature of the 1982 Medi-Cal reform package was the transfer of responsibility for care of medically indigent adults (MIAs) from the Medi-Cal program to the counties. The counties were to determine eligibility for the MIA program, and to provide medical care for those eligible. To fund MIA care, the State initially provided the counties with 70 percent of the funding which previously had been used to provide Medi-Cal services to this population. Since 1982, this funding level has been adjusted on a county-by-county basis.

The Medi-Cal reforms also resulted in initial decreases in reimbursement to health care providers. At the time that the reforms were enacted in 1982, the Legislature stipulated that there was to be a 10 percent decrease in reimbursement rates for all health care professional services and institutional patient services. Further, a policy of granting "no net increases" in future funding was adopted. As part of the change in the reimbursement structure, the legislation encouraged health care providers that provided medical services on a "capitated" basis, i.e., flat fee per person per month, rather than the "fee-for-service" basis. This was done to encourage a unified case management system of services, and a reduction of duplicated or redundant services. Cost avoidance was provided by coordination of records and services. In addition, it was hoped that this payment method would encourage the practice of preventative medicine, thereby further limiting in-patient hospital costs. Subsequently, the

Governor and the Legislature have granted cost-of-living adjustments to various categories of providers.

Finally, the Medi-Cal reforms provided for an increase in state administrative reviews. These included increased claims and utilization reviews, increased procedures for prior approval of medical procedures, and changes in the manner in which claims were processed for payment.

EFFECTS OF MEDI-CAL REFORMS

The combined effect of the Medi-Cal reforms of 1982 has been dramatic on all the parties involved in the Medi-Cal system, including hospitals, physicians, other health care providers, and current and former Medi-Cal recipients. The Commission examined three major areas that have been affected, including the fiscal cost to the State, the effects of the reforms on the various categories of acute-care hospitals, and the impact on the availability and quality of care for current and former Medi-Cal recipients. Each of the areas are discussed separately in the following sections.

The Medi-Cal Reforms Have Resulted in Significant Cost Savings for the State

In the period from 1982 through the present, data collected by both the California Hospital Association (CHA) and the Office of Statewide Health Planning and Development (OSHPD) indicates that in-patient hospital costs are being contained. The change in reimbursement practices, a reduction in inflation rates, a significant increase in cost control practices by hospital management, and the general "no-net-increase" policy implemented by the State for payment of Medi-Cal benefits have contributed to minimize the annual increase in Medi-Cal costs to less than a third of what it was prior to 1982. Moreover, contracted hospital expenditures have increased at slightly above the rate of expenses when controlled for inflation.

The California Medical Advisory Commission (CMAC) estimates that the cost savings in the hospital care program in FY 1982-83 were only $13 million out of an expenditure of almost $1.8 billion. However, these cost savings have increased to the point that the CMAC projects there will be $385 million in cost savings out of a total in-patient hospital expenditure budget of $1.3 billion in FY 1986-87.

Meanwhile, the total budget for Medi-Cal health benefits, after reaching a high of $4.91 billion in FY 1982-83, dropped initially but has gradually increased over the last four years. It is currently estimated that the cost of Medi-Cal benefits will total approximately $5.14 billion in FY 1986-87.

In December 1986, the Department of Health Services announced that there would be a deficit of approximately $178 million in the Medi-Cal operating budget for the current year. This deficit was due to a number of factors, including:

- a $115 million variance in the amount of funding needed for benefit costs;

- o $19.6 million in unbudgeted but mandatory nursing home cost of living allowances;

- o $14.6 million in court-ordered nontheraputic Medi-Cal abortions;

- o $26 million for an unbudgeted "checkwrite" payment to Medi-Cal providers; and

- o $2.8 million in other areas, such as adjustments for accelerated provider claims.

The Governor and the Department have taken preliminary steps to reduce the current year deficit in Medi-Cal funding. These steps include:

- o A 10 percent reduction in the reimbursement rate for most Medi-Cal providers, including physicians, dentists, and out-patient clinics. This reduction, if implemented, is expected to save approximately $18.7 million in the current fiscal year. However, the reduction does not extend to hospital in-patient and long-term care facilities, or obstetrics services. However, a pending court case may mitigate or cancel the effect of this measure.

- o A proposed change in the treatment utilization review procedures used by the Medi-Cal fiscal intermediary. This step was originally anticipated to save the General Fund approximately $4.2 million in the current year and increased amounts in future years. However, the actual amount of money to be saved is still in question.

The exact details of the measures to be used in meeting the current year deficit are now being considered by the Legislature and Governor. Senate Bill 690, Chapter 11, Statutes of 1987, appropriated $215.2 million in General Fund monies for additional reimbursement of Medi-Cal providers in FY 1986-87.

For FY 1987-88, the Administration has initially proposed spending a total of $5.165 billion in Medi-Cal benefits, $2.581 billion of which would come from the state's General Fund. This expenditure is accompanied by a number of proposed program changes which will result in a net savings of approximately $75.01 million to the General Fund. These proposed changes include:

- o A major restructuring of the Medi-Cal program, estimated to save $37.0 million in General Fund expenses. The details of the restructuring were specified in the Governor's Medi-Cal reform package issued May 11, 1987.

- o A variety of cost avoidance and recovery initiatives, estimated to save approximately $24.5 million in General Fund monies.

- o Restrictions on nontheraputic abortions, estimated to save $14.7 million. However, some substantially similar provisions have been overturned by the courts in each of the last several years.

- o A six-month postponement of the AFDC Medi-Cal cost of living adjustment from July 1, 1987 to January 1, 1988, which would reduce General Fund costs by $4.5 million.

- o An increase of $4.2 million to cover the initial operating costs of the San Mateo County Health System.

- o An increase of $1.49 million in General Fund monies to increase rates currently paid to intermediate care facilities for additional supervisorial staff for certain groups of the developmentally disabled. These proposed changes, along with others being considered, are currently being considered by the Joint Medi-Cal Task Force established by the Legislature.

Although the Medi-Cal program is currently experiencing some budgetary problems, it is evident that the Medi-Cal reforms have helped to contain in-patient hospital costs in the past five years. However, in view of the present budgetary crisis in the Medi-Cal program, policy makers are reassessing which health services the State should fund and at what level such services should be provided.

The Medi-Cal Reforms Have Encouraged Hospitals to be More Cost Conscious

The selective cost contracting and the utilization assessment and cost containment provisions of the Medi-Cal reforms have had an impact on how hospitals in California conduct their business operations. According to information gathered by the CHA, the State's 537 general acute care hospitals have been showing an increase in net profit and surplus revenue since 1981. For many hospitals, this has been accomplished by the imposition of cost containment measures, such as those encouraged by the Medi-Cal reforms and the operation of hospitals in a more business-like manner.

Hospitals with Medi-Cal contracts have changed their business practices to qualify for contracts, while non-contracting hospitals have taken almost the same measures to remain competitive for private health insurance contracts. In addition, the Medi-Cal contracting reforms have triggered the use of similar competitive bidding and cost containment measures by private carriers of health care.

The utilization of more expensive hospital in-patient services has been decreasing since the Medi-Cal reforms were instituted in 1982 and only began to stabilize in the first quarter of 1986. Although specific figures vary from one organization to another, all agree that the pattern of in-patient utilization has changed drastically. The use of hospital out-patient and clinic services has increased an average of four percent every calendar quarter since 1983. In addition, the overall fiscal health of many hospitals has continued to be good through the present date.

The Medi-Cal Reforms Have Had a Severe Fiscal Impact on County Hospitals

Prior to 1982, the State Medi-Cal program was responsible for caring for MIAs. One aspect of the 1982 reforms was the shift of responsibility for care of MIAs from the Medi-Cal program to the counties and county

hospitals. With that shift in responsibility, the State provided counties with 70 percent of the fiscal year 1981-82 expenditures for MIAs.

County hospitals have historically maintained high Medi-Cal patient loads, both prior to and subsequent to contracting. When the MIA caseload was added to this already considerable caseload, county hospitals experienced, and are continuing to experience, an extreme crisis in payment for in-patient services. In 1985, approximately 44 percent of all in-patient days in county hospitals were Medi-Cal patients, and an unknown number were medically indigent patients. With a lack of sufficient initial funding, and with no subsequent cost of living adjustments, county hospitals now estimate that they are receiving only 61 percent of the reimbursements needed to cover the cost of in-patient care for MIAs. This lack of funding has forced many counties to impose stringent requirements for MIA eligibility, thus limiting the size of the MIA population that qualifies for services and the type of services they receive.

County hospitals also are having extreme problems with providing undercompensated care. The gift subsidies and voluntary donations available to county hospitals, along with the funds from the State's medically indigent services program, offset less than half of the cost of bad debt and charity care in the county hospitals. The CHA, in conjunction with the California State County Hospital Association, is currently conducting research to determine the specific impact this large demand for uncompensated care is having on county hospitals. However, they have tentatively concluded that the survival of several county hospitals is threatened by the loss of paying patients and the increase in the number of non-paying or under-paying patients in these facilities.

An example of this problem is the fact that San Bernardino County Medical Center opted out of the Medi-Cal program in December 1986. According to the hospital's chief administrator, at the time the hospital left the Medi-Cal program it was being reimbursed $200.00 per day less for each Medi-Cal in-patient than the hospital's actual cost. In addition, the hospital had incurred a deficit of approximately $2.5 million in FY 1985/86 for the treatment of MIAs.

The Medi-Cal Reforms May Have Encouraged Patient "Dumping"

The cost containment measures and the contracting provisions of the Medi-Cal reforms resulted in a significant change in the manner in which health care was provided to the recipients. In-patient hospital days decreased significantly beginning in 1982 and have only recently stabilized at a level approximately 35 percent lower than in fiscal year 1981-82. Out-patient and clinic services have been encouraged both by the contracting hospitals and also by subsequent direct action of the State Legislature in providing funding for such facilities. According to data from both the CHA and the OSHPD, in-patient utilization has decreased an average of 2 1/2 percent each quarter since the beginning of 1983. At the same time, utilization of out-patient services has increased an average of 15 percent per year over the same period.

This change in practice setting and level of care, combined with the termination of benefits or change in benefit levels for a number of

recipients, appears to have led to some major problems. First is the continuing allegation that non-Medi-Cal contracting hospitals are "dumping" Medi-Cal and medically indigent patients on county or contracting hospitals. Current federal law requires all hospital emergency rooms and emergency physicians to provide emergency care regardless of the patient's ability to pay. County hospitals and other Medi-Cal contracting facilities, among others, have indicated that current statutes do not prevent patient "dumping." For example, at a special hearing of the Assembly Joint Committee on Medi-Cal Oversite held in Alameda County in December 1985, evidence was introduced of the apparent widespread practice in the East Bay of transferring patients who were critically ill or in need of acute emergency care from non-contracting hospitals to either county hospitals or contracting facilities. Among the cases cited at this hearing were the following:

- An Oakland man who was shot during a dispute was taken to a private hospital which did not have a Medi-Cal contract. He was allegedly left without anything other than minimal emergency treatment for 18 hours until he was transferred to a contracting hospital. Physicians at the contracting hospital stated that the man had received no treatment aside from minimal use of pain killers and inadequate bandaging of the wound. In addition, it appeared that little or no effort was made to clean the wound or to stabilize the man's condition. The patient's relatives had alleged that at the time he was taken to the non-contracting hospital's emergency room he was asked whether or not he had private insurance. Upon being told that the relatives could not find documentation of coverage, he was refused treatment and was told he would be transferred to either the county hospital or a contracting facility; and

- In December 1985, a pregnant woman in labor entered the emergency room at another non-contracting facility in Alameda County. She was allegedly told that her Medi-Cal status was unclear and that they could provide no help. She then went to a second non-contracting hospital where she was also turned away. At the second hospital, a fetal monitor was used and it was determined by the staff of that facility that the baby was in medical distress. The woman was then driven in a car to a county hospital where she was admitted. Her baby was delivered stillborn 30 minutes after arrival. The physician who handled the delivery indicated that "this was a full-term baby that would have been alive right now if the system hadn't shuffled her around."

Numerous other instance of "dumping" Medi-Cal and medically indigent patients throughout the State have been cited at various times, but as yet there has been no statistically valid work done on the incidence of patient transfer from non-contracting to contracting facilities. Furthermore, no statistically valid study has been done on the medical conditions and outcomes of the patients moved. Both the CHA and the OSHPD have indicated that to the best of their knowledge there has been no deterioration in the quality of health care either for Medi-Cal or MIA recipients.

The Medi-Cal Reforms May Have Resulted in Poorer Health for Some Medically Indigent Adults

The responsibility for the care of MIAs was turned over to the counties as a part of the 1982 reform package. At the same time, the requirements for admission to the program were made more stringent. In addition, the counties were given further indirect incentive to tighten requirements and cut MIA caseloads by virtue of the decrease in state funding from 100 percent to 70 percent of the prior year's funding. As a result, the Medi-Cal reforms may have had a negative impact on the health of MIAs.

In 1983 and 1984, a special study was made by the University of California-Los Angeles School of Medicine regarding the effects of the termination of Medi-Cal benefits and the transfer to county care on the physical health and well being of a sample group of MIAs. This study showed that a minimum of 68 percent of the 186 patients surveyed reported at least one specific episode in which they had not obtained care that they believed necessary. Seventy-eight percent of those patients not obtaining care specified cost as the reason for not obtaining it. Of the 186 MIAs surveyed, a total of 7 died during the one-year study period from January 1983 through January 1984.

The investigation of the circumstances of death in the study by the UCLA Medical School suggested that the lack of access to medical care or insufficient medical care played a major role in at least four of the seven deaths. These four cases included a presumed heart attack by a cardiac patient who had run out of medication, a perforated ulcer by a patient who delayed seeking care for 10 days because of her inability to pay, a brain hemorrhage by a hypertensive patient who had run out of medicine, and pneumonia and malnutrition by a diabetes patient who delayed obtaining care due to lack of funds. The general health of the patients surveyed deteriorated to a significant extent according to this study. The study concluded that although further research is needed in several areas, the reforms of Medi-Cal may have resulted in poorer health in affected patient populations.

RECOMMENDATIONS

The Commission recognizes the severe financial problems that the Medi-Cal program is currently facing. To cope with these financial difficulties, the Governor and the Legislature are presently considering a number of potential solutions. While the Commission realizes that some significant changes may be necessary to keep the Medi-Cal system afloat, the Commission believes the current crisis also creates a "window of opportunity" to address not only the overall funding level of the Medi-Cal program, but also the problems of uncompensated care and access to health care by the medically indigent. Specifically, the Commission recommends the following:

1. The Governor and the Legislature should support reforms which strengthen existing law prohibiting illegal patient transfers and nonadmissions. Patient transfers or referrals from hospital emergency rooms to other facilities should be allowed only when needed speciality or tertiary care is not available at the

transferring facility, or when the patient has been medically stabilized and can safety be transferred. The legislation should define the conditions under which patient transfer or nonadmission is permissable and should further provide the Department of Health Services and the Board of Medical Quality Assurance with authority to discipline hospitals and individual physicians after an appropriate administrative hearing and adjudication.

2. The Governor and the Legislature should allocate additional funding to disproportionate share in-patient hospital providers of Medi-Cal services. Specifically, the Legislature should make a separate appropriation of funds to be distributed on a sliding-scale basis to disproportionate share in-patient hospital providers. These funds should be provided over and above the rates that contract hospitals negotiate with the California Medical Assistance Commission.

3. The Governor and the Legislature should jointly appoint a study commission on uncompensated care and access to health care by the medically indigent. The commission should be comprised of representatives of affected health care providers, the medically indigent, and the Department of Health Services. The commission should work with public and private agencies to develop a concensus and recommendations for improving access to care for the medically indigent.

4. The Governor and the Legislature should consider establishing an augmented revenue pool to cover the cost of care to current MIAs and noneligible medical indigents. The pool could be funded by state MIA appropriations to the counties, and possibly by an increased excise tax. Such funding would be required to be spent specifically on care for the medically indigent.

The Commission believes that the Governor and the Legislature should take these actions to ensure that the Medi-Cal program can provide access to adequate health care services for all the citizens of California, including medically indigent adults, while at the same time recognizing the financial demands made upon disproportionate share providers of Medi-Cal services.

Sincerely,

NATHAN SHAPELL, Chairman
Haig Mardikian, Vice Chairman
Senator Alfred Alquist
Mary Anne Chalker
Albert Gersten, Jr.
Senator Milton Marks
Assemblywoman Gwen Moore
M. Lester Oshea*
George E. Paras**
Abraham Spiegel
Richard Terzian
Jean Kindy Walker
Assemblyman Phillip Wyman*

* Commissioner's Oshea and Wyman dissent from this report. A letter of dissent is attached to the report.

** Commissioner Paras was not a member of the Commission when this study was commenced.

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JOINT COMMITTEE ON THE
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Commission on California State
Government Organization and Economy
1127 - 11th Street, Suite 550
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May 12, 1987

We believe the facts presented in the report on Medi-Cal reforms do not support its recommendations for increased funding.

The Legislature, in enacting the Medi-Cal reforms of 1982, took various steps to control the burden on California taxpayers imposed by Medi-Cal and to encourage economies in state-subsidized health care, including transferring responsibility for determining MIA eligibility to the counties. It was understood that in some cases, beneficiaries would receive a different level of services as a result of the reforms. However, the report focuses on isolated incidences that might appear to represent the statewide effects. We believe this misrepresents the true picture of our state and counties' efforts to provide necessary medical services to medically indigent persons. A more realistic representation would also portray the many California taxpayers who pay for their own medical care but do not have access to the variety or volume of services currently available to Medi-Cal recipients.

Government's role is not to provide services to the poor that exceed services the average taxpayer can afford for himself or herself. This Commission continually hears pleas for increased funding at its hearings. Yet resources are not unlimited and many taxpayers are far from affluent. No data have come to our attention that would suggest that California lags in this area. Rather, to the extent that data on coverage under Medi-Cal and comparable programs in other states are indicative, the contrary is suggested. California provides subsidized medical care to 13 percent of its residents, compared to a national average of 8 percent. California also provides 30 of 32 optional programs to Medi-Cal beneficiaries.

We appreciate the inclusion of several of our comments in the report on the Medi-Cal reforms, however, we must disagree with recommendations 2, 3, and 4 contained in the report. We also believe the following recommendations should be considered by the Governor and the Legislature:

1. Consider reviewing existing eligibility categories of persons that the federal government does not require the state to cover. Additionally, the Governor and the Legislature should review existing optional benefits provided under the Medi-Cal program, as California currently provides 30 of the 32 federal optional benefits besides several state-only programs.

2. Consider alternatives in order reduce long-term care costs to accommodate California's increasing aging population. Such alternatives could include long-term insurance, community-based services to enable people to remain in their own homes longer, and tax-deferred health savings individual retirement accounts so that our younger population can save toward their future long-term care needs.

3. Consider increasing Medi-Cal beneficiary copayments and extending copayment requirements to all services except inpatient hospital and those exempt under federal law.

4. Consider streamlining Administrative procedures wherever possible, including eliminating the regulatory process for setting Maximum Allowable Ingredient Costs (MAIC's) for drugs, and establishing mandatory arbitration for capitated contracts to facilitate appeals and malpractice claims.

We dissent:

Assemblyman Phillip D. Wyman
Commissioner

Lester Oshea
Commissioner