A SMARTER WAY TO CARE:

TRANSFORMING MEDI-CAL FOR THE FUTURE

LITTLE HOOVER COMMISSION

May 2007

State of California

LITTLE HOOVER COMMISSION

May 24, 2007

The Honorable Arnold Schwarzenegger
Governor of California

The Honorable Don Perata
President pro Tempore of the Senate
and members of the Senate

The Honorable Dick Ackerman
Senate Minority Leader

The Honorable Fabian Núñez
Speaker of the Assembly
and members of the Assembly

The Honorable Michael Villines
Assembly Minority Leader

Dear Governor Schwarzenegger and members of the Legislature:

The leaders of this state have opened an important and vigorous debate on health care, looking to solve the problem of the people of California who lack health care insurance, a problem that vexes the rest of the nation as well.

If it leads the change, California can play a powerful role in reshaping health care in the United States.

To truly start the process, the state will have to transform the Medi-Cal program as well. As California's single largest purchaser of health care, the Medi-Cal program is too big to be an afterthought in the debate on how to untie the knot of rising health costs, the lack of affordability, and the growing burden of cost-shifting on business.

For far too long, the state has focused on what Medi-Cal is paying for health care, not on what it is buying. The sheer size of the Medi-Cal budget – $37.7 billion and growing fast – demands a smarter approach.

To save money, the state has held down reimbursements to providers, weakening California's health infrastructure and, as the governor described, putting a hidden tax on the businesses that buy health benefits for their employees.

Better by far for the state to focus on what the state is buying for its billions – better for accountability to taxpayers and better for delivering promised health benefits to California's poor and disabled. By knowing what it is buying, the state can focus its dollars on what works to improve the health of Medi-Cal's 6.6 million enrollees. And it can stop spending money on treatment that doesn't add value.

Major purchasers of health care in the private sector have used this strategy for years. And they are purchasing care from many of the same health plans, physicians and hospitals Medi-Cal does. The federal government is getting involved as well, asking states to transform their Medicaid plans into value-driven purchasers of health care.

But Medi-Cal is not prepared for this transformation. Nor is the program prepared for rising costs the state has said will make Medi-Cal unsustainable in its current form. Medi-Cal represents 15 percent of the state's General Fund expenditures. Left unchanged, Medi-Cal's growth rate is on course to expand to 19 percent in 2010 and 21 percent in 2015.

Milton Marks Commission on California State Government Organization and Economy ◆ http://www.lhc.ca.gov/

925 L Street, Suite 805 ◆ Sacramento, CA 95814 ◆ 916-445-2125 ◆ *fax* 916-322-7709 ◆ *e-mail* littlehoover@lhc.ca.gov

Medi-Cal's cost trends only will be exacerbated by demographic shifts ahead, swelling the numbers of seniors in the program as Baby Boomers retire.

The federal government has made it clear; so do the cost and demographic trends: The old approaches aren't going to work any more. With the debate about health care finally underway, the governor and lawmakers must take this opportunity to talk bluntly and honestly about Medi-Cal's future.

The governor must articulate a vision for the transformation of Medi-Cal, one that meets head-on the challenges the program faces. The newly reorganized Department of Health Care Services must give the governor a strategic plan to deliver on that vision.

For the health of California's people – and to reduce the future number of Medi-Cal seniors with high-cost medical issues – the state must build its health policies around prevention. And these prevention policies can be extended to include attention to the chronic conditions that affect 38 percent of California's population.

Increased emphasis on using Medi-Cal managed care is one avenue to increase prevention and chronic care activities.

Another promising avenue lies in the innovation the Commission saw in visits to community health clinics and large urban medical centers. Counties and community groups are finding new ways of serving their very different populations in ways that address the specific needs of different cultural groups.

In their ability to provide cost-effective primary care tailored to their community's needs, they reach people who might otherwise not be pulled into an organized system of care, people who might otherwise turn to far more expensive hospital emergency rooms for their primary care or wait to seek care until their medical problems permanently damage their health and the costs of their medical treatment skyrockets.

These clinics represent an immense current asset for the state. They also show potential to be even more valuable, by delivering higher levels of care, such as coordinated care for people with chronic conditions. The state should invest in this promising approach by funding pilot projects to foster innovation and by removing barriers to new, more cost-effective ways that clinics can deliver care.

The Department of Health Care Services also must invest in the basic analytic capacity that will allow it to measure and evaluate the care received by Medi-Cal's enrollees. Measuring outcomes is the key to accountability and effectiveness. It is crucial to Medi-Cal's transformation into a value-based purchaser of high-quality health care.

Other states have started the process, but California, if it can truly transform its Medi-Cal program, can drive the transformation of the system as a whole. To do so, the state must tap its rich resources of expertise at all levels of its health care system. It must learn from other examples, such as the Veterans Health Administration's transformation. And it must set loose the energy and ideas of its own committed professionals in state service.

Sincerely,

Daniel W. Hancock
Chairman

A Smarter Way to Care:
Transforming Medi-Cal for the Future

Table of Contents

Executive Summary i
Challenges Demand Change 1
Focus on Prevention 15
Driving Data to Transformation 31
Aligning Enrollment Process with Goals 45
Conclusion 55
The Commission's Study Process 57
Appendices 59
- Appendix A: Public Hearing Witnesses 61
- Appendix B: Advisory Panel and Site Visit Participants 63

Notes 67

Table of Sidebars & Charts

Spending per Beneficiary 2
Medi-Cal Budgeted General Fund Expenditures 4
Recommendations from Secretary Leavitt's Medicaid Commission 5
Medicare and Medicaid 6
Medicaid 7
Transforming Government: Lessons from the VHA 12
Beneficiaries and Cost 15
Preventive Care Services 16
Medi-Cal Beneficiaries in Fee-for-Service vs. Managed Care 17
Managed Care Penetration in the Ten Most Populous States 18
County Organized Health Systems (COHS) 21
Access to Care 22
Clinic Licensing 23
Perverse Incentives in Payment Structure 24
Care for Chronic Conditions 25
No one size fits all 26

Institute of Medicine on Value-Based Purchasing..... 32
The Care Management Institute at Kaiser..... 34
University Partnership for Data-Driven Policy in Medicaid..... 36
Health Information Technology..... 40
Shining a light on "never-events" 42
Consequences of Churning..... 45
A Patchwork of Programs 47
Medi-Cal Application Packet is Extensive..... 48
County Eligibility Computer Systems..... 51

Executive Summary

California's debate about health care is changing long-held assumptions and revealing new opportunities as features of the state's health care landscape are re-evaluated in a new light. The problems remain immense. But so does the potential for transformational change, to a degree unimaginable even five years ago.

Much of the focus of this year's debate has been on how the state can help extend health insurance to the 6.5 million Californians who lack health insurance.[1] It is an important discussion but incomplete without consideration of the 6.6 million low-income, senior and disabled Californians who rely on state government for health coverage through the Medi-Cal program, more formally, the California Medical Assistance Program.[2]

The Medi-Cal program is the second single largest investment the state makes, behind only education.[3]

Several of the recent proposals to provide health coverage to the uninsured involve the Medi-Cal program, but without addressing the fundamental weaknesses in the program, adding more people to Medi-Cal will only stress an already overburdened system.

As it is, the Medi-Cal program consumes $37.7 billion a year in state and federal tax dollars, but the Department of Health Care Services lacks a system or a structure to measure whether its outlays improve the health outcomes of its millions of enrollees.[4] Both taxpayers and enrollees deserve smarter spending.

Better measurement is essential, as costs in the program are rising rapidly, at twice the inflation rate and more quickly than the overall state budget.[5] By 2010, the Medi-Cal budget is expected to reach $53.9 billion, an increase of 43 percent from its current outlays. Of that total, $19.7 billion will come from the General Fund, an increase of 33 percent from the General Fund's $14.6 billion contribution in 2007.[6]

Medi-Cal's growth rate puts it on course to expand from 15 percent of the General Fund budget in 2003, to 19 percent in 2010 and 21 percent in 2015.[7]

In a 2005 reform attempt to slow rising costs, the department acknowledged that Medi-Cal's growth was not sustainable and, left unchanged, would force cuts in other parts of the budget or a need for higher taxes.[8] Nothing has changed and Medi-Cal's costs continue to outpace state revenues.

Also ahead is the retirement of the Baby Boom generation, set to become the state's fastest growing population group. Seniors already represent the fastest rising cost population among Medi-Cal's members, and their expanding numbers will fuel further cost increases in the program.

These dynamics are not limited to California. Faced with many of the same pressures, the federal government is pushing California and the rest of the states to transform their programs to increase health care quality, transparency and accountability.

But the Medi-Cal program isn't prepared to meet these challenges.

As the state grapples with the problem of the uninsured, California also must transform its Medi-Cal program. The governor needs to articulate a vision for that transformation and the reasons for it. The Department of Health Care Services needs to develop a strategic plan to reengineer the Medi-Cal program so that it can ensure that its health spending improves health outcomes for enrollees. It must focus its efforts on prevention and improved care of chronic conditions, to reduce the number of Medi-Cal enrollees who develop acute health problems and avoidable disabilities.

As the state's largest purchaser of health care, Medi-Cal has the potential to reshape the state's health care market for all Californians by measuring performance and using incentives to improve heath outcomes. To accomplish this, it will need to know its beneficiaries better, to know what care they are receiving, how it compares to what is recommended, and whether it is working. That will require not only a strategy, but the analytical power to inform policy making as well as the data management systems to support the analysis.

At the same time, the state will need to streamline and modernize its enrollment and eligibility process to bring it in line with federal requests for simplification. Lower enrollee churn will shrink administrative costs and reduce lapses in care.

When the Little Hoover Commission began its examination of publicly funded health care, one of its goals was to determine whether state operations could be made more efficient and whether potential savings could be used to extend coverage to more uninsured Californians.

The answer is a qualified yes, as the state will need to invest to modernize the program before it can realize any potential savings. In the short run at least, improvements in quality and access are likely to increase costs as enrollees find it easier to get health care and seek care for previously unaddressed or under-treated health problems.

If the state can show, however, that it is serious about transforming the Medi-Cal program, it can start to reap immediate dividends in accountability and legitimacy with taxpayers.

The Commission interviewed dozens of state and federal health officials, doctors, nurses, social workers and researchers and visited clinics and hospitals where Medi-Cal enrollees and poor people seek treatment.

What the Commission found was exciting:

- Non-profit community clinics providing primary care for poor people who otherwise might have turned to a much more costly hospital emergency room.
- Ways to use claims and payment records to identify people within a population with chronic diseases to ensure that, as a group, they were getting the most appropriate care.
- New methods of measuring value and quality that focus on outcomes – improved patient health – helping to ensure health dollars are spent most efficiently.

The health professionals the Commission met – inside the government and out – were passionate about improving health care and energized by the prospect of truly transformational change, change that will increase access to health care, improve health outcomes of patients and reduce inefficiency, waste and errors in the health care system.

This is encouraging, because the state – through its people, purchasing power and policies – can be a powerful catalyst for change. And as California's largest single purchaser of health care, the Medi-Cal program is the place to start.

Less than half of Medi-Cal's members are enrolled in managed care plans, despite research that shows managed care can lower costs and improve care, even for people with complex health needs.[9] Most of the program's beneficiaries with the highest cost health problems are not in managed care, but in fee-for-service part of Medi-Cal, where the state has little ability to coordinate care and lacks the tools to assess the value of the care they receive.

The state must enroll more of its aged and blind and disabled beneficiaries in managed care plans. But first, the state must ensure the plans are on stable financial footing so that they can handle the influx of new, high-need members. And it must put in place a system to evaluate readiness so that the state's most vulnerable citizens can be assured they will get high quality care.

To improve access to primary care that is the foundation of prevention, the Department of Health Care Services must bolster the state's network of community health clinics, and provide incentives for communities to try new approaches to primary care. The state must help California's clinics develop their capacity to deliver chronic care as well. In this way, the state can help these clinics serve Medi-Cal enrollees in the most cost-effective setting and reduce the burden of non-urgent visits to hospital emergency rooms. In many counties, clinics are parts of larger health plans, providing many of the coordinated care benefits and access to specialists that managed care offers. The state must create more opportunities for communities to innovate in this way.

In rural areas where Medi-Cal cannot enroll more of its senior and disabled beneficiaries in managed care, it must borrow the managed care strategy of disease management, which allows experts to focus on an enrollee's most serious health problems.

The state should lead by setting standards for health information technology and raising the quality bar for managed care plans serving all Californians. Additionally, the state should consolidate the purchasing power of all of its operations, including its mental health hospitals and the California Public Employees' Retirement System, to drive improvements in value and quality.

Governor Schwarzenegger's executive order on health information technology outlines a vision for how the state can lead in introducing new tools to connect patients, laboratories, pharmacies, hospitals and physicians. It is a vision that connects health information systems with the goals of transparency for consumers and accountability. It recognizes the importance of collecting and analyzing data to improve performance.[10]

To deliver on the governor's vision will require an action plan, and that plan must include transformation of the Medi-Cal program. Such transformation could not only improve health care for all Californians, but ultimately holds the potential to lower costs for all Californians.

Fear of such extensive change is understandable, especially in a program as complex as Medi-Cal. In addition to policy changes, transforming the

state's publicly funded health care system will require purchasing and installing new computer technology, critical to reducing fraud, speeding claims payment and organizing and analyzing patient records.

In state offices, however, there is a palpable apprehension of adding another failed state computer system to the list of expensive government technology debacles.

But there also is a growing national list of successful new computer systems, as well as new public-private approaches to tackling technology challenges. California can learn from the successes of other states. Harnessing the assets it has at hand and the opportunities within its reach, it can change the health care landscape in the nation's largest state and give others the chance to learn from its success.

California has paid the price in the past for its failure to size up its challenges and its opportunities honestly. The Medi-Cal program has to change. Rising costs, shifting demographics and a new federal stance demand it. Here the state has the opportunity to embrace the challenge and make Medi-Cal the model for the rest of the nation.

To their credit, the governor and legislative leaders have engaged in the debate about California's uninsured, developing proposals that reflect a deep understanding of the complex issues involved. But also they need to look at reform of the state's own operations as a critical component to any meaningful solution.

The debate – and the state – will benefit by making the transformation of Medi-Cal the starting point for revolutionary and lasting health care reform, using the state's purchasing power as leverage to improve the health of its most vulnerable residents and deliver true accountability to its taxpayers.

Recommendation 1: The Department of Health Care Services must transform the Medi-Cal program into a value-driven purchaser of health care. Specifically, the department should:

- ***Develop a strategic plan that emphasizes prevention.*** The state must adopt a strategic plan for transformation that emphasizes prevention through increased access to primary and chronic care. The strategic plan should include goals and timetables to:
  - ✓ Expand managed care where possible and provide medical homes and disease management programs where managed care is not an option. The plan should guide the department in managing costs and improving health through better coordinated care of chronic

conditions, a reimbursement structure that rewards improved health outcomes, and better health system transparency.

- ✓ Collect and analyze data on health care quality provided to its enrollees to guide policy and decision-making.
- ✓ Reduce barriers to enrollment for eligible Californians.

- ❑ ***Designate a leader and a strategy team.*** The department director must develop and articulate a long-term strategy to transform the Medi-Cal program. The director should designate an individual dedicated to directing the strategy and policy efforts of this transformation, separate from the responsibility for day-to-day operations of the program. That individual should lead a formally recognized strategy team located within the Medi-Cal program. Together with the strategy team, the leader should be focused on the long-term planning and program needs and projected changes within Medi-Cal's enrollee population.
- ❑ ***Develop a Medi-Cal succession plan.*** The Department of Health Care Services should take specific steps to develop leadership and management capacity for transforming the Med-Cal program to ensure that transformation efforts are not tied to specific individuals, but can outlast personnel and administration changes.
- ❑ ***Use Value-based purchasing.*** The Department of Health Care Services should adapt and adopt value-based purchasing strategies used by other large purchasers of health care, such as CalPERS and business consortiums, that build incentives for improved health quality outcomes into contracts with providers.

Recommendation 2: To improve health outcomes and spend public resources more efficiently, the Department of Health Care Services must ensure that Medi-Cal beneficiaries have access to care, particularly prevention and coordinated care. The department should:

- ❑ ***Strengthen and expand managed care.*** The department should increase the number of beneficiaries in managed care plans where such plans exist. To do so, it must revive the open stakeholder process to develop standards for readiness and plans to monitor managed care plans for their ability to care for elderly and disabled beneficiaries. The department also must ensure capitation rates are fair and provide incentives for improving health outcomes.
- ❑ ***Experiment with new approaches.*** The department must encourage innovation through grants and pilot projects, by setting health quality goals and by allowing providers at the community level to try new approaches to create medical homes, either through clinics or community-based health plans. Where necessary, the state should seek federal waivers to allow money to be spent where it can have the

largest long-term benefit – on primary care that can reduce the need for future acute care.

- ***Create incentives to improve outcomes.*** The Department of Health Care Services should create incentives in its Medi-Cal reimbursement structure to improve health outcomes of enrollees through education, prevention, case management, disease management and chronic care programs.
- ***Encourage emergency room alternatives.*** The department should provide incentives and adapt reimbursements to encourage safety net hospitals to open primary care clinics to treat non-urgent cases, preventing inappropriate use of emergency department resources.
- ***Ensure that patients in fee-for-service Medi-Cal have medical homes.*** The department should expand the use of case managers to coordinate care for beneficiaries who remain enrolled in Medi-Cal fee-for-service and promote the use of disease management strategies to target chronic conditions.
- ***Encourage patient responsibility.*** The department should develop prevention and chronic care strategies that encourage enrollees, once educated and given the tools to evaluate care, to take more responsibility for their health.

Recommendation 3: The Department of Health Care Services must have the data and analytical capacity to measure health outcomes, plan for the future, prevent fraud, and promote the most appropriate and cost-effective health care. The Department of Health Care Services should:

- ***Develop a data plan.*** The Department of Health Care Services, working with stakeholders in other state agencies, must develop a strategic plan for data needs based on health quality goals. The plan should link existing systems and accommodate new data management systems.
- ***Use data to track quality and fight fraud.*** The Department of Health Care Services should use patient data to determine quality and health outcomes and in areas of measured low quality performance, encourage the use of best practices to improve health outcomes. The new system should be designed in collaboration with the Office of the Attorney General to build in optimal fraud detection capability before claims are paid.
- ***Leverage outside research assets.*** Until the department can develop its own research team, it should contract with the California Medicaid Research Institute at the University of California to analyze clinical data collected by the state. The department must use research from its operations to develop policies to improve health outcomes for enrollees.

- ***Replace claims payment information system.*** The department should prepare for replacement of the Medi-Cal Management Information System, including the hiring of staff to extract business and professional rules from the present system. Top priorities for the new system include the ability to quickly and accurately process payments as well as to capture a range of clinical data from patient encounters with providers, laboratories and pharmacies.
- ***Integrate electronic patient information.*** In coordination with other state purchasers of health services, the Department of Health Care Services must develop a strategy to integrate health information technology into its purchasing policies. As a first step, Medi-Cal can adopt standards and timetables for health information technology protocols in areas where private and non-profit providers have taken the lead and are prepared to participate.

Recommendation 4: To ensure that qualified Californians are enrolled in programs for which they are eligible, the Department of Health Care Services, working with other involved departments, local governments and community-based organizations, should:

- ***Align application, eligibility and renewal procedures with federal rules.*** Application forms, eligibility determinations and renewal procedures should be simplified as required by federal law. The state should consider whether the costs of an assets test outweigh the benefits.
- ***Make electronic applications available to the public.*** The department should transition to an Internet-based system for enrollment and eligibility determination and adopt existing software technology to simplify and streamline the process; to improve accuracy and retention; and, eliminate waste and duplication.
- ***Encourage "one-stop" enrollment.*** Drawing on the experience of counties already doing so, the department should help all counties adopt a "one-stop" approach to enrollment for publicly funded health programs so that families with members who qualify for different programs can make a single application to all publicly funded health programs for which they might qualify.
- ***Encourage innovations in renewal procedures.*** The department should promote and lead county innovations to simplify and streamline the Medi-Cal renewal process by doing the following:
  - ✓ Communicate patients' renewal dates to providers and encourage providers to distribute renewal forms.
  - ✓ Allow annual re-determination to occur anytime throughout the year, as long as it occurs annually.
  - ✓ Gather and share information on county innovations with other counties so that best practices can be adopted to streamline

procedures and maximize administrative resources. Examples of innovations include pre-populating the forms that are sent to beneficiaries and providing for call-in renewal.

- ✓ Ensure that each applicant is screened for every Medi-Cal program.

I. Challenges Demand Change

California's Medi-Cal program exists today as a complex agglomeration of regulations, initiatives, mandates and good intentions – all bolted to a 1966 chassis.[11]

Medi-Cal is the biggest single purchaser of health care services in the state.

When Medi-Cal was established four decades ago, it paid for health care on a fee-for-service basis, the typical payment arrangement for health care in general at the time. An enrollee needing health care would see a physician who had been approved for the program. The physician's bill would be sent to Medi-Cal, entered into a claims payment system and eventually processed and paid at a discounted rate. More than half of Medi-Cal's enrollees continue to receive care in this method.[12] It was set up around a physician and hospital-based model of medicine, which focused resources on treating disease at the acute stage.

The program originally was designed to provide health insurance for families and seniors with low incomes and people with disabilities. Like other insurance plans, it does not provide medical services directly. Unlike other insurers, however, it cannot turn down applicants based on their health status or adjust premium rates to reflect the costs high-risk enrollees would impose on the program. Eligibility has since been broadened to include political refugees, pregnant women and people with AIDS. The program has added benefits and extended benefits to cover individuals and families with higher income levels.[13]

Medi-Cal has restrictions – state and federal – on what services can be reimbursed and what types of providers can perform these services. Many of the restrictions reflect the old, hospital and physician-based model of health care.

Over the years, a major focus has been on holding down costs, either through adjustments to eligibility and benefits or by freezing or reducing reimbursements to physicians, hospitals and managed care plans.[14]

In the face of rising health care expenses in the early 1990s, Medi-Cal began to rely more heavily on a managed care strategy, shifting low income families and children from fee-for-service into managed care

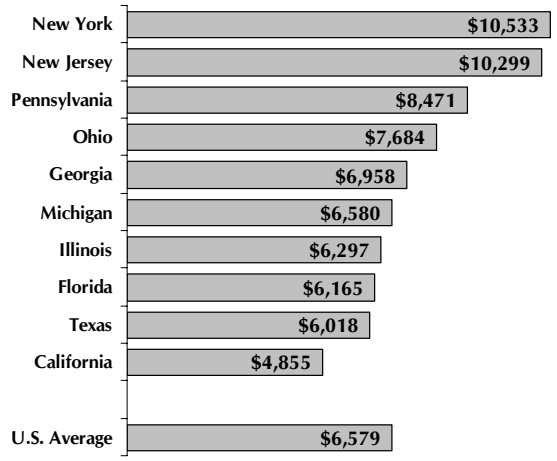
plans.[15] In this way, the state can transfer some of the cost risks associated with providing coverage to the managed care plans. California, unlike other states, has three distinct models of managed care: not-for-profit county organized health systems, commercial health plans and local initiative health plans. They operate in 22 counties with urban population centers.[16] Medi-Cal's goal was to rein in cost growth as well as provide members a more coordinated approach to health care. Enrollment in Medi-Cal managed care plans grew from 600,000 people in 1996 to more than 3 million in 2006.[17]

Today, half of Medi-Cal beneficiaries are enrolled in managed care. In counties with managed care plans, enrollment is mandatory for children, women and non-disabled adults. In the eight counties where managed care is organized through a county-based system, managed care enrollment also is mandatory for seniors and people with disabilities. This year, managed care for children and families will expand to 13 additional counties.[18]

Managed care plans do not provide total coverage; some areas of health care, such as AIDS treatment and mental health, have been "carved out" and are provided and reimbursed separately.[19]

The population served by managed care plans is made up largely of children and families.[20] More than three-quarters of Medi-Cal's disabled and aged enrollees are enrolled in fee-for-service Medi-Cal, though many live in counties with managed care plans. Most of the rest of the fee-for-service population is made up of families and children who live in rural counties not served by managed care plans.[21]

Spending per Beneficiary



Source: Kaiser Family Foundation. 2004. *State Health Facts*. Cited in Stan Rosenstein. September 28, 2006. Written Testimony to the Commission.

Reflecting its roots, Medi-Cal today functions foremost as an administrative entity – determining eligibility, enrolling beneficiaries, processing claims, negotiating contracts with managed care plans and hospitals, and attempting to safeguard against fraud. The program's culture, systems and regulations are engineered around these tasks.

Organized this way, it pays for health coverage for one in six Californians under the age of 65, a quarter of the state's children, more than 40 percent of all births and two thirds of all nursing home days in California.[22] It does so spending less per average beneficiary than any other state, $4,855 in 2004, compared with the national

average of $6,579 and the top spender, New York, at $10,533.[23]

Like other state entities, the Department of Health Care Services, which runs the Medi-Cal program, is bound by the budget cycle. The annual budget process, with its various players in both the administration and the Legislature, tends to give priority to short-term budget savings, leaving long-term issues to future policy-makers and taxpayers. The Department of Health Care Services has not consistently forecasted or developed policy plans for long-term trends, partly the result of resource constraints, but also a reflection of the short-term bias of the culture it operates within.

While the department has a small group of policy analysts, during tough budget years, research and analyst positions are often either eliminated or left unfilled.[24] For research projects and forecasts, the department typically seeks outside help through contracts with health policy researchers at universities, consulting firms and foundations.

New Demands Will Determine Medi-Cal's Future

Medi-Cal has focused its efforts on the formidable challenge of delivering health care to a growing number of low-income and otherwise vulnerable Californians while striving to control its expenditures in the face of structural budget deficits.

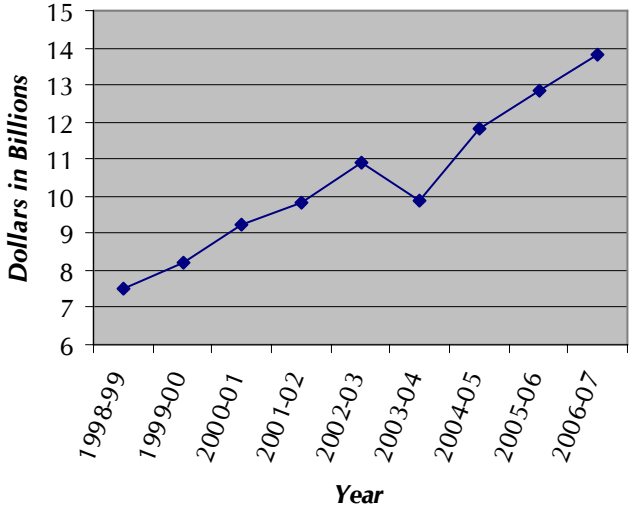
While those efforts have been virtually all consuming, other powerful challenges have emerged that likely will shape much of Medi-Cal's future:

- Health care costs are projected to grow at more than twice the rate of inflation, and in California, outpace the projected growth of state revenues.[25]
- The fastest growth in California's population is projected to be in the age group – people over the age of 65 – that accounts for a disproportionate part (and fastest growing) of Medi-Cal's expenditures.[26]
- The federal government, which will contribute $20.9 billion to California's Medi-Cal program this year, is changing the way it does business in the health arena. The federal goal: to emphasize value in purchasing health care, connecting costs to outcomes, and care to quality.[27]

Forecast: Medi-Cal growth is unsustainable

In preparation for its 2005 Medi-Cal Redesign reform proposals, the department asked outside researchers to forecast its cost growth. The SPHERE Institute, working through the Public Policy Institute of California, developed a model for the department that showed benefit costs in the fee-for-service part of Medi-Cal will climb 8.5 percent a year over the next decade, outpacing the expected 6 percent annual growth in state revenues.[28]

Medi-Cal Budgeted General Fund Expenditures



Source: Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services. September 28, 2006. Written testimony to the Commission.

Fueled by this cost growth, the Medi-Cal budget will reach $53.9 billion, by 2010, with $19.7 billion of the total paid from the state General Fund. This puts Medi-Cal's growth rate on course to expand from 15 percent of the General Fund budget in 2003 to 19 percent in 2010 and 21 percent in 2015.[29] As currently structured and barring a sustained surge in state revenues, Medi-Cal will account for an increasingly large share of the budget, forcing policy-makers to take money from other programs, cut Medi-Cal, or raise taxes, the report said.[30]

Making its case for the 2005 reforms, the Department of Health Care Services said cost and demographic trends will make Medi-Cal unsustainable as it is currently structured and managed.[31] The trends remain unchanged.

The outer limit of the SPHERE projections is 2015. By that year, the bulk of the Baby Boom generation will have reached retirement age, its demographic bulge shifting into Medi-Cal eligibility categories for low income people over age 65. By 2025, the number of Californians 65 and over is expected to double.[32]

Some indication of what that might mean can be seen in comparing average costs in fee-for-service Medi-Cal: Seniors in fee-for-service Medi-Cal averaged $10,139 a year in costs in 2005, compared to the average child in fee-for-service, who incurred $1,895.[33] That gap will likely widen: Medi-Cal enrollees over the age of 65 currently account for the highest increases in costs, 10 percent a year, driven largely by their relatively heavier use of inpatient hospital services and prescription drugs, the two biggest expenses in the fee-for-service part of Medi-Cal.[34]

Efforts to Keep Medicare Solvent Now Shifting to Medicaid

At the federal level, persistent cost increases in Medicare has generated concern that the Medicare system could run short of money. The U.S. Department of Health and Human Services has embarked on an ambitious campaign to fundamentally transform the health system using as its main vehicle the Centers for Medicare and Medicaid Services, (CMS), the agency that funds Medicare and the federal portion of the Medicaid program. Through CMS, the federal government this year will spend $427.6 billion on the Medicare program and another $192.5 billion on its share of the Medicaid program, making CMS the nation's largest purchaser of health care services.[35]

With the passage of the Deficit Reduction Act of 2005, the federal government has made it clear that it will limit the growth of Medicaid spending and that it is encouraging states to fundamentally overhaul their Medicaid programs.[36]

The federal government's expectations of what a transformed system would look like have been laid out in a series of executive orders and program initiatives from President George W. Bush and the U.S. Department of Health and Human Services.[37] They require providers to:

- Measure health quality according to recognized standards;
- Disclose prices so that consumers can make meaningful comparisons; and,
- Give consumers more choice as well as responsibility for those choices.

HHS has adopted the Institute of Medicine's standards for quality and health system transformation and is pushing states to transform their programs around these standards. The CMS initiative is inspired by the Institute's report, "Crossing the Quality Chasm," aimed at assuring quality health care through accountability, performance-based payment programs and public disclosure.[38]

HHS is pushing the nation's health system to implement new information technology that will

Recommendations from Secretary Leavitt's Medicaid Commission

A commission convened by Michael Leavitt, secretary of the U.S. Department of Health and Human Services, recommended that state Medicaid plans should:

- Promote personal responsibility.
- Promote integrated, home or community-based care.
- Provide states greater flexibility in designing benefit packages to meet beneficiaries' needs.
- Simplify eligibility rules.
- Provide tax credits or subsidies for the uninsured to purchase private health insurance.
- Reimburse states at higher rates for the most vulnerable beneficiaries.
- Promote the implementation of health information technology.
- Require states to provide coordinated systems of care and a medical home for all beneficiaries.
- Require states to collect and analyze data to determine which programs, providers and services are effective, and which need improvement.
- Incentivize states to purchase quality health care outcomes, rather than simply reimbursing for health care processes.

Source: Medicaid Commission. December 29, 2006. *Final Report and Recommendations*. Presented to Michael Leavitt, Secretary, U.S. Department of Health and Human Services. http://aspe.hhs.gov/medicaid/122906rpt.pdf.

create interoperable electronic patient medical records and connect physicians, hospitals, clinics, laboratories and pharmacies.[39] One part of President Bush's 2004 executive order established a National Health Information Technology Coordinator to set standards for health information technology, assess health information technology costs and benefits, and develop and implement a strategic plan to guide the nationwide implementation of interoperable HIT in the public and private health care sectors.[40]

In August 2006, President Bush issued an executive order setting a 10-year time-table for transparency – making health care quality measures and price information available to the public – in all federal agencies as well as entities that do health care business with the federal government. Under the order, health systems and insurers who receive federal money must adopt interoperable health information technology products.[41]

The goal of these initiatives is to drive down costs and increase competition by allowing people to compare prices, reducing duplicated services, eliminating medical errors and speeding communication between the various pieces of the health care industry.

CMS has broadened its vision from simply reimbursing care to using its influence, reimbursement systems, regulatory authority and leadership to promote widespread transformation of the health care system in the U.S. And it is encouraging Medicaid programs nationwide to follow suit.[42]

Medicare and Medicaid

Public sector health care in the U.S. is primarily funded through Medicare and Medicaid. The two federal programs—Medicare and Medicaid—are briefly described below.

Medicare provides health insurance for people over the age of 65 and many people who are on social security because of a disability. The program covers 95 percent of the nation's elderly population and finances 19 percent of all health spending in the U.S. The Medicare program has four parts:

- Part A provides coverage for hospital services.
- Part B provides supplementary medical insurance.
- Part C, or the Medicare + Choice program, was established in 1997 to enable beneficiaries to choose to receive benefits through a variety of health plans.
- Part D, began offering insurance coverage for prescription drugs on January 1, 2006.

Medicaid Asking States to Innovate

As part of the Deficit Reduction Act, the federal government encouraged states to innovate in their use of existing money to improve measurable health outcomes in their Medicaid programs, such as reducing patient errors rates through implementing electronic health records or electronic decision-making tools.[43] CMS also has developed a quality strategy for Medicaid and its State Children's Health Insurance Program (SCHIP) designed to help states improve performance management through the used of evidence-based measurement systems already widely used in the health care industry. The strategy also encourages states to adopt payment systems aligned with quality measures as a step toward a pay-for-performance model.[44]

The administrator for the CMS regional office in San Francisco, Jeff Flick, spoke to this new desire for innovation in testimony to the Commission. While there are federal rules and regulations with which the state must comply, the federal government is now more flexible than it ever has been, he said.

If California has ideas about how it could spend Medicaid dollars more effectively, CMS wants to work with the state to implement those ideas, Flick said.[45]

In his own series of executive orders, and in his plan to address the needs of Californians without health insurance, Governor Schwarzenegger has made clear that he wants California to move in the

Medicaid. Medicaid is a federal program that assists states in providing health insurance for poor residents. States can voluntarily participate in the program. The federal government matches California's expenses at a 50 percent rate, though for other states, the reimbursement rate is as high as 70 percent. Approximately 40 million U.S. residents are covered by Medicaid programs.

Federal laws and regulations outline broad guidelines for state Medicaid programs, but each state administers its own program. States establish eligibility standards, covered services and provider payment rates. To receive federal matching money, states must cover certain categories of individuals including:

- Low-income families in CalWORKS and those who meet the financial requirements for Aid to Families with Dependent Children that were in effect in July 1996.
- Seniors and people with disabilities participating in the Supplemental Security Income (SSI) program.
- Pregnant women and children with family incomes below specified levels.
- Children receiving foster care and adoption assistance.
- Certain low-income Medicare beneficiaries.

Eligibility determinations and enrollment into Medi-Cal are managed by county health and social service departments.

Sources: California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. "Eligible Groups." Oakland, CA. Accessed at http://www.chcf.org. Page 10. Also, Janet D. Perloff. "Medicare and Medicaid: Health Policy." *Encyclopedia of Social Work*. 2003 Supplement. Washington, DC: National Association of Social Workers.

same direction, pushing for the adoption of health information technology and standards, urging the state to improve the use of health data to build policy, assess outcomes and value-based purchasing.[46]

Medi-Cal Is Not Ready

The shift in federal policy together with rising costs and changing demographics represent major challenges for California.

The Department of Health Care Services, however, is not positioned or prepared to make this transformation, in part because it has focused its energy and resources on running an increasingly difficult to manage Medi-Cal program. The department and the program face significant capacity issues, both in staffing and in its operational systems, primarily its systems for managing data in its claims payment operation and its enrollment and eligibility operations.

The limitations imposed by Medi-Cal's information systems have hobbled the program's ability to analyze its existing operation and plan for change. Installing new systems will help, but are only part of a solution, and not sufficient on their own. Health system experts with experience in using data to transform large organizations emphasized to the Commission that adding new information systems won't be an effective tool without first building a strategy that embodies a vision for transforming Medi-Cal.[47] To meet the challenges it faces, Medi-Cal needs to move from a program organized primarily around processing and paying claims to one that uses its purchasing power to ensure access, value and accountability.

In exploring these challenges, it is important to keep foremost in mind that California has an extraordinary array of intellectual resources – both inside and out of the government – that can help it develop strategies and solutions. But progress cannot be made without the political and financial support that only the governor and the Legislature can provide.

The Department of Health Care Services needs to put in place a system that allows it to measure whether its annual expenditures improve the health outcomes of its 6.6 million enrollees.

The increasing cost of the program will become harder to justify to taxpayers without a transparent system to demonstrate that the state is getting value for its expenditures. Given the reality of finite tax revenues, the state must have a system to make sure it is spending its health dollars in a way that gets the best results, both for taxpayers and for the low-income families, seniors and disabled enrollees in the Medi-Cal system.

Timing Right for New Strategic Plan

In 2007, the state spun off the department's public health functions into a new department, giving the health services department the opportunity to engage the challenges the Medi-Cal program faces.[48] Without its public health duties, the bulk of the Department of Health Care Services' mission will be centered on the Medi-Cal program. The department's current strategic plan, which reflects its dual duties, is now outdated; staff said a new plan will be developed once the public health spin-off is complete.[49] This provides the opportunity to develop a strategic plan that focuses on the program's future. The department director should assemble a separate team for the purpose.

> ***"What we have before us are some breathtaking opportunities disguised as insoluble problems."***
>
> John Gardner, Secretary of Health, Education, and Welfare, 1965

Department leaders can use this period to lay out a strategy that can motivate and guide employees and cue stakeholders. The strategy must lay out a vision of transformation, what it can accomplish and what will be required.

Essential components of the strategic plan include:

- Building the required policy development capacity to support transformation.
- Rigorous data analysis to inform strategy.
- Improved data systems and health information technology that can drive innovation and track health outcomes and quality.
- Specific assignments and timetables for achieving measurable transformation goals.

Interviews with staff in various parts of the Department of Health Care Services indicate there is an ample store of ideas and energy as people try to develop pilot programs, seek grants to try out new ideas and explore collaborations with outside groups.

The Medi-Cal program already has some experience, though limited, with quality incentive initiatives in its managed care operations. And its 2006 applications for Medicaid transformation grants, though unsuccessful, show it is pursuing some of the possible solutions.[50]

But these projects will remain isolated efforts with no future unless they are part of a wider effort. These efforts need resources to take hold, and they need to be unified into a clearly articulated vision of where the Medi-Cal program is headed. This is a job for the department's top leaders.

Leadership Needed to Sell Vision of Transformation

The process of building the strategic plan can be used to unify and orient the team that will be executing it. Once finished, the plan can be used to market the transformation strategy outside the administration and as important, inside the department. That way, the department's various operations can see how their work fits into the larger goal.

The plan is a tool to lead, though not a substitute for leadership. It will be up to the director to communicate, lobby and persuade stakeholders and other policy-makers of the benefits transformation promises. The importance of leadership in shaping, communicating and executing a vision was the central lesson of the transformation of the Veterans Health Administration (VHA). But the job cannot be accomplished by the director alone. The director will need the active support and cooperation of other departments, such as the Department of Finance, and most important, the governor and Legislature.

The department leaders and the managers who run the Medi-Cal program acknowledge the need for change, but daily operations are very much dominated by the priorities that existed when the program was started 40 years ago, determining eligibility, processing claims and attempting to safeguard against fraud. While it has built quality initiatives into its relationships with managed care plans, and has embarked on several promising pilot projects, Medi-Cal's culture, systems and regulations are not engineered to focus on health outcomes.

The department's deputy director, Stan Rosenstein, said the program staff has as much as it can handle and is running full speed simply to operate the existing system, keep up with changes from the federal government and implement changes from the Legislature.[51]

Jean Fraser, director of the San Francisco Health Plan, told Commissioners that while she is often frustrated by the program's sometimes perverse incentives to providers, she sympathizes with its managers, who she said would like to be able to do more.

"They just don't have the bandwidth," Fraser said.[52]

According to health professionals who have worked with the program, Medi-Cal has been slow to embrace and integrate change, partly a reflection of its self-perceived lack of resources and a slow decision-making process.

Adopting any substantial change also is hampered by Medi-Cal's aging claims processing system, into which all program changes must be

entered, a system now vulnerable to collapse, according to a consultant's report.[53]

Policy analysis is handled by just a handful of top staff, who must borrow managers from Medi-Cal operations to develop grant proposals or create new initiatives.

Staff Short on Analysis Capacity

One of the department's main challenges is finding enough analysts – both on the policy-making side and in the data management operations – to conduct the kind of data analysis essential to developing policy proposals.

Both the policy staff and operations managers share the limited number of data analysts able to pull reports out of the claims payment system. In this, the Department of Health Care Services faces some of the same barriers to hiring as other state agencies, many of which were identified in the Commission's 2005 report, *Serving the Public: Managing the State Workforce to Improve Outcomes.*

Decision-making is centralized, a function of the intimate knowledge of the intricacies of the program Mr. Rosenstein has developed during his three decades with the program. Mr. Rosenstein attempted to retire at the end of 2006, but was persuaded to return by Health and Human Services Agency Secretary Kimberly Belshé.[54] The state's efforts to keep the director reflect both a respect for his institutional knowledge and desire for stability at a critical time – the governor concurrently was rolling out his complex health care initiative. It also revealed, however, a lack of management depth and a weakness in succession planning, issues that are endemic to state government.[55]

Health system professionals both inside Medi-Cal and out who are familiar with Medi-Cal credit Mr. Rosenstein's mastery of the intricacies of the Medi-Cal program, its layers of systems, and relationship with federal officials with keeping the program going through budget crises and changes in political direction.

But many of the same health system professionals said that while Mr. Rosenstein's mastery of the present system will make him an important part of the transformation process, the job of developing a vision for transforming the system will need to be done at a higher level of the organization and by someone with fewer ties to the existing system.

Leadership Central to VHA Transformation

Transformation on such a scale is possible. The Veterans Health Administration's turnaround of its health system is the best example. While the VHA had a key advantage not found in the state's Medi-Cal program – the VHA is a closed, vertically integrated system – the state can learn from two crucial components of the VHA's success: The importance of leadership and a focus on quality, backed by the tools to measure outcomes.

Transforming Government: Lessons from the VHA

The Veterans Health Administration (VHA), the federally funded health care system for veterans, underwent a large-scale transformation to improve performance beginning in 1995. The agency's efforts have resulted in substantial improvements and offer the following lessons to guide transformation in Medi-Cal:

- Lesson 1: Appoint leaders whose backgrounds and experiences are appropriate for the transformation.
- Lesson 2: Follow a focused and coherent transformation plan.
- Lesson 3: Persevere in the presence of imperfection.
- Lesson 4: Match changes in the external environment with changes in the internal environment.
- Lesson 5: Develop and manage communication channels from the highest to the lowest levels of the organization.
- Lesson 6. Do not overlook training and education.
- Lesson 7: Balance systemwide unity with operating-unit flexibility.

Source: Gary J. Young. June 2000. "Transforming Government: The Revitalization of the Veterans Health Administration." The PricewaterhouseCoopers Endowment for The Business of Government.

In a case study prepared for PricewaterhouseCoopers Endowment for The Business of Government, the top lesson from the VHA transformation was the importance of appointing leaders with the experience and background for transformation. Key attributes identified in the case study were: "Outsider status, substantial leadership experience in the public sector and knowledge of private-sector innovations in the financing and delivery of health care systems."[56]

Prior to its decade-long overhaul, the VHA health system was mainly a hospital-based system with a reputation for low quality such that many veterans eligible for its services chose to go elsewhere for care. In the early 1990s, it began a transformation that changed the VHA's culture and structure.

A strong leadership team under Kenneth W. Kizer was able to articulate a vision of change into a system focused on quality and the need for it and communicate it deep into the organization.

Under Kizer, who had previously been director of the California Department of Health Services, the VHA moved away from an in-patient orientation that took care of veterans' acute health needs in 173 independent and often competing hospitals. Kizer's team reorganized the VHA's hospitals and its 400 clinics, 133 nursing homes and 200 counseling centers into 22 Veterans Integrated Service Networks. The new system emphasized prevention and chronic care through an increased use of outpatient services. Each patient was assigned a physician, or a physician-led team of caregivers.

Tools for transformation included electronic medical records and technology that allowed easy data exchange of radiology and laboratory results and pharmacy orders. Hospitals and outpatient facilities were electronically linked nationwide, allowing veterans, and their doctors, to have the same access to their health histories anywhere in the country. Within two years, all facilities had telephone advice services. The VHA also streamlined and simplified paperwork, in the process eliminating nearly two-thirds – 2,626 – of the paper forms then in use.[57]

Leadership Produced Quality Improvements

More important was what the VHA did with the data. The VHA vastly improved its ability to assess the outcomes of health care and track how closely its treatments matched the care recommended for patients. It linked incentives such as bonuses to quality improvements. Studies of the VHA's transformation found that the symbolic value of the accountability system outweighed its flaws by signaling to the entire organization the importance of data-based performance measurement.[58]

The reorganization also included building a "culture of quality" that relied heavily on the use of electronic patient medical records, but had at its core a strategy of building care around quality standards and systematically monitoring that quality.[59] Researchers found that in 2000, the percentage of VHA patients who received appropriate care was 90 percent or greater for 9 of 17 quality measures and above 70 percent for 13 of 17 care quality measures, outperforming Medicare on 12 of 13 indicators. [60]

Since 1995, along with the shift to primary care, the VHA has seen its patient base double to more than 5 million and costs per patient fall.[61] This has presented a new challenge – how to handle the influx – but one based on a reputation for high-quality care.

California needs the same intensity of vision, backed up by a strategic plan to execute it, to transform Medi-Cal into a program focused on value-based purchasing and improving health outcomes.

Recommendation 1: The Department of Health Care Services must transform the Medi-Cal program into a value-driven purchaser of health care. Specifically, the department should:

- ***Develop a strategic plan that emphasizes prevention.*** The state must adopt a strategic plan for transformation that emphasizes prevention through increased access to primary and chronic care. The strategic plan should include goals and timetables to:

- ✓ Expand managed care where possible and provide medical homes and disease management programs where managed care is not an option. The plan should guide the department in managing costs and improving health through better coordinated care of chronic conditions, a reimbursement structure that rewards improved health outcomes, and better health system transparency.
- ✓ Collect and analyze data on health care quality provided to its enrollees to guide policy and decision-making.
- ✓ Reduce barriers to enrollment for eligible Californians.

- ❑ ***Designate a leader and a strategy team.*** The department director must develop and articulate a long-term strategy to transform the Medi-Cal program. The director should designate an individual dedicated to directing the strategy and policy efforts of this transformation, separate from the responsibility for day-to-day operations of the program. That individual should lead a formally recognized strategy team located within the Medi-Cal program. Together with the strategy team, the leader should be focused on the long-term planning and program needs and projected changes within Medi-Cal's enrollee population.
- ❑ ***Develop a Medi-Cal succession plan.*** The Department of Health Care Services should take specific steps to develop leadership and management capacity for transforming the Med-Cal program to ensure that transformation efforts are not tied to specific individuals, but can outlast personnel and administration changes.
- ❑ ***Use Value-based purchasing.*** The Department of Health Care Services should adapt and adopt value-based purchasing strategies used by other large purchasers of health care, such as CalPERS and business consortiums, that build incentives for improved health quality outcomes into contracts with providers.

II. Focus on Prevention

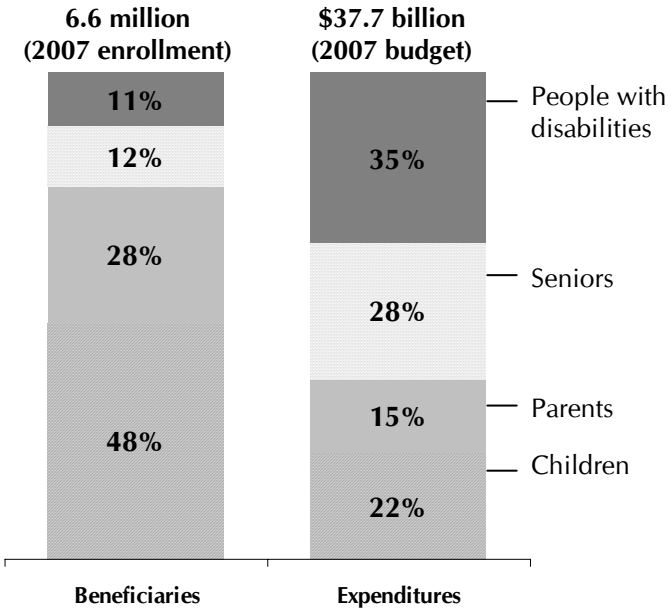
Costs in the Medi-Cal program are highly concentrated in two populations of enrollees, senior beneficiaries, and blind and disabled enrollees. Though the two groups together account for 23 percent of the program's enrollees, they incur 63 percent of the overall costs. And costs in these groups are rising more quickly than for other groups in the program.[62]

Many of the enrollees in these groups have one or more chronic conditions that lead to high hospital and pharmacy costs and represent the two largest expenses in the Medi-Cal program.[63] Statewide, 38 percent of the population, or 14 million people, have chronic conditions, whether heart disease, hypertension or asthma. Half of those suffer from two or more diseases, making prevention and chronic care essential pieces to any solution to California's health care problems.[64]

While 20 percent of the population has multiple chronic illnesses, they account for 60 percent of health care resources.[65] Poorly managed chronic conditions lead to a disproportionate 44 percent of emergency room visits in California.[66]

Diabetes is a particular challenge for California in that it disproportionately affects people with low incomes. Three of five patients with Type 2 diabetes also suffer complications that include heart disease, stroke, blindness, kidney disease or circulation and nervous system damage that can lead to amputation. The cost diabetics incur because of their condition is significant, averaging $10,000 a year.[67]

Beneficiaries and Cost



Note: Percentages based on 2005 data.

Source: Medstat analysis of Medi-Cal MIS/DSS, updated through October 2005 (May 2005 data) cited in Chris Perrone, July 27, 2006. Presentation at the Commission's Advisory Panel Meeting.

Most seniors, disabled enrollees are not in managed care

In California today, three quarters of the Medi-Cal beneficiaries who are seniors or are disabled are in fee-for-service, where the Medi-Cal program does not employ a system or strategy to coordinate care or measure the quality of care enrollees receive. The costs of providing treatment for chronic conditions and their complications are concentrated in these two groups.[68] As a result, these groups represent not only the Medi-Cal program's most expensive populations, but also the source of the program's largest cost increases, 8 percent annually for adults with disabilities and 10 percent a year for seniors. These increases reflect their more complex medical needs as well as rising pharmacy and hospital costs.[69]

Preventive care services

Preventive care can occur at any stage of illness, but is typically understood in three stages:

Primary preventive care preserves normality and health, and focuses on stopping a problem before it begins.

Secondary preventive care catches a disease before it becomes symptomatic, such as screening for cancer.

Tertiary preventive care occurs after a health problem has begun and focuses on restoring and optimizing the patient's functioning.

Source: Antronette K. Yancey, Professor, Department of Health Services, UCLA School of Public Health. March 16, 2007. Presentation at the California Health Policy Forum, California State Capitol, Sacramento, CA. Center for Health Improvement.

Moving more of these groups into managed care plans has been a goal of the state, and the federal government, both to better manage costs as well as to improve care.

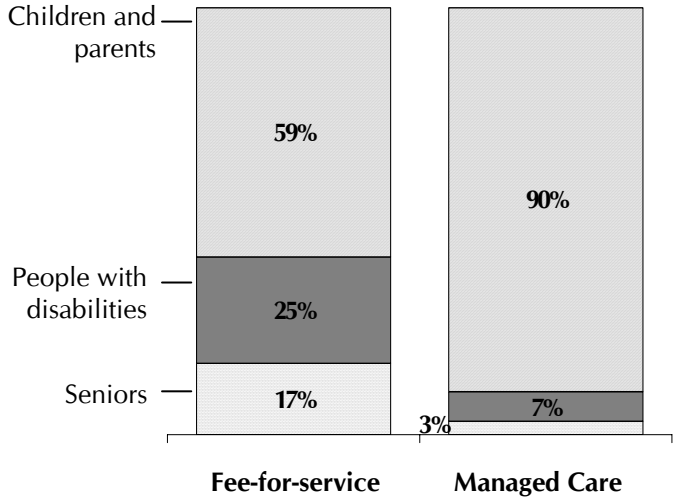
Short-term approaches to reducing costs and improving the quality of care from these groups focus on such strategies as disease management and coordinated chronic care. Both offer ways to increase the chance that enrollees are receiving the right care and to slow the progression of chronic conditions and avoid preventable hospitalizations.

For the Medi-Cal population as a whole, the only way in the long term to reduce the number of people who develop serious health problems and disabilities caused by disease is to focus on prevention. That requires expanding access to primary care for Medi-Cal beneficiaries and ensuring that they have a medical home where their care can be coordinated. The focus on prevention is included in Governor Schwarzenegger's health plan. It also has been the foundation of the Kaiser Permanente approach to managed care.

In site visits, testimony and interviews, the Commission learned that primary and preventive care as well as care for chronic conditions can be provided successfully in a variety of settings, including community health clinics and managed care plans, which in some areas include those same clinics.

Yet managed care improves outcomes, saves money

Consistently, research indicates that the managed care model has been able to improve care and lower costs compared to fee-for-service arrangements.



Source: Stan Rosenstein. September 28, 2006. Written Testimony to the Commission.

One study from the University of California, San Francisco showed that Medi-Cal managed care plans in California have been better at reducing avoidable hospitalizations for disabled enrollees than fee-for-service Medi-Cal – a key indicator of how well a chronic condition is being controlled and slightly better at providing access to specialists.[70]

A 2004 study showed that managed care is associated with greater access to medical services as well as having a usual source of care across all racial and ethnic groups while rates of disease management – which targets focused care on a specific disease – are higher in managed care than in fee-for-service care. The study showed that the differences between managed care and fee-for-service care were greater in Medi-Cal than in employment-based insurance.[71]

National studies show managed care plans can reduce costs for Medicaid programs. A 2004 review of 14 studies by the Lewin Group found savings of 2 percent to 19 percent compared to fee-for-service, with savings higher for some groups because of decreased hospitalizations and lower pharmacy costs.[72]

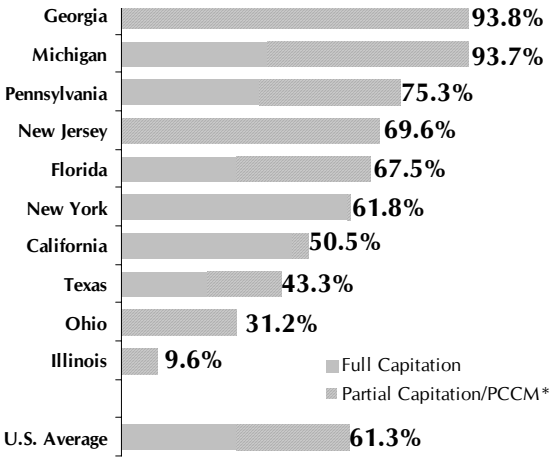
Medi-Cal managed care comes in a variety of forms, depending on where an enrollee lives. Eight counties feature county-run managed care plans where enrollment for seniors and disabled Medi-Cal enrollees is mandatory. In 14 other counties (this year expanding to another 13 counties), choices for Medi-Cal enrollees include commercial plans.[73]

Statewide, however, only half of Medi-Cal's beneficiaries are in managed care, and 90 percent of them are children and families.[74] Approximately 300,000 of them are seniors or blind or disabled beneficiaries.[75]

Other large states rely more on managed care

Other states with large populations have a much higher percentage of their beneficiaries in some form of managed care, including New York with 61.8 percent, Florida with 67.5 percent, and Michigan with 93.7 percent. According to the Kaiser Commission on Medicaid and the Uninsured, 14 states, including Washington, Oregon and Arizona, have more than 75 percent of their beneficiaries enrolled in some form of managed care, either managed care plans, or primary care case management, where enrollees' care is coordinated by a case manager.[76]

Managed Care Penetration In the Ten Most Populous States



* Primary Care Case Management. In California, this category includes AIDS patients in PCCM.

Source: California HealthCare Foundation estimates using 2004 data from Kaiser Family Foundation (www.statehealthfacts.org).

Part of the reason behind California's relatively low managed care participation is geography. Managed care plans are concentrated in the state's urban centers where population density can support managed care plans. Large areas of California, however, are sparsely populated, with relatively fewer health care providers, leaving fee-for-service care the prevalent model. Most of the families and children who make up 59 percent of the fee-for-service population live in rural parts of the state.

Medi-Cal Reform Effort Blunted by Earlier Cost-Cutting

In 2005, as part of the Medi-Cal Redesign, the Department of Health Care Services sought to expand the enrollment in Medi-Cal managed care.[77] The plan was seen as a way to improve care and address the long-term budget problems posed by Medi-Cal's surging costs. It was ambitious, and instead of looking for short-term fixes to satisfy budget-cycle demands, it looked to the long-term challenges the program faced.

The Department of Health Care Services won legislative approval to expand mandatory managed care into 13 counties, one part of the redesign, which will add 262,000 people, families and children to managed care plans in those counties.[78]

The department also proposed moving 554,000 aged and disabled Medi-Cal enrollees into mandatory managed care plans, a move the state estimated would save up to $89 million in General Fund money in fiscal year 2008-2009, with total program savings of $177 million.[79]

The department's efforts to expand managed care to more senior and disabled beneficiaries were undercut by previous efforts to slow the growth of Medi-Cal spending, including a "budget adjustment factor" and a 5 percent managed care rate roll-back to address the 2002-2003 fiscal crisis (restored January 1, 2007).[80] These actions, aimed at solving short-term budget problems, pushed many of the managed care plans into well-publicized financial difficulty. The state has been forced to raise rates individually for several plans when they exhausted their reserves after posting several years of operating deficits.[81]

Advocates for seniors and disabled enrollees and legislators expressed concern that financially pressed managed care plans would not be prepared to handle the influx of people with intense medical needs or multiple chronic conditions. They saw it at best as a benefit reduction by eliminating choice, but having the far worse potential of putting some of the state's most vulnerable people at risk. They also expressed doubt that the Department of Health Care Services knew enough about Medi-Cal managed care plans to ensure their readiness.[82]

The department anticipated resistance, and had previously organized a stakeholder process to sort through issues of concern. As part of the redesign, the Department of Health Care Services agreed to monitor managed care plans to ensure they were capable and ready to accept new aged and disabled enrollees. But first they needed to develop a monitoring protocol with performance standards. The California HealthCare Foundation convened stakeholders to develop a system to determine readiness and provided it to the department in November 2005.[83] The process appears to have stalled; in correspondence with stakeholders, the department has said that it will not issue performance standards for Medi-Cal managed care plans for people with disabilities.[84]

Ultimately, the Legislature rejected the proposal, a policy defeat that came with a costly penalty. The proposed managed care expansion had been part of a complex Medicaid waiver that included restructuring the way Medi-Cal funded hospitals. Failing to expand managed care meant the state had to forfeit a promised $180 million a year in federal money tied to the plan.[85] Rene Mollow, the associate director for health policy at the Department of Health Care Services, has said that expanding managed care is something that the department still wants to pursue because administrators believe managed care is best for enrollees. Ms. Mollow said, however, that the department won't come out with another proposal until it has done all the necessary preparation.[86]

The state should continue to pursue the goal of expanding managed care, as it provides a structured way to coordinate medical treatment for enrollees and ultimately can provide the state with a way to efficiently

measure health outcomes. But the Department of Health Care Services first must ensure the plans are financially stable and prepared for new, high-need, members.

Given the political opposition to expanded mandatory managed care for senior and disabled enrollees, it appears that any increase in managed care enrollment will have to be voluntary. That puts the onus on the state – and the various managed care plans – to demonstrate that they can offer higher quality care and access to specialists, through education and outreach or marketing. In its favor, the Department of Health Care Services has a track record of annual quality initiatives with the managed care plans it contracts with, and has introduced performance-based incentives in 14 counties, using the Health Plan Employer Data and Information Set (HEDIS) to evaluate the quality of the health plan process.[87]

Other Opportunities for Better Care

The state, however, has other opportunities to provide primary care and increase its capacity for chronic care. In testimony from experts, in public hearings and through site visits to hospitals and clinics, the Commission learned about the opportunities for community-based clinics to provide preventive health care and chronic care in cost effective settings:

- Partnerships between public hospitals and community clinics in Los Angeles County have led to improvements in the health care delivery system for uninsured and Medi-Cal patients. The partnerships have reduced unnecessary use of emergency departments and established a medical home at a community clinic for patients who lack ongoing primary and preventive care.[88]
- A County Operated Heath System in Contra Costa that serves both Medi-Cal enrollees and county employees provides group visits to expectant mothers, where they gain support, trade experiences and meet with a physician in a venue that enriches their understanding and maximizes the physician's time.[89]
- In Humboldt, a rural county with no county-operated public hospital, health care is provided to residents through a web of community services including a clinic network, community non-profits, local hospitals and private medical providers.[90]

Some of the clinics the Commission visited were part of managed care networks, though the lessons they offered could be used outside of managed care, and could be used for populations, particularly senior citizens with chronic conditions, who are not enrolled in managed care.

Each is an example of providing the most appropriate care for the patient in the most appropriate venue. The emphasis is on primary care with a goal toward preventing disease that requires more costly treatment. Each is an effort to maximize access to care given the constraints of limited money and physician time.

In Los Angeles, the hospital triage clinic and Clínica Msr. Oscar Romero, located across the street, are providing primary care. At the hospital, one goal is to avoid the cost, and often, worse health outcomes, of patients using the far more expensive emergency room. At Clínica Romero, primary care services are geared toward preventing the need for more acute treatment and to make the best use of physician hours with care provided through non-physician care givers and educators.

Clínica Romero officials said they could see more patients – and perhaps divert more people from area emergency rooms – if the clinic had the money to stay open later during the week and offer weekend hours.

A recent survey by Harris International, completed for the California HealthCare Foundation, indicated that more than half the people who visited emergency rooms – who had public or private insurance coverage – would have gone to a primary care physician had one been available.[91]

County Organized Health Systems (COHS)

County Organized Health System (COHS) plans are publicly-run, managed care models for the Medi-Cal population within a given geographic area. Although they are funded by taxpayers, the state's five COHS plans operate as private companies, negotiating rates to allow the poor and disabled the same access to health care providers as those covered through their employers. Rates vary based on the eligibility categories of the Medi-Cal members.

COHS plans serve more than 555,000 people in eight counties and are very cost-effective. Specialization allows COHS plans to be culturally sensitive and serve the specific needs of low-income members in its region. According to the state Legislative Analyst's Office, COHS plans save the state General Fund $150 million a year.

CalOptima of Orange County is the largest COHS plan, serving 290,000 Medi-Cal beneficiaries from a $790 million budget. Its members are treated by doctors from 11 different health care networks with more than 3,500 primary care physicians – roughly 10 times the number of physicians available before CalOptima formed in 1995.

In its early years, when the state paid higher rates for Medi-Cal patients, CalOptima built up reserves. In 2003, the state cut Medi-Cal rates by $2.3 billion or 34 percent. Instead of cutting payments to doctors and hospitals, CalOptima continued spending as usual. By January 2006, it had a $48 million deficit.

In February 2006, state officials announced a rate increase to CalOptima totalling $50 million, a recognition that its earlier rates were not sufficient. This would allow it to continue serving poor, elderly and disabled residents.

Sources: Courtney Perkes. January 28, 2006. "Fund woes cloud care of neediest." *The Orange County Register.;* The Legislative Analyst Office. 2003. "Analysis of the 2003-04 Budget Bill: Health and Human Services, California Medical Assistance Program." Available at the LAO Web site: http://www.lao.ca.gov/analysis_2003/health_SS/hSS_5_4260_an103.htm.; and, the CalOptima Web site: www.caloptima.org.

Clinics offer access, stem unnecessary hospital visits

Clínica Romero is part of a network of nonprofit community-based clinics contracted with L.A. Care Health Plan, the 800,000 member community health plan in Los Angeles County. The health plan was created under Medi-Cal's "two plan" managed care model, one of three such models in California.[92]

If a patient requires more extensive care, they are referred to specialists at the hospital, the more cost-effective and appropriate use of limited medical resources, both for the hospital and the clinic. And growing use of electronic patient health records provide a backbone for coordinated care.[93]

In Contra Costa County, similar types of partnerships exist between county and community providers. County administrators have found group classes to be a particularly effective method of care, as well as training residents as outreach workers to educate their friends and neighbors about healthy living and the health services available in the county. Contra Costa's County Organized Health System is one of five in the state and is another model of Medi-Cal managed care, one that relies on a more tightly organized network of clinics than in Los Angeles.[94]

The decreasing numbers of primary care physicians, dentists and other providers who accept Medi-Cal poses particular difficulties for rural counties such as Humboldt County. Unlike Contra Costa or Los Angeles

Access to Care

More than half of Medi-Cal enrollees report some difficulty in finding a physician. Much of the discussion around access to care has focused on low provider reimbursements, which advocates say essentially ration care. Medi-Cal reimbursement rates to health care providers are 59 percent of Medicare's reimbursement rates, which are discounted from the rates providers charge to commercial health plans. Overall, only half of California's doctors participate in Medi-Cal; the rate for specialists is lower. Physicians who do accept Medi-Cal patients often limit the number of Medi-Cal enrollees they'll see, in part because of reimbursement rates, but burdensome paperwork also has been cited as a factor. The overall rate of 46 primary care physicians willing to accept Medi-Cal patients for each 100,000 Californians is below the federal workforce standards of 60-to-80 for each 100,000 and doesn't take into account regional differences that put the number far lower in rural areas. The rates of non-participation are much higher in California than in other states and well below the national Medicaid average of 85 per 100,000. Governor Schwarzenegger's health care proposal acknowledges this in calling for a $4 billion increase in reimbursements to providers and hospitals. The governor said chronic underpayment to Medi-Cal providers has resulted in cost-shifting by providers to private insurers.

Sources: Medi-Cal Policy Institute. 1999. Medi-Cal Beneficiary Survey. Also, Urban Institute/Center for Studying Health System Change. 2003 Medicaid Physician Fee Survey, cited by the California HealthCare Foundation. Also, Andrew Bindman, Jean Yoon, Kevin Grumbach and Lucy Street. 2003. "Physician Participation in Medi-Cal." Medi-Cal Policy Institute. Also, Bindman, et al. "Trends in Physician Participation in Medicaid: The California Experience." *Journal of Ambulatory Care Management*, 26(4):334-343. Also Peter Cunningham. 2002. "Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997-2001." Center for Studying Health System Change, Washington, D.C.

County, Humboldt County, like much of the northern part of the state, lacks the population density and physicians required to support integrated managed care plans.[95]

Lacking a comprehensive plan to link separate initiatives, Humboldt County in 1999 started to pull together all health and human services in the county. The county has found that an integrated system prevented resources from being wasted or duplicated and results in significantly higher quality, more efficient, effective, holistic and outcome-based services.[96] These partnerships have implemented a telemedicine program and provided residents over the age of 50 free hour-long consultations with a public health nurse.[97]

These clinics, and others like them, also see many of the state's uninsured adults, who might otherwise seek treatment for primary care health needs in emergency rooms at a far higher cost. The clinics incur expenses to provide health care, but those expenses can create savings in the form of reduced non-acute emergency room visits or avoided hospitalizations – to another part of the health system, though it may not benefit the clinic.

A 1994 study showed that Medi-Cal fee-for-service enrollees who used community health centers regularly were 33 percent less expensive overall compared to enrollees who did not use the health centers, and had 27 percent less total hospital costs.[98] A similar study in New York also showed lower costs, with savings offsetting primary care visits because of avoided hospitalizations and lower inpatient costs for those who were admitted.[99]

Clinic Licensing

Legislation in 2003 recognized the increasing need for primary care clinics, but found that the licensing system for those clinics "is out of step with contemporary health care delivery systems, and results in a significant waste of taxpayer and community resources that could otherwise be devoted to patient care." That legislation required that the licensing process be streamlined by January 2006, yet the department recently expanded the scope of the licensing application forms. For some clinics in the state, delays in the state licensing process have jeopardized federal grant funding which require that new or expanded clinics be operational within an expedited time period advocates said. The licensing application fee was recently increased from $30 to $600 for free and community primary care clinics. The lack of a smooth and seamless licensing and certification process impedes the creation of new clinics which could offer preventive and primary care in the most cost-effective way.

Sources: SB 937 (Ducheny), Chapter 602, Statues of 2003. Also, Law Office of Regina M. Boyle. September 22, 2006. Letter to Kathleen Billingsley, Deputy Director, Licensing and Certification, California Department of Health Services. New Access Points and Expanded Access grants. U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care. Licensing and Certification Program License Fees 2006-2007. Accessed at http://www.dhs.ca.gov/lnc/pubnotice/LicensingFeeSchedule/LicenseFeesATTACHMENT_A.pdf. Also, Jennette Lawrence, Director, Government and Community Relations, Family Health Centers of San Diego. March 19, 2007. Personal communication.

Perverse Incentives in Payment Structure

Several current state reimbursement policies impede the ability of communities to achieve health outcomes. Instead of promoting prevention and cost-effective practices, many reimbursement policies promote costly, inefficient services. For example:

- Reimbursement codes do not exist for newer practices that can better and more efficiently meet the needs of patients such as group visits, team treatment and chronic care.
- Visits to registered nurses are not reimbursable, even when care can be provided more effectively by a registered nurse than a doctor.
- Registered dental assistants cannot be reimbursed for placing sealants on children's teeth unless they have a prescription, though they are authorized to do so.
- Instead of increasing the number of specialists at San Francisco General Hospital to meet increasing demand, local officials have attempted to reduce referrals to specialists by providing triage advice to primary care doctors, but the triage consultation is not reimbursable.
- Specialists receive large reimbursements for performing procedures, but none for consultations — creating the incentive to perform procedures that might not be necessary.
- A provider may refer a patient to a second provider to better meet the patient's needs, but Medi-Cal will only reimburse one visit for an individual patient each day. This is especially problematic for mental health needs which could require immediate attention, but also a major inconvenience for people who need to arrange sitters, transportation and time away from work.

Medi-Cal lacks a designated individual or team of individuals who are charged with the task of continually evaluating and updating reimbursement rules to ensure that policies support local efforts to achieve health outcomes, spur innovation and reduce costs.

Note: Senator Darrel Steinberg has introduced legislation, SB 260, that would allow multiple medical, dental or mental health visits that occur on a single day to be reimbursed by Medi-Cal in some circumstances.

Source: Little Hoover Commission. October 17, 2007. Los Angeles County Advisory Committee meeting. Also, Little Hoover Commission. September 11, 2007. Contra Costa County Advisory Committee meeting.

To the extent that limited hours at community-based clinics result in Medi-Cal beneficiaries (and others ultimately covered by Medi-Cal) turning to hospital emergency rooms for non-urgent care, the state could avoid emergency room costs for non-acute care by supplementing managed care plan capitation rates for extended clinic hours and reducing other barriers to opening clinics. The state also could build on the example of such hospitals as LAC/USC Medical Center and its triage ambulatory clinic by allowing hospitals to use some of their Medi-Cal safety-net funding to open on-site primary care clinics.[100]

In the areas where clinics are part of a Medi-Cal managed care plan, the state already is benefiting from the clinic approach to providing cost-efficient primary care to the Medi-Cal beneficiaries who are members of the plans. For fee-for-service Medi-Cal beneficiaries, however, Medi-Cal will not reimburse methods that practitioners have found to be more effective and cost-efficient, such as group visits with a health educator and health check ups that could be handled by nurse practitioners. The

benefits to the state provided by community clinics could be enhanced if the program were to adapt its reimbursement system to pay clinics for preventive care that doesn't require a physician.

Increasing opportunities to provide improved care for chronic conditions

The emergence of chronic diseases as the leading cause of death and a major driver of rising health costs has built an awareness of the importance of continuing coordinated care of chronic conditions. Chronic care programs now are a central component of health plans' overall wellness strategies. Increasingly, community-based health centers, too, are integrating chronic care programs into their missions to keep such conditions as asthma, diabetes, high blood pressure and heart disease from progressing.

In San Diego, a chronic care program called Project Dulce has seen success in searching out diabetics who weren't being monitored, enrolling them in an intensive case management program that involves self management and close tracking of their condition.[101]

In Los Angeles, the county medical director saw up to 25 percent of the patients in emergency rooms return within 90 days, usually the result of chronic conditions such as asthma or congestive heart failure flaring up. Taking advantage of a federal waiver, Dr. Jeff Guterman organized two programs, one that used four mobile "Breathmobile" clinics to travel to 93 area schools to bring asthma care directly to children. The project reduced emergency room visits and inpatient days by 70 percent, and school absenteeism by more than 90 percent. Dr. Guterman used a team approach for the repeat visitors with congestive heart failure, enrolling them in programs to educate them about their disease. He got them to agree to a treatment plan and monitor themselves, using nurses to check for compliance. The program reduced hospitalization rates by 35 percent and for each avoided hospitalization, saved between $20,000 and $40,000.[102]

Further north, Partnership HealthPlan, a county-organized health system serving Medi-Cal beneficiaries in Solano, Yolo and Sonoma

Care for Chronic Conditions

Effectively caring for chronic conditions requires a transformation of the relationship between patient and provider into a collaborative partnership that includes a team of physician and non-physician caregivers, family members and peers. Chronic care is proactive and prevention oriented. It employs professional-led group visits, peer mentors, reciprocal peer partnerships, and e-mail and phone exchanges to support patients in managing their condition.

Research shows, however, that health care systems generally fail to provide appropriate care for chronic conditions, resulting in higher costs primarily because of avoidable hospitalizations. Rather than promoting effective care for chronic conditions, traditional Medi-Cal payment policies reimburse the treatment of acute problems rather than addressing the underlying conditions.

Source: California HealthCare Foundation, Chronic Disease Care Program.

counties, has turned to a private disease management firm, LifeMasters Supported SelfCare, to focus its efforts on care coordination on a test group of 70 members who had chronic conditions – such as kidney failure. The program reduced hospital admissions and shortened stays for those who were admitted. Health care costs per enrollee fell by $2,700.[103]

These programs are small and are not coordinated with each other, but they all use a similar model for chronic care, the same used by such managed health care giants as Kaiser Permanente, with its 6.2 million California members. They share the same goals of keeping people healthy and getting them to the right place for the care they need. Each draws on a model that employs a team approach, evidence-based medicine and a focus on measurable outcomes in patient health.

In each example, the organization attempted to create a medical home, the linchpin to effective preventive and chronic care. Though there isn't a fixed definition for the term, a medical home generally refers to a continuing relationship between a patient and a health system or a specific provider, where health needs can be coordinated and monitored.[104]

A system-wide approach to chronic care could pay huge dividends to Medi-Cal, in improving the health of its many beneficiaries who suffer from chronic conditions, though major determinants of success include the motivation of the beneficiary to change health habits, and the quality of the provider staff. Enlisting the state's network of community based clinics in this effort likely will require more state support. Dr. Sophia Chang, who heads the California HealthCare Foundation's Chronic Disease Care Programs, said community health clinics that have focused on primary care often face a steep learning curve in taking on chronic care and may lack the resources or expertise to expand their mission without help.[105]

Properly supported, however, community health clinics offer a cost-effective way to reach Medi-Cal enrollees for primary care and increasing chronic care. They can provide medical homes with increased potential for coordinated care, and as seen in several counties, they can serve as care-appropriate front-doors for managed care-like systems, better allocating health resources, using clinics for primary and chronic care and hospitals for acute and specialty care.

No one size fits all

Despite the lessons the state can glean from various local efforts, administrators in each locality noted that in a state as diverse as California, there are components of reforms that require conditions unique to that county. In California, no one size fits all and state policy must account for that diversity.

In a 2003 report the Commission recommended that the complexity of the state's health and human services system be transitioned to a county-based system of care. The Commission recommended that the state set statewide goals for health and wellbeing; provide funding, personnel and other resources; and, monitor progress toward goals.

The state should look for ways to leverage this asset through pilot projects to enhance the ability of clinics to deliver these services, starting in counties with established clinic systems, such as Alameda, Santa Clara or San Mateo counties. Options that could help clinics reach more senior fee-for-service beneficiaries with chronic conditions include changing reimbursements to allow clinics to be paid for preventive care that does not require a physician and group education and self-care classes for seniors with chronic conditions.

Encouraging the role of community-based clinics to provide a medical home also is promising, especially given the flexibility they offer in providing culturally appropriate care. They offer the opportunity for greater access to primary and preventive care, and increasingly, as the Commission learned from Clínica Romero in Los Angeles and Project Dulce in San Diego, opportunities to provide chronic care for often hard-to-reach populations.

The Department of Health Care Services can lead in this area by eliminating barriers to opening more community clinics and seeking the necessary waivers so that prevention activities and chronic care can be reimbursed.

It should start in counties that already have established community health clinics and encourage the development of centers for specific groups, such as seniors. The state can look to such successful programs as the On Lok SeniorHealth program in San Francisco and Fremont to attract seniors who do not have a medical home.[106] And it can fund more innovation as it has in Humboldt County and other places, setting standards for what it expects and helping counties learn from successful models.

Disease Management Another Route

Managed care plans, by design, are supposed to provide medical homes for their members. Community health clinics can fill this role as well. But other arrangements also can provide many of the same benefits, sometimes without a primary care physician in the main coordinating role. Such arrangements, with different degrees of coordination and control, include primary care case management and specialty disease management programs for people with chronic conditions.[107]

Other states are wrestling with the same issues of how to provide the benefits of a medical home to their Medicaid enrollees who aren't in managed care, as many states also have large numbers of senior and blind and disabled enrollees in fee-for-service care.

Nearly three dozen states are trying a strategy known as disease management. This strategy differs from case management in that it focuses on a specific disease in an effort to make sure the patient is getting the recommended care and monitoring their condition closely, with the goal of intervening early in the progression of the disease.

Of those, Florida was the earliest and most ambitious in its approach, starting in 1999, after its legislature mandated development of a disease management program. Due to slow implementation, Florida's program hasn't achieved its legislature's projected savings targets, which may have been unrealistic. Through 2004, however, the state's programs have showed a net savings of more than $19 million as well as gains in a range of health outcomes, such as fewer hospital admissions, weight loss, reduced smoking and greater use of recommended prescriptions.[108]

A survey of nine established plans by the Kaiser Commission on Medicaid and the Uninsured found that Medicaid disease management plans showed improvements in care, though limited cost savings.[109]

Disease management in the Medicaid arena is still evolving as states learn to adapt strategies that are successful in commercial health care programs to more complicated Medicaid populations, where obstacles include enrollee turnover and often frequent changes in address. Other obstacles the Kaiser Commission identified were provider dissatisfaction because of low provider rates and incomplete or out-of-date state records and the complicated and contentious process of establishing a cost-savings formula. Some states have found that the programs had the tendency to drive up costs in their early stages as enrollees, equipped with more knowledge about their condition, saw physicians more often.[110]

As a result, many states are modifying their programs. Several states, including Washington and Indiana, are taking a broader approach and integrating some or all elements of the Chronic Care Model developed by Dr. Edward Wagner.[111]

Most states, including California, have some of their Medicaid beneficiaries enrolled in disease management programs through managed care plans that offer such programs, whether offered by the plan's own staff, as in the case of Kaiser Permanente, or through an outside vendor, such as Partnership Health Plan's contract with LifeMasters Supported SelfCare, Inc. The Kaiser Commission on Medicaid and the Uninsured report found that few states, however, had the ability to judge how successful those efforts were.[112]

California Starting Pilot Projects

In response to a 2003 request from the Legislature, Medi-Cal is in the process of setting up a pilot for a coordinated care management project. Data from the Department of Health Care Services show that expenditures are extremely concentrated in the group of beneficiaries with the most serious health problems, with just 5 percent of Medi-Cal's enrollees accounting for 60 percent of the program's expenditures.[113]

The pilot will build on the state's experience with its medical case management program, a small program that targets high-cost fee-for-service Medi-Cal enrollees who have already entered the acute stage of a disease and have experienced a major health crisis. A Medi-Cal case manager works with the beneficiary's physician and other provider staff to ensure continuity of appropriate care from the beneficiary's discharge from the hospital through follow-up outpatient care, smoothing and streamlining the process where necessary. The program is designed to last up to a year with the goal of stabilizing beneficiaries and helping them engage with other public resources for their long-term health needs.

Two disease management pilot programs are underway, one that focuses on Medi-Cal enrollees with AIDS. In the other, a contractor, McKesson Health Solutions, is targeting beneficiaries with chronic conditions in parts of three counties. McKesson, which will keep a share of any savings, plans to target the most expensive cases with a strategy that combines education, medication monitoring, establishing a medical home for patients to coordinate care, and the use of a 24/7 advice line.[114]

If Medi-Cal cannot expand the number of its beneficiaries who have medical homes for coordinated care by enrolling them in managed care plans, a broad disease management strategy might be the next best solution, especially for beneficiaries who don't have access to managed care plans.

The state should work out ahead of time its goals for such programs, as cost savings aren't automatic, and when they exist, tend to be diluted as the population added to the program grows. As long as the programs are carefully monitored and the results measured, they provide an opportunity to see what works and what doesn't. Dr. John Hsu, a physician and researcher at the Kaiser Permanente Institute of Health Policy, said the decisions on how to proceed are easy when data shows a program doesn't work, or clearly saves money.[115] Having goals established beforehand becomes important when results are mixed, as when a disease management improves health outcomes of beneficiaries,

but does not provide savings. Then goals become essential for the discussion on how to proceed.

Recommendation 2: To improve health outcomes and spend public resources more efficiently, the Department of Health Care Services must ensure that Medi-Cal beneficiaries have access to care, particularly prevention and coordinated care. The department should:

- ***Strengthen and expand managed care.*** The department should increase the number of beneficiaries in managed care plans where such plans exist. To do so, it must revive the open stakeholder process to develop standards for readiness and plans to monitor managed care plans for their ability to care for elderly and disabled beneficiaries. The department also must ensure capitation rates are fair and provide incentives for improving health outcomes.
- ***Experiment with new approaches.*** The department must encourage innovation through grants and pilot projects, by setting health quality goals and by allowing providers at the community level to try new approaches to create medical homes, either through clinics or community-based health plans. Where necessary, the state should seek federal waivers to allow money to be spent where it can have the largest long-term benefit – on primary care that can reduce the need for future acute care.
- ***Create incentives to improve outcomes.*** The Department of Health Care Services should create incentives in its Medi-Cal reimbursement structure to improve health outcomes of enrollees through education, prevention, case management, disease management and chronic care programs.
- ***Encourage emergency room alternatives.*** The department should provide incentives and adapt reimbursements to encourage safety net hospitals to open primary care clinics to treat non-urgent cases, preventing inappropriate use of emergency department resources.
- ***Ensure that patients in fee-for-service Medi-Cal have medical homes.*** The department should expand the use of case managers to coordinate care for beneficiaries who remain enrolled in Medi-Cal fee-for-service and promote the use of disease management strategies to target chronic conditions.
- ***Encourage patient responsibility.*** The department should develop prevention and chronic care strategies that encourage enrollees, once educated and given the tools to evaluate care, to take more responsibility for their health.

III. Driving Data to Transformation

Increasing access to health care and emphasizing prevention are important strategies to improving the overall health of Medi-Cal beneficiaries. Whether these strategies pay off in cost savings, however, will be unanswered questions unless the state can determine the results and act on what it learns.

The Department of Health Care Services can demonstrate value to taxpayers by ensuring that the health care services it purchases meet nationally recognized quality standards and improve the health outcomes for Medi-Cal beneficiaries.

This effort will require the department to know its enrollees and the health treatment they receive at a much deeper level and to be able to measure the results of health care both at the individual level and for different population groups within the program.

Roughly 40 percent of the adults and children with disabilities enrolled in Medi-Cal suffer from chronic conditions, while 38 percent of the senior population in Medi-Cal have one or more chronic condition.[116] Disabled adults with chronic conditions on average cost the program more than five times more than a non-disabled adult.[117]

The higher costs may be appropriate, but whether enrollees are receiving appropriate care is another question, and one that the Medi-Cal program today cannot answer, according to testimony from Dr. Sophia Chang, director of Chronic Disease Programs for the California HealthCare Foundation.[118]

Considering that national research suggests that patients with chronic conditions receive only 56 percent of the recommended care, there is a good chance that Medi-Cal's patients are not getting the appropriate level of care and that Medi-Cal is paying for care that is not needed.[119]

The only way to know is to measure.

"Data, or health information, is a primary window into understanding the quality of care we are paying for and receiving," Chang said.[120]

A good place to start is diabetes, a chronic disorder caused by the body's inability to produce enough insulin. That condition causes the level of blood sugar to rise, which can lead to a number of complications. Type 2 diabetes is associated with obesity, an increasing problem for the state. Because of the systemic damage the disorder causes, diabetics often have other chronic conditions, as well.[121]

Governor Schwarzenegger, in his health care proposal, has called for California to create a national model for the prevention and treatment of diabetes.[122]

For diabetics, blood sugar monitoring is essential, as are regular eye examinations and tests of kidney function. The 300,000 diabetes-related hospitalizations in California each year cost more than $3.4 billion.[123]

If the state were able to know how many diabetic people were enrolled in Medi-Cal and who they were, it could track what treatments they were receiving and what test results showed. That way it could signal providers and patients that an eye test or blood test was due, and it could determine, based on test results, what follow-up treatment was warranted. On a system level, the state would be able to tell whether patients were getting the recommended treatment and whether the state's efforts were resulting in fewer hospitalizations, less blindness and fewer amputations.

Institute of Medicine on Value-Based Purchasing

An Institute of Medicine report outlines the following items that should be measured to accelerate improved health outcomes:

- ***Process improvement.*** Health plans should monitor the rate at which preventive services are provided and whether effective pharmaceuticals are prescribed. This is the easiest information to track, as it should be available from billing or other managerial systems.
- ***Outcome improvement.*** Insurers should track the rate at which providers reduce patients' symptoms, prevent hospitalizations, and assist patients in maintaining better control of chronic conditions like diabetes or hypertension. While this should be an ultimate goal, it is difficult to gather this type of information and often requires patient self reports or lab results.
- ***Care-system structure.*** Payers should assess whether practices are designed and organized to meet the needs of patients. This can be achieved through self assessments by providers regarding their level of support for patient self-management, performance measurement, quality improvement, and management of complex patients.
- ***Quality.*** The quality of patients' experiences should be monitored.
- ***Efficiency.*** Efficiency measures should be employed to assess whether care is wasteful or unnecessarily expensive.

Source: Institute of Medicine. March 1, 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy of Sciences. Washington, DC. Accessed at http://www.iom.edu/?id=12736.

Data can be used for improvements

In this way, the state can use data as a tool for dialogue, to establish a common understanding of health care issues and problems, said health systems researcher Dr. Andrew Bindman, a professor of health policy and biostatistics at the University of California, San Francisco, and chief of the division of general internal medicine at San Francisco General Hospital.[124]

In a transformed system, the Medi-Cal program would be able to know the average hemoglobin A1c level – a basic blood sugar measure – for the population of patients with diabetes. To evaluate access, Medi-Cal would know the number of days beneficiaries wait for an appointment. And for medication systems, the department would be able to know the number of adverse drug events per 1,000 doses.

Health experts say the state's best chance for reining in health costs and improving health care is to focus its resources on evidence-based practices that keep people healthy, make them better and prevent avoidable disabilities.

The state can only reduce the prevalence of disabilities due to chronic conditions by aggressively managing those conditions to prevent them from progressing.

In testimony to the Commission, Dr. Bindman stressed the potential for the state to use data as a tool for collaborative, quality improvement to make all providers better, rather than simply to winnow out low-quality providers, an important point given the low level of provider participation in Medi-Cal. Dr. Bindman and other medical researchers emphasized that for physicians, simply seeing how their performance compares to others is often a powerful motivation to improve.[125]

For Medi-Cal, a primary source for health data is contained in claims information. Though designed for payment, claims data has key components that include patient identifiers, gender, age, diagnosis and treatment codes that can be used to measure overuse, under-use or misuse of medical treatment. Analyzing claims data can suggest whether an enrollee is not receiving recommended treatments, such as a regular mammogram, or is getting too much, such as more than the called-for number of steroid injections for a given diagnosis.

The most detailed claims data are available from the fee-for-service side of Medi-Cal, though Medi-Cal also collects encounter data from managed care plans with similar information. This data should be analyzed with equal intensity, and the department should provide incentives to

encourage managed care plans to supply more detailed data on their Medi-Cal members.

Data Analysis Is Routine Elsewhere

Large commercial health plans use this kind of data analysis far more intensively to improve health care and reduce costs. Analyzing such data and applying it to care practices is at the heart of Kaiser Permanente's Care Management Institute, an effort to spread evidence-based best practices to its entire system.[126] It is a critical component to setting capitation rates for managed care plans as well as for financial incentives built into pay-for-performance contracts.

The Care Management Institute at Kaiser

For the past decade, Kaiser has worked to augment its focus on prevention and evidence-based medicine with the creation of the Care Management Institute. Care management is a comprehensive systems approach to medical care that combines the latest medical knowledge on the best clinical methods, population-based outcomes measurement and evaluation, and advanced practice tools. The Care Management Institute is a national entity that synthesizes knowledge on the best clinical approaches. It works with local Kaiser medical groups to create, implement and evaluate health programs. The Institute seeks to understand how to prevent the complications of chronic illnesses, develop analytical and care management tools, and disseminate successful care approaches using the latest technologies.

Source: Peter Juhn, Neil Solomon and Helen Pettay. Spring 1998. "Care Management: The Next Level of Innovation for Kaiser Permanente." *The Permanente Journal*. Accessed at http://xnet.kp.org/permanentejournal/spring98pj.cmi.html. Also, Kaiser Permanente Care Management Institute web site. http://www.kpcmi.org/.

The state, in its role as both a major purchaser of health services and a regulator, needs data to ensure it is accountable in the way it allocates resources, just as it is asking providers to be accountable for how they treat the most vulnerable people under their care. That task will be made easier once health information technology is integrated into the state's health infrastructure, providing an electronic backbone that will allow easy exchange of information between doctor's offices, pharmacies, hospitals and laboratories. That may be a decade away, however.

Dr. Chang, drawing on her experience in data analysis while at the Veterans Health Administration during its transformation, said the state has opportunities now to use existing electronic health information, including claims data it has now, and pharmacy and laboratory information it can collect by requiring that it be included in payment claims.

Some of the pieces, such as the patient claims and encounter data, already exist within the Department of Health Care Services, though both Dr. Chang and Dr. Bindman emphasized that more detailed data is needed, and could be collected, through an improved payment system. Specifically, in its fee-for-service claims, the state needs to collect patient-level data on clinical conditions, processes of care and outcomes, such as test results, that can be used to determine quality.[127]

Despite its shortcomings, the existing claims payment database represents an extraordinarily rich trove of records, representing decades of medical treatments for millions of Californians, including the fee-for-service payment records for the most medically needy and most expensive-to-serve people in the Medi-Cal program.

The Department of Health Care Services also has a large enrollment database with eligibility files for millions of Californians.

Data Housed in Different Places

Important pieces of data exist elsewhere in state government. The Office of Statewide Health Planning and Development (OSHPD), for example, collects patient-level data on hospital discharges, avoidable hospitalizations and health disparities by ethnic groups. It has used its discharge data to create reports on heart attack outcomes, coronary bypass graft surgery, community acquired pneumonia and intensive care outcomes. The office is part of the Health and Human Services Agency but not part of the Department of Health Care Services.

The Office of the Patient Advocate, which collects information on patient satisfaction with managed care plans, is located in the Business, Transportation and Housing Agency, which oversees the Department of Managed Health Care.

These entities each have their own data systems, which do not communicate easily with each other.[128] But when researchers have the time to match files from different data sets, they can learn more about the health system. Dr. Bindman and a team of researchers from the University of California, San Francisco, linked Medi-Cal eligibility files to OSHPD patient discharge files and were able to demonstrate that Medi-Cal managed care was associated with a large reduction in preventable hospitalizations compared to Medi-Cal fee-for-service.[129] This is the kind of research that can be useful to policy-makers trying to allocate limited resources.

To date, the state has relied on outside researchers for deeper looks at the Medi-Cal program and its operations, turning to University of California researchers at different campuses, non-profit organizations, such as the California HealthCare Foundation and the Public Policy Institute of California, and private consulting firms. The state, and particularly the Department of Health Care Services, however, will need to conduct such research, as well as forecasting, on a far more routine basis, organized around what it needs to know to run a transformed Medi-Cal program.

University Partnerships for Data-Driven Policy in Medicaid

Efforts to link data analysis and Medicaid policy in other states have resulted in partnerships between the Medicaid agency and a public university. A few of these partnerships:

Massachusetts. The Executive Office of Health and Human Services (EOHHS) has partnered with the Center for Health Policy and Research at the University of Massachusetts Medical School to improve health outcomes for Medicaid beneficiaries and effectively manage costs by enhancing the evaluation and research capabilities of the EOHHS.

Maine. The Maine Institute for Health Policy at the University of Southern Maine links research and policy to improve health care through projects including evaluations of payment policies and analysis of claim, utilization and other health data to understand trends and assess performance.

Maryland. In collaboration with the Maryland Department of Health and Mental Hygiene, the Center for Health Program Development and Management at the University of Maryland, Baltimore County monitors health outcomes, analyzes health care policies and develops delivery and financing models to ensure that Maryland's publicly-funded health insurance programs achieve desired outcomes.

Sources: Jay Himmelstein, Director, University of Massachusetts Center for Health Policy and Research. January 3, 2007. Personal communication. Also, Andy Coburn, Director, Maine Institute for Health Policy. January 2, 2007. Personal communication. Also, Health Management Associates. October 2005. *A University – Medi-Cal Research and Policy Partnership: An Assessment of Feasibility, Benefits and Issues*. Prepared for the California HealthCare Foundation. On file.

The Commission, in its 2003 report, *Real Lives, Real Reforms*, recommended forming an advanced research office within the Health and Human Services Agency that would consolidate much of the state's health data collection and analysis.[130]

Several states have formed formal relationships with their public research universities for just this kind of work. It is an avenue that the Department of Health Care Services has explored with the University of California, which if implemented, would have the added benefit of qualifying for federal matching money. In anticipation of an agreement with the department, the UC established the California Medicaid Research Institute. The institute has as its mission conducting research to improve the quality of care for Medi-Cal beneficiaries.[131] Dr. Bindman is one of the institute's organizers.

Such an arrangement, if signed, would enable the state to augment its own research efforts, enhance Medi-Cal's health information and statistical capabilities and offer the opportunity to more quickly assess Medi-Cal policies and use research results to improve the program. It also could allow the state to do more regular forecasting.

Barriers to Mining Data

Outside researchers, including Dr. Bindman and Dr. Chang, point to several current barriers to doing more of this kind of research, some of which have to do with where and how the data is stored.

One barrier is system-based: claims data are organized by episode of treatment, and not by patient, making it difficult for researchers to easily track the history of a patient's health care. The current files do not allow researchers to determine a patient's health status, as the files do not contain test results or other outcome measures. It also makes it impossible for a physician seeing a patient for the first time to call up the patient's medical history.

The second barrier is the lack of trained data analysts with the combination of skills and experience to mine data and create statistically valid performance reports from linked Medi-Cal data files. "Although highly qualified, Medi-Cal's professional data staff are too few in number to address all of the needs from within state government," Dr. Bindman said.[132]

This shortage has acted as a constraint to doing the maintenance work required to update the system as well as to conduct research.

Department officials fault the state's personnel and hiring procedures, which are partly to blame for the department's lack of data analysis capacity. Like other state agencies and departments, the Department of Health Care Services is hampered by state personnel policies that impede departments' abilities to recruit, hire, train and retain qualified and motivated employees.[133]

"State government does not have the staff to spend time analyzing the data," Sandra Shewry, director of the department, said.

Director Shewry contrasted the department to private sector health care purchasers, which have entire teams devoted to reviewing patient data and monitoring market trends and conditions. Director Shewry said that there should be analysts to do more of this for the Medi-Cal program. Although policy-makers value data analysis in developing policy, internal staff are the first to be cut when budgets get tight, Director Shewry said.[134]

This shortage has been exacerbated by retirements and a state pay structure for highly trained data analysts that has lagged behind the private sector. Also contributing to the shortage: the Medi-Cal claims payment management information system is built on a 1978 platform

that uses COBAL-based software. COBAL, though a reliable and powerful programming language, since has been supplanted by more modern software. New hires familiar with modern software packages have to learn COBAL to work on the state's claims payment system. [135]

Data Hard to Reach

The biggest hurdle to using the Medi-Cal program's own beneficiary data is not staff but the claims payment processing system itself, formally known as the California Medi-Cal Management Information System, or CaMMIS. Eclipse Solutions, the consulting firm that evaluated the system for the department, estimated that CaMMIS, with 2.5 billion records, is larger than 90 percent of similar systems worldwide and has far exceeded the seven-to-ten year average lifespan for information technology systems of its size.[136]

Each month, it processes and stores 14 million claims for physician visits, laboratory tests, dental care, prescription drugs and more.[137] These records, if easier to compile and analyze, could give researchers a greatly detailed view of what care beneficiaries receive and what diseases they have.

Adapting the system to new requirements, such as federal privacy laws or adding provider identification numbers to existing files, is a complicated process that increasingly results in unanticipated payment errors.[138]

The system is actually an aggregation of several, with 90 different applications written in seven computer languages, managed by five different data management systems. The system uses three different hardware architectures – mainframe, UNIX and Windows computer servers. The largest is the mainframe, which is responsible for the core claims processing and storage.[139]

Making plans for a new system

Officials at the Department of Health Care Services have known that CaMMIS is beyond its prime and vulnerable to failure. But they have been reluctant to move too quickly to replace the existing system, in part because of the resources required to even start the project and because of the experiences of other states, which initially foundered in their transitions to new data systems.

Last year, however, Medi-Cal officials became more confident following several successful launches of new MMIS systems in other states. The

success of other states, together with the emergence of enough providers to create a competitive market, encouraged the department to make plans for a new MMIS. The department has submitted a budget change request for money for data analysts that are needed to create specifications for requests for proposals from vendors.[140]

The cost of a new system, estimated at $150 million, would be borne largely by the federal government through incentive matches as high as 90 percent, as long as the new system complies with federal Medicaid Information Technology Architecture standards. By comparison, the cost of backlogged maintenance and system updates is estimated at nearly $100 million.[141] These costs are growing, due to the increased maintenance the system requires and devising workaround solutions to software problems.

New System Could Aid Fraud Detection

A new claims payment management information system also would help the Medi-Cal program assess fraud, according to the California Office of the Attorney General's Medi-Cal Task Force.[142] The Department of Health Care Services has its own anti-fraud investigators and works with the Office of the Attorney General, which has a separate investigative staff that focuses on providers. It also works with other state and federal agencies. It is worth noting that the one area in which Medi-Cal has focused its analysis of claims data is fraud detection and prevention. In its most recent analysis of "at-risk" Medi-Cal payments, the department found that 5.17 percent were payment errors and 3.23 percent, representing $542 million, were potentially fraudulent.[143] The AG's report said industry estimates are far higher, up to 10 percent, though the task force did not assess the Medi-Cal program specifically.[144]

The task force was formed to look at ways to enhance the existing anti-fraud efforts using a modern technology based approach. "However, after initial examination, the current structure of the Medi-Cal system is such that minor changes to the system will not yield significant improvements in either the ability to detect or prevent fraudulent behavior," the report said, adding that the current MMIS system left the program unduly exposed to fraud.[145]

The task force said that a system using modern systems architecture could not only "dramatically improve" Medi-Cal's anti-fraud efforts, but deliver a higher quality of service to beneficiaries.

Health Information Technology

Technology offers promise for health care improvements.

The federal government and advocate groups have been encouraging the adoption of health information technology (HIT) improvements and expansions, a call taken up by California in the past year as well, as a way to decrease medical errors, reduce duplication of tests, speed communication and improve quality of care. Though upfront costs can be immense, advocates believe the increased efficiency ultimately will reduce costs.

Health information technology is a broad term, referring to tools such as electronic health records to store patient medical information digitally and allow secure access by patients, providers, laboratory technicians and pharmacists in different locations. HIT also describes innovations such as telemedicine, with the potential to link patients in rural areas to providers in major medical centers. New technology also can provide physicians with immediate decision support and up-to-date medical knowledge. Electronic-prescribing, another component of health information technology, allows doctors to submit prescriptions electronically to pharmacists.

Hurricane Katrina catalyzed efforts to improve HIT. Images of storm victims being evacuated on gurneys with their medical records duct-taped around them and the thousands of victims evacuated to other cities with no way to get their health records underscored the fragility of a paper-based health system. Recent research on quality of care also has created momentum for health information technology. A study by the RAND Corporation found that 20 percent of patients receive treatment that is inappropriate for their diagnoses. HIT could decrease duplicative or counterproductive medical services and enable measurement of quality that can be used for pay-for-performance strategies.

State, federal and private sector efforts.

A 2004 federal executive order called for a nationwide interoperable HIT infrastructure. It established an HIT coordinator to set standards, assess costs and benefits, and to develop and implement a strategic plan to guide HIT implementation in the public and private health care sectors.

A majority of states have issued legislation or executive orders calling for the implementation of HIT and, in California, Governor Schwarzenegger has made HIT a priority, setting a goal for 100 percent electronic data exchange in the next decade. The governor convened an eHealth Action Forum where participants agreed on the following items as state priorities for implementing HIT:

- California must leverage its power as a purchaser of health care to demand quality.
- The state must designate a "HIT Czar" to establish a vision for HIT, lead implementation of the vision and coordinate the various entities and individuals involved.
- California must align financial incentives for all payers.
- The state should push the development of e-prescribing and telemedicine infrastructure.
- The state should play a role in driving HIT infrastructure.

Kaiser, an early pioneer in health information technology, currently is rolling out electronic health records for members and an HIT infrastructure to link patient data to pharmacies, laboratories, clinics and hospitals region-wide and ultimately, system-wide. And five major U.S. corporations—Applied Materials, BP America, Intel, Pitney Bowes and Wal-Mart—have each contributed $1.5 million to develop an Internet-based electronic health record storage system for the 2.5 million employees they cover. The system, called Dossia, seeks to reduce the inefficiencies—and associated costs—of the current health care system by compiling and storing all elements of individuals' health records in a single electronic file. And groups like the California Regional Health Information Organization (CalRHIO) are bringing together health plans, providers, hospitals, consumers, public agencies and policy leaders to build a secure statewide health information exchange system.

Standardization is a primary challenge.

Various obstacles have impeded the widespread adoption of HIT. While experts state that the benefits of HIT are well worth its costs, they also caution that the costs of implementing health information technology systems must account for training people to use the new systems and the lost productivity that results from the change. The primary challenge in fully leveraging the benefits of HIT has been a lack of consistent standards for interoperability.

Because each HIT vendor sells a proprietary system; and each provider, lab and pharmacy uses their own internal and idiosyncratic codes to describe diagnoses, treatments, tests and prescriptions; the various HIT systems that do exist are unable to communicate with each other. But California can use its purchasing power to promote standardization.

HIT is no substitute for an efficient system.

Dr. Andrew Wiesenthal, one of the leaders of Kaiser Permanente's effort to create an electronic health record across all aspects of care for its 8.6 million patients nationwide, said the promise of HIT is immense, but he offered several cautions. Simply automating an ineffective system will only create an ineffective system that is more expensive, he said. And if a health plan does a very poor job at managing its patients, a computer system can offer the potential to improve patient management but won't be successful unless the health plan improves its management culture. HIT should be seen as one of many tools to assist in improving performance of the health care system.

Dr. Wiesenthal and Dr. Sophia Chang of the California HealthCare Foundation said the state can play a leadership role without a huge initial investment, simply by leveraging its market power. Implementing HIT will be a gradual process, but Medi-Cal can start simply by requesting that providers who contract with the state adopt basic standards for how health information is documented and communicated. At a minimum, providers should use the standard and universal Logical Observation Identifiers Names and Codes (LOINC) and should employ Health Level 7 (HL7) standards for the electronic exchange of clinical, financial and administrative information.

California should join with other large states.

Lori L. Hack, as director of government relations and policy for CalRHIO, has been working with the state and with large health care providers on developing standards and resolving privacy and security issues involved in health information exchange. Ms. Hack said California can accelerate the adoption of national standards by having the state work with other states that have large Medicaid programs, such as New York, Illinois and Texas. It could create de facto standards by setting standards for a large portion of the nation's Medicaid population.

Sources: See page 83

Better data can be used to link performance to pay

Lacking data to measure performance, compensation at all levels of the health care delivery system traditionally has failed to reward appropriate care. Increasingly, however, large health care purchasers are using data to insist on value and enlisting hospital systems in the effort. Pay-for-performance and value purchasing are two such efforts to realign payment incentives with health outcomes, recognizing that how health

Shining a light on "never-events"

New mandatory reporting requirements by states that hospitals publicly disclose so called "never-events" – preventable adverse medical events resulting in serious injury, illness or death – is part of a broader trend toward greater measurement of health care outcomes and patient safety. Reporting laws also are an attempt to address Institute of Medicine findings that medical errors caused the death of between 44,000 to 98,000 patients each year in the U.S.

In 2002, the National Quality Forum, a non-profit membership organization created to develop and implement a national health care quality measurement reporting strategy, released a report identifying 27 serious but largely preventable adverse medical events – never-events -- to serve as the source of national state-based event reporting systems.

Never-events include surgery performed on the wrong body part; surgery performed on the wrong patient; unintentional retention of a foreign object in a patient after surgery; death or serious disability associated with the misuse of a drug or medical device; an infant discharged to the wrong person; death due to the transmission of incompatible blood, and; maternal death or serious injury during labor in a low-risk pregnancy.

In 2006, California became the fifth state to pass legislation mandating the public reporting of these 27 events when the Governor signed Senate Bill 1301 (Alquist). Effective July 1, 2007, SB 1301 requires acute care hospitals to report adverse events to the Department of Health Care Services no later than five days after the event occurred.

The federal Centers for Medicare and Medicaid Services is reviewing its policy on reimbursing hospitals for never-events, and in 2008 will adjust its Medicare payments for hospital-acquired infections.

In a survey asking hospitals to commit to patient safety principles, The Leapfrog Group – a program leveraging employer purchasing power to improve health care – asks hospitals to waive all costs related to never-events, apologize to the patient or survivors, report the event, and investigate the cause and find a remedy to prevent future errors.

Medi-Cal has the opportunity to offer incentives for improved quality. Equipped with the new "Never-Events" law, Medi-Cal should reinforce its quality goals by declining to reimburse hospitals for serious, preventable medical errors.

Sources: National Quality Forum Web site: www.qualityforum.org; California Senate Health Committee. April 19, 2006. SB 1301 Bill Analysis; and, California Statutes Chapter 647 (2006).

care is paid for can lead to improved health care quality, moderate costs and increase consumer engagement. Pay for performance imposes common standards and expectations and increases transparency and accountability by rewarding higher performing providers.

In 2005, pay-for-performance efforts in California led by the Integrated Healthcare Association resulted in an additional 60,000 women screened for cervical cancer, nearly 12,000 more diabetics tested, and approximately 30,000 more children immunized compared to 2004.[146]

One of the largest of such national efforts is the program organized by The Leapfrog Group, which represents major corporations and insurers. It uses the purchasing power of its members to encourage the nation's

health providers to make advances in health care safety and quality and, that such efforts will be recognized and rewarded.[147]

A similar group in California is the Pacific Business Group on Health, which in addition to major corporations, counts the California Public Employees' Retirement System among its members. The group is a forum for value-based purchasing strategies, including pay-for-performance, and acts as a catalyst for pushing for quality improvement and promoting value. Its 50 members purchase health care coverage for 2.5 million Californians.[148]

The Department of Health Care Services can learn from these groups, especially from their public members, such as CalPERS. And once armed with the data on health outcomes of its Medi-Cal enrollees, it can become a quality-demanding purchaser, exercising the leverage it has as the state's largest purchaser of health care. These steps will require investments, but they will allow the Medi-Cal program to spend dollars more discriminately and push providers to improve the quality of care they offer.

The Medi-Cal program will need time to implement many of the components necessary for transformation. But it can begin planning now how to link incentives – ultimately in the form of higher reimbursements – to desired performance goals, such as the adoption of health information technology as well as measuring and reporting quality and health outcomes.

Recommendation 3: The Department of Health Care Services must have the data and analytical capacity to measure health outcomes, plan for the future, prevent fraud, and promote the most appropriate and cost-effective health care. The Department of Health Care Services should:

- ***Develop a data plan.*** The Department of Health Care Services, working with stakeholders in other state agencies, must develop a strategic plan for data needs based on health quality goals. The plan should link existing systems and accommodate new data management systems.
- ***Use data to track quality and fight fraud.*** The Department of Health Care Services should use patient data to determine quality and health outcomes and in areas of measured low quality performance, encourage the use of best practices to improve health outcomes. The new system should be designed in collaboration with the Office of the Attorney General to build in optimal fraud detection capability before claims are paid.

- ***Leverage outside research assets.*** Until the department can develop its own research team, it should contract with the California Medicaid Research Institute at the University of California to analyze clinical data collected by the state. The department must use research from its operations to develop policies to improve health outcomes for enrollees.
- ***Replace claims payment information system.*** The department should prepare for replacement of the Medi-Cal Management Information System, including the hiring of staff to extract business and professional rules from the present system. Top priorities for the new system include the ability to quickly and accurately process payments as well as to capture a range of clinical data from patient encounters with providers, laboratories and pharmacies.
- ***Integrate electronic patient information.*** In coordination with other state purchasers of health services, the Department of Health Care Services must develop a strategy to integrate health information technology into its purchasing policies. As a first step, Medi-Cal can adopt standards and timetables for health information technology protocols in areas where private and non-profit providers have taken the lead and are prepared to participate.

IV. Aligning Enrollment Process with Goals

An estimated 437,000 California adults and children are eligible for Medi-Cal, but are not enrolled, adding to the ranks of the state's uninsured.[149] For many of these individuals, a complicated application and eligibility determination process impedes enrollments; others have been covered by the program in the past, and although they remain eligible, have lost coverage due to a renewal process that could be simplified. Still others are eligible, but were denied coverage because of errors in the eligibility determination process.

Enrolling eligible applicants and keeping eligible beneficiaries enrolled in Medi-Cal results in cost savings to the state and improved health for beneficiaries. When otherwise eligible beneficiaries churn in and out of the Medi-Cal program – failing to renew their coverage during the required eligibility re-determination period, only to re-apply after their coverage has been dropped – administrative costs are increased and limited staff time is consumed. When individuals eligible for Medi-Cal benefits but lack on-going preventive and primary care turn instead to emergency rooms, costs rise for the health care system as a whole.

As part of broader efforts to expand health insurance in California, and improve health outcomes, the state can avoid waste and improve health outcomes by enrolling and providing continuous coverage to all Medi-Cal eligible individuals.

Consequences of Churning

Costs to state, counties, health plans and providers:

- Costs associated with enrolling, un-enrolling and re-enrolling.
- Costs associated with providing "new member" services multiple times.
- Additional administrative costs associated with researching and reconciling billing problems.
- Cost-shifting when Medi-Cal is not available to reimburse safety-net providers.
- Extra staff time and costs to track and assist individuals participating in disease management programs who have lost coverage.
- Costs associated with verifying enrollment status, counseling consumers about coverage status and assisting with enrollment.

Negative impacts on beneficiaries' health:

- Reduced effectiveness of disease management programs.
- Compromised continuity of care as returning enrollees are assigned to different plans or providers.
- More difficulty measuring quality of care.
- Difficulty accessing care, especially preventive care.
- Difficulty arranging care, particularly specialty care.
- Unmet health care needs.
- Care provided in inappropriate settings.

Source: Laura Summer and Cindy Mann, Georgetown University Health Policy Institute. June 2006. Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies. The Commonwealth Fund.

Previous improvements to Medi-Cal application process

The state has made previous attempts to streamline and simplify the Medi-Cal application, eligibility determination process and renewal procedures. In 1998, the program created mail-in applications for children and pregnant women and a joint Healthy Families/Medi-Cal application.[150]

In 1999, the program eliminated face-to-face interviews as part of the Medi-Cal application process. In 2000, the assets test was eliminated for children. The program granted children 12 months of continuous eligibility once enrolled by exempting them from mid-year and quarterly status reports. In 2001, the state launched the Health-e-App web-based application for the Healthy Families program and eliminated quarterly status reports for families.[151] Legislation adopted in 2002 sought to simplify the renewal process for beneficiaries by requiring eligibility workers to use multiple sources to check beneficiaries' eligibility before contacting them.[152] But not all changes resulted in simplification: In 2003, mid-year status reports for some adults were reinstated.[153]

Despite the state's progress in streamlining application, eligibility determination and renewal procedures, challenges remain. Advocates for enrollees said the application process continues to be overly complicated. The complexity of eligibility determinations sometimes results in eligible applicants being turned away. And a needlessly complex renewal process causes some still eligible beneficiaries to lose coverage.

Overly complex application process

Federal law governing the Medicaid program requires that states administer their Medicaid applications in the most simple manner.[154]

People can qualify for Medi-Cal in an immense variety of ways, one indication being the more than 125 aid codes that denote eligibility for services.[155] A large share of its members qualify by the fact they and their families are enrolled in the California Work Opportunity and Responsibility to Kids (CalWORKs) Program and the program for individuals who meet the requirements in section 1931(B) of the Social Security Act, which applies to people who meet the income requirements for CalWORKS but choose not to enroll in that program.[156]

Medi-Cal is one of several programs that provide health benefits to Californians, a list that includes Healthy Families and Healthy Kids, which have less restrictive eligibility requirements.

Health workers, researchers and managers of community clinics say a primary reason for lack of coverage is a cumbersome application process, made more complicated by the patchwork of computer systems that counties use to communicate with the state's main enrollment data system, the Medi-Cal Eligibility Data System, or MEDS.

Application and Eligibility Determination Process

Each year, county eligibility departments receive some 1.1 million applications for Medi-Cal. Approximately 700,000 of those applications are approved, providing coverage for approximately 1.4 million children and 500,000 adults.[157] Californians can apply for health coverage through Medi-Cal by:

- Mailing in an application
- Calling or going to a county welfare department
- Requesting assistance from a certified application assistor at a community-based organization
- Or, for children, filing at their doctor's office.

Regardless of the path by which an individual applies for Medi-Cal, the application ultimately goes to the regional county welfare department, where an eligibility worker determines whether the applicant is eligible for Medi-Cal.[158]

The process of determining Medi-Cal eligibility begins with the eligibility worker inputting information from the application into an eligibility computer system. There are four such systems throughout the state. The

A patchwork of programs

Individuals are eligible for Medi-Cal if they meet one of 125 codes or criteria. Those codes can be grouped into the following major categories:

Cash-Related Programs:

CalWORKS. Individuals who receive cash assistance through the California Work Opportunity and Responsibility to Kids program are automatically eligible for Medi-Cal.

SSI. The Supplemental Security Income program provides cash assistance for the elderly, blind and people with disabilities. Those who receive SSI also receive Medi-Cal benefits.

Foster Care and Adoption Assistance. Children in foster care are eligible for Medi-Cal.

Refugee Medical Assistance. Refugees who are eligible for CalWORKS are also eligible for Medi-Cal.

1931(B). Individuals who meet the income eligibility requirements for CalWORKs but choose not to enroll are eligible for Medi-Cal, as specified in section 1931(B) of the Social Security Act.

Children's Programs:

The 200 Percent Program provides Medi-Cal for infants up to age 1 whose family income is at or below 200 percent of the Federal Poverty Level (FPL).

The 133 Percent Program provides Medi-Cal coverage for children age 1 to age 6 whose family income is at or below 133 percent FPL.

The 100 Percent Program provides Medi-Cal coverage for children age 6 to 19 whose family income is at or below 100 percent FPL.

Other Children's Programs, such as Minor Consent Services, Accelerated Enrollment and National School Lunch Express Enrollment allow children to access Medi-Cal benefits.

Medically Needy. Individuals who meet the SSI requirements but who do not receive cash assistance are eligible for Medi-Cal.

Other. Other Medi-Cal programs include pregnancy-related programs, programs for Medically Indigent and transitional coverage for people who have lost cash assistance.

Sources: *Medi-Cal Eligibility Procedures Manual*. Accessed at www.dhs.gov. Also, Gerry Fairbrother and Amy Cassedy. *Churning and Racial Disparities in Medi-Cal*. The California Endowment.

applicant's information is transmitted electronically from the county eligibility system to the MEDS data base.[159]

Errors and omissions in eligibility determinations

Some of the eligible uninsured are denied coverage because their application was not screened for all of the possible Medi-Cal aid codes. Others are turned down for one Medi-Cal program without being considered for other Medi-Cal programs for which they are eligible.[160]

Each year, more than 10 percent of the children enrolled in Medi-Cal – more than 300,000 children – go in and out of the program, losing coverage and regaining it within a few months. Over a three-year period, more than 20 percent of children transition in and out of Medi-Cal,

Medi-Cal Application Packet is Extensive

Despite 2000 legislation requiring the department to simplify the Medi-Cal application package, a 136-page packet is distributed to Medi-Cal applicants when they apply for coverage. The packet contains the following state and federally mandated forms:

- Medi-Cal Mail-In Application and Instructions – 16 pages
- Medi-Cal – What it Means to You (PUB 68) – 61 pages
- Health Insurance Questionnaire (DHS 6155) and Attachment (14-47 HHSA) – 2 pages
- Property and Resources Reporting (MC 210 S-P) – 3 pages
- Supplement to Statement of Facts for Retroactive Coverage/Restoration (MC 210 A) – 1 page
- Supplement to the MC 210 for Additional Children (MC 210 S-C) – 2 pages
- Supplement to the Medi-Cal Statement of Facts for Student Educational Expenses (MC 210 S-E) – 2 pages
- Vocational and Work History (MC 210 S-W) – 2 pages
- Supplement to the MC 210 Statement of Facts for Income In-kind/Housing Verification (MC 210 S-I) – 2 pages
- Statement of Citizenship, Alienage, and Immigration Status (MC13) – 2 pages
- Important Information for Persons Requesting Medi-Cal (MC 219) – 4 pages
- Citizenship/Immigration Status Information for Applicants and Beneficiaries for Medi-Cal (MC 009) – 2 pages
- Medi-Cal Information Notice (MC 007) – 8 pages
- Women, Infants and Children (WIC) Brochure – 2 pages
- Your Rights (PUB 13) – 2 pages
- Early and Periodic Screening Diagnosis and Treatment (EPSDT) Brochure (MC 003) – 2 pages
- CHDP (DHS PHE-P265) – 2 pages
- Authorization for Release of Medical Information (MC 220) – 1 page
- Applicant's Supplemental Statement of Facts for Medi-Cal (MC 223) – 8 pages
- Notice Regarding Standards for Medi-Cal Eligibility (DHS 7077) – 1 page
- TMC Flyer (MC 325) – 2 pages
- Notice to Medi-Cal Beneficiaries About Mental Health Benefits – 1 page
- Would You Like to Register to Vote (16-64 DSS) – 2 pages
- Motor Vehicle Property Sheet (14-59 HHSA) – 2 pages
- Attention Medi-Cal Beneficiaries With A Share of Cost (MC 177) (14-40 DSS) – 1 page
- Child Support Forms – 3 pages

though most gaps in coverage average only 4 months. These gaps in coverage primarily occur at renewal time, when changes occur in the program the child is eligible for, and when the child's family moves. [161]

A study by the Health Consumer Alliance found that 75 percent of terminations of Medi-Cal coverage reported to the Alliance were improper, preventable and required consumer action to keep coverage.[162]

The Health Consumer Alliance research found that less than one-third of valid Medi-Cal terminations reported to the group by consumers were because the consumer no longer met the eligibility criteria. The majority of valid terminations were the result of the beneficiary failing to comply with paperwork requirements, though the beneficiary was still eligible and still seeking benefits.[163]

California does not have the data to determine how many of these otherwise eligible beneficiaries re-enroll, but studies of churning in other states show up to 60 percent of Medicaid beneficiaries who lose coverage regain it within one year.[164]

Renewal Process

Federal law requires that eligibility for Medi-Cal be re-determined annually or anytime there is a change in the amount or source of the beneficiary's income, assets or expenses. As of August 2003, California law requires that adult beneficiaries who are not aged, blind or disabled re-apply for Medi-Cal every six months.[165]

As with eligibility determination, the semi-annual re-determination process is delegated to county welfare offices. Counties conduct more than 6 million Medi-Cal renewals each year.[166] While each county works within the parameters of Medi-Cal regulations, annual re-determination practices vary from county to county. In all counties, the re-determination process begins when the county welfare office mails an annual renewal packet to beneficiaries. Most counties mail these packets one to two months prior to the renewal date. Beneficiaries must fill out the forms and return them to the county welfare office, where they are screened to determine whether the beneficiary is still eligible. If beneficiaries no longer meet Medi-Cal requirements, they are referred to other health programs, such as Healthy Families, Access for Infants and Mothers (AIM), or California Children's Services (CCS).[167]

The federal government has urged simplification

The federal Centers for Medicare and Medicaid Services have encouraged states to eliminate questions that are not required by federal Medicaid policy.[168] Yet California's application, eligibility and renewal procedures are more rigorous than is required by federal law, with added questions, more frequent income status reports, signature requirements and an extensive asset verification process. Each is seen as a hurdle to gaining benefits.

Where federal law requires Medicaid beneficiaries to reapply for their benefits once a year, California asks beneficiaries to submit income status reports every six months. The only beneficiaries who are exempt are the enrollees who are aged, blind or disabled. The mid-year status report requirement was introduced during the 2002-03 budget crisis and was assumed to save $42.5 million by reducing caseload by an estimated 96,000 recipients.[169] Processing these status reports adds to the workload of eligibility workers and often results in qualifying individuals losing coverage because of failing to submit paperwork. Prior to 2000, however, quarterly income reports represented an even bigger administrative burden.

In 2006, Legislators asked Medi-Cal to create a pilot project to implement self-certification of income and benefits in two counties to self-certify their income and assets. The pilot project is underway in Orange and Santa Clara counties.[170] Other counties continue to require a lengthy income verification process. The federal government has encouraged, and other states have adopted, self-verification of income at both the time of initial application and renewal.[171] Estimates from the Lewin Group show that 12,600 currently eligible but not enrolled individuals would enroll if able to self-certify their income.[172] These individuals, though their low incomes make them eligible, have not enrolled because they have not met income documentation requirements.

Though California has exempted children from an assets test, counties are required by state law to conduct the assets test for adult beneficiaries, a process that is estimated to take up 20 percent of the time required to process an application.[173] Twelve states and the District of Columbia have eliminated the assets test for parents and families and found that it helped simplify and streamline paperwork and increase worker productivity without large increases in program costs.[174] The Lewin Group, in a cost benefit analysis of assets tests, estimated that up to 24,500 people who were currently eligible but not enrolled would gain coverage if the assets test were eliminated.[175] The state may want to consider further evaluation in this area to see if the benefits of an asset test in reducing inappropriate benefits exceed the administrative burden

created by conducting the tests and the cost of uninsured, but eligible, families to the health care system.

Silos result in inconsistencies and inefficiencies

Each of California's different health care programs has different eligibility requirements and different funding sources. As a result, families applying for benefits can find that different family members may be eligible for one program and not another. A parent of three children may have to use several sets of forms and respond to multiple requests for duplicative information because each child might qualify for coverage through a different program. Attempts to create combination forms include the joint Medi-Cal/Healthy Families mail-in application, and the Internet-based Health-e-app and One-e-app.[176]

Each county is responsible for analyzing changes in rules and policy and determining how to apply them. This allows for local innovations, but introduces the potential for inconsistent implementation across counties. Renewal policies, for example, vary by county, though federal law requires that Medicaid programs be implemented uniformly throughout each state.[177]

Many counties have found that the overly-complicated process results in eligible beneficiaries losing coverage and have put through changes to simplify the process. These efforts vary from using new, streamlined forms and instructions to collaborating with health plans, community clinics and other organizations to notify beneficiaries of upcoming renewal. Four counties send a personalized re-enrollment form that is pre-populated with information previously submitted by the beneficiary. In other counties, eligibility workers complete the renewal form by telephone and mail the completed form to the beneficiary for review and signature. But there is no statewide mechanism for sharing information about renewal innovations in one county with other counties.[178]

County Eligibility Computer Systems

County eligibility workers use one of four computer systems to determine whether an applicant is eligible for Medi-Cal, and to send and receive information from the state's overarching data system, MEDS. When changes to eligibility rules occur, each of the systems must be modified to reflect the changes. Each of the four systems differ in their capabilities and are summarized here:

LEADER is used in Los Angeles County.

I-SAWS is the oldest system and typically requires complex and costly programming when upgrades are required. This system is used in 35 mostly small counties, but these counties will migrate to the C-IV system over the next two years.

C-IV is currently used in Merced, Riverside, San Bernardino and Stanislaus counties. It is a more modern system that is easier to update and has greater data analysis capacity than I-SAWS.

CalWIN was the last system to be fully implemented and also is a more modern system than I-SAWS. It is used in the following 18 counties: Alameda, Contra Costa, Fresno, Orange, Placer, Sacramento, San Diego, San Francisco, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Tulare, Ventura and Yolo.

Source: "Medi-Cal Eligibility Primer." February 1, 2007. County Welfare Directors Association of California.

Technology Barriers

Counties use one of four separate automated welfare eligibility computer systems to coordinate with the state's MEDS system. Each system is separately programmed, maintained and updated when changes are made to aid codes or eligibility rules.[179] Implementation of the new county systems has not been entirely smooth. Several counties have reported dropped enrollees or beneficiaries being sent conflicting letters about their status. A recent lawsuit in Santa Mateo County revealed that a malfunction in the CalWIN system resulted in the termination of Medi-Cal coverage for some Medi-Cal seniors, a problem which the department says has been resolved.[180]

The California HealthCare Foundation created the One-e-App Internet-based software to replace the current paper-based application process. Though the state has not adopted the free software, some counties are beginning to implement this software on their own.[181]

Recommendation 4: To ensure that qualified Californians are enrolled in programs for which they are eligible, the Department of Health Care Services, working with other involved departments, local governments and community-based organizations, should:

- ***Align application, eligibility and renewal procedures with federal rules.*** Application forms, eligibility determinations and renewal procedures should be simplified as required by federal law. The state should consider whether the costs of an assets test outweigh the benefits.
- ***Make electronic applications available to the public.*** The department should transition to an Internet-based system for enrollment and eligibility determination and adopt existing software technology to simplify and streamline the process; to improve accuracy and retention; and, eliminate waste and duplication.
- ***Encourage "one-stop" enrollment.*** Drawing on the experience of counties already doing so, the department should help all counties adopt a "one-stop" approach to enrollment for publicly funded health programs so that families with members who qualify for different programs can make a single application to all publicly funded health programs for which they might qualify.
- ***Encourage innovations in renewal procedures.*** The department should promote and lead county innovations to simplify and streamline the Medi-Cal renewal process by doing the following:
  - ✓ Communicate patients' renewal dates to providers and encourage providers to distribute renewal forms.
  - ✓ Allow annual re-determination to occur anytime throughout the year, as long as it occurs annually.

- ✓ Gather and share information on county innovations with other counties so that best practices can be adopted to streamline procedures and maximize administrative resources. Examples of innovations include pre-populating the forms that are sent to beneficiaries and providing for call-in renewal.
- ✓ Ensure that each applicant is screened for every Medi-Cal program.

Conclusion

The Governor and lleaders want to find solutions to ensure that more of California's uninsured have health care coverage. Many of their proposals rely in part on Medi-Cal, the program that since 1966 has provided health care coverage to low income families and people with disabilities.

The program is a critical part of the state's health care system, providing coverage to 6.6 million vulnerable Californians who otherwise would be uninsured. But it must perform better, both for the people it has committed to serve and for the taxpayers who pay for it.

The way the program operates reflects the health care system as it was when Medi-Cal was launched 40 years ago. The intervening years have seen revolutions in all parts of health care and the state now needs to focus on what Medi-Cal should look like to serve Californians for the next 40 years and beyond.

Medi-Cal cannot continue to operate as it has without eating up a growing share of the General Fund, forcing the state to divert resources from other programs or cut services. Health care costs are expected to continue to increase. And one of the most expensive populations to treat, senior citizens, is becoming the state's fastest growing population group.

The federal government, the state's partner in the Medi-Cal program, already has signaled it is reining in growth in the program and at the same time, is pushing for changes in the health care system to increase price transparency, improve quality and encourage the adoption of health care information technology by health care providers.

Governor Schwarzenegger, in his health care proposals and in executive orders, has shown he wants the state to pursue the same goals. This vision of transformation has to include California's single largest purchaser of health care – Medi-Cal.

There's no question that transforming Medi-Cal would be difficult and complicated, just as there is no question that this is the most opportune time to start. The Department of Health Care Services, now that it has

split from its previous public health obligations, can focus its energy on developing a strategic plan for transforming Medi-Cal.

Many of the ideas emerging from proposals to help the uninsured center on ways to provide primary care in the most cost-effective venue; the Governor's plan emphasizes prevention as well. These are critical pieces to any kind of health reform.

Just as they should be part of the discussion of transforming Medi-Cal, so should transforming Medi-Cal be part of the broader debate on changing the health care system in California.

The state must expand primary care access to Medi-Cal beneficiaries and the uninsured alike by removing barriers to opening more community-based clinics, adapting Medi-Cal's reimbursement structure to pay for evidence-based care that improves health but does not require a physician, and by encouraging more innovation at the local level through pilot programs.

And the state can help clinics develop the ability to deliver coordinated care for chronic conditions, which not only holds the potential to improve the health of enrollees, but also could reduce future disabilities resulting from the complications of chronic disease.

These are elements of the on-going relationships patients find in a "medical home," where treatment can be coordinated, one of the cornerstones of the best managed care plans. The state must renew its efforts to enroll more Medi-Cal beneficiaries in Medi-Cal managed care plans in the various forms in which they exist in California. The first step in that process must be to ensure plans are financially strong enough to serve these groups with heavy medical needs and have systems in place that demonstrate they are capable of delivering such care.

The state can lead transformational change by using Medi-Cal's market leverage to improve health care quality and value. This year the state will spend $37.7 billion through the Medi-Cal program. In the past, the state has focused primarily on what Medi-Cal pays for health services. Now, and in the future, Medi-Cal must harness data about its enrollees to monitor what it is buying with taxpayer dollars. That way, it can start to focus on evidence-based treatments that improve health outcomes for enrollees and use incentives to improve quality. Such a strategy promises to transform the health system not only for Medi-Cal enrollees, but for every Californian.

The Commission's Study Process

The Commission previously examined health care in its 1987 and 1990 reports on Medi-Cal, a 1993 report on health care reform, and in its 2004 study of health and human services. It also has done extensive work on public health, addiction and mental health.

The Commission initiated this study in the summer of 2006 in an effort to determine whether there were efficiencies that could be achieved in California's publicly funded health care programs and to investigate whether resulting savings could be used to expand coverage to more of California's uninsured.

In pursuing its study, the Commission and its staff relied upon the generosity of many individuals who assisted in guiding the Commission's review, identifying best practices and suggesting opportunities for improvement.

The Commission convened three public hearings, three advisory committee meetings and two site visits – one to Contra Costa County and one to Los Angeles County.

In a September 2006 public hearing, the Commission convened state, local and community experts to discuss the State's goals for health care, the policies and practices in place to achieve those goals and the associated challenges. They expressed frustration with the fragmentation of California's health care "un-system." They described the agencies, policies and programs that are intended to provide the most essential services to Californians as a patchwork of uncoordinated and siloed artifacts of a delivery system that has slowly and non-strategically evolved over time. Often these programs do more to impede positive health outcomes than to assist in achieving health. Participants at this hearing insisted that to achieve required changes, California needs cohesive and strong leadership to coordinate disparate interests and align financial incentives for meaningful health care reform.

At a second hearing in January 2007, experts discussed opportunities for the State to transform the Medi-Cal program to focus on improving health outcomes by using data to drive decision-making and being a more demanding purchaser of health care. They described Medi-Cal as a program that has very little information about the beneficiaries it serves, and that fails to use the information it does have to plan for the future of the program. Witnesses described opportunities to improve the services

Medi-Cal provides and increase the efficiency of the program by using data to drive decision-making.

A third hearing, held in February 2007, brought together analysts, advocates and health care economists to discuss the components of the various health care reform proposals presented by the Governor and legislative leaders. Those components include individual mandates, employer mandates, purchasing pools, high deductible health plans, expanded public programs and premium subsidies. These experts discussed the advantages and disadvantages of each component, the tradeoffs associated with each, and how proposed reforms would affect the State's existing publicly funded health care programs.

In addition to the public hearings, the Commission's three advisory panel meetings and two site visits provided the opportunity to meet with experts and practitioners. In July 2006, the Commission held an advisory panel meeting in Sacramento to explore the demographics and financing of health care in California, to document barriers to care, and to discuss obstacles that have impeded reform of the state's health care system.

In September 2006, the Commission visited health facilities in Contra Costa County and convened an advisory panel meeting to explore the community operations of publicly-funded health care and to discuss how well the service delivery system meets community needs. During an October 2006 site visit and advisory panel meeting in Los Angeles County, the Commission explored the community operations of publicly-funded health care and efforts to expand access to care. The advisory panel also discussed current funding strategies and associated strengths and challenges and explored the role and status of state support for innovation, service integration, and performance and outcome measurement.

Public hearing witnesses and advisory panel participants are listed in the appendices. The Commission greatly benefited from the contributions of all who shared their expertise, but the findings and recommendations in this report are the Commission's own.

Appendices & Notes

- ✓ ***Public Hearing Witnesses & Written Comments Submitted***
- ✓ ***Advisory Panel and Site Visit Participants***
- ✓ ***Notes***

Appendix A

Little Hoover Commission Public Hearing Witnesses and Written Comments Submitted

Witnesses Appearing at Little Hoover Commission Public Hearing on Health Care, September 28, 2006

Leona M. Butler
Chief Executive Officer
Santa Clara Family Health Plan

Phillip R. Crandall, Director
County of Humboldt Health and Human Services Department

Lesley Cummings, Executive Director
Managed Risk Medical Insurance Board

Crystal Hayling
President and Chief Executive Officer
Blue Shield of California Foundation

David Kears, Director
Alameda County Health Care Services Agency

Allen Miller, Chief Executive Officer
COPE Health Solutions

Stan Rosenstein, Deputy Director
Medical Care Services
Department of Health Services

Lucien Wulsin, Jr., Director
Insure the Uninsured Project

Witnesses Appearing at Little Hoover Commission Public Hearing on Health Care, January 25, 2007

Kimberly Belshé, Secretary
California Health and Human Services Agency

Andrew B. Bindman
Professor of Medicine
Health Policy, Epidemiology and Biostatistics
University of California, San Francisco; and
Policy Chief, Division of General Internal Medicine, San Francisco General Hospital

Sophia Chang, Director
Chronic Disease Care Programs
California HealthCare Foundation

Lucinda "Cindy" Ehnes, Director
Department of Managed Health Care

Jeff Flick, Regional Administrator
Centers for Medicare and Medicaid Services

Lori L. Hack, Director of Government Relations and Policy
California Regional Health Information Organization

Emma Hoo, Director
Value-Based Purchasing
Pacific Business Group on Health

Andrew M. Wiesenthal
Associate Executive Director
The Permanente Federation

Witnesses Appearing at Little Hoover Commission Public Hearing on Health Care, February 22, 2007

Peter Harbage
Senior Program Associate
Health Policy Program
New America Foundation

Gerald F. Kominski, Associate Director
UCLA Center for Health Policy Research

Glenn Melnick
Professor and Blue Cross of California Chair in Health Care Finance; School of Policy, Planning and Development; University of Southern California

Anthony Wright, Executive Director
Health Access California

Written Comments Submitted

Donna Fox
Regulatory Policy Specialist
California Nurses Association

Scott Graves, Senior Policy Analyst
California Budget Project

Mitchell Katz, Director of Health
San Francisco Department of Public Health

Ken Shachmut, Senior Vice President
Safeway Inc.

Appendix B

Advisory Panel and Site Visit Participants

Participants at the Little Hoover Commission Sacramento Advisory Panel Meeting on July 27, 2006

Vicki Bermudez
Regulatory Policy Specialist
California Nurses Association

Teri Boughton, Chief Consultant
California State Assembly Committee
on Health

Farra Bracht
Principal Fiscal and Policy Analyst
Legislative Analyst's Office

Kelly Brooks, Legislative Representative
Health and Human Services
California State Association of Counties

Elena Chavez, Policy Analyst
Consumers Union

Lesley Cummings, Executive Director
Managed Risk Medical Insurance Board

Roger Dunstan, Consultant
Senate Health Committee

Jan Emerson, Vice President
External Affairs
California Hospital Association

Kirk Feely, Senior Fiscal and Policy Analyst
Legislative Analyst's Office

Marti Fisher, Legislative Advocate
Workers' Compensation
Health Care and Insurance
California Chamber of Commerce

Brooke Fox, Regional Workgroup Director
Insure the Uninsured Project

Elia Gallardo
Director of Governmental Affairs
California Primary Care Association

Dietmar Grellman, Vice President of
Managed Care and Legislative Counsel
California Hospital Association

Linda Minamoto
Assistant Regional Director, Region IX
Centers for Medicare and Medicaid Services

Erica Buehrens Murray
Senior Policy and Program Associate
California Association of Public Hospitals
California Health Care Safety Net Institute

Peggy O'Brien-Strain
Senior Research Associate
SPHERE Institute

Chris Perrone, Senior Program Officer
Public Financing and Policy
California HealthCare Foundation

Deborah Riordan
Research Analyst/Epidemiologist
Central Valley Health Policy Institute

Sarah Rodgers, Consultant
Office of Senator Sheila Kuehl

Stan Rosenstein, Deputy Director
Medical Care Services
Department of Health Services

Seren Taylor, Principal Fiscal Consultant
Senate Republican Fiscal Office

Diane Van Maren, Consultant
Senate Budget and Fiscal Review
Subcommittee #3 on Health

William Walker, Chief Executive Officer
Contra Costa Health System and Chair
California Association of Public Hospitals
Board of Directors

Lucien Wulsin, Project Director
Insure the Uninsured Project

Participants at the Little Hoover Commission Contra Costa Site Visit and Advisory Panel Meeting on September 11, 2006

Pittsburg Health Center, La Clínica Pittsburg Medical Center and the Contra Costa Regional Medical Center

Wendel Brunner, Director
Contra Costa Public Health Department

Jean Fraser, Chief Executive Officer
San Francisco Health Plan

Jane García, Chief Executive Officer
La Clínica de la Raza

Agnes Lee, Principal Consultant
Health and Human Services
Senate Office of Research

Viola Lujan, Regional Director
La Clínica de la Raza

Lorena Martinez-Ochoa, Program Specialist
Family, Maternal and Child Health Programs
Contra Costa Health Services

Nancy McCoy, Clinical Services Manager, Pittsburg Health Center

Jacque McLaughlin, Director
Solano Kids Insurance Program

Christina Reich, former Head Start Mom and Director/Analyst, Contra Costa County Head Start Program

Dorothy Sansoe, Senior Deputy County Administrator, Contra Costa County Administrator's Office

Wanda Session, Manager
Financial Counseling
Contra Costa Health Services

Jeff Smith, Executive Director
Contra Costa Regional Medical Center

Mellissa Stafford Jones
President and Chief Executive Officer
California Association of Public Hospitals

Patricia Tanquary
Deputy Executive Director
Contra Costa Health Plan

William Walker, Director and Health Officer
Contra Costa County Health Services
Chair, California Association of Public Hospitals Board of Directors

Participants at the Little Hoover Commission Los Angeles County Site Visit and Advisory Panel Meeting on October 17, 2006

LAC + USC Medical Center and La Clínica Romero

Teri Boughton, Chief Consultant
California State Assembly Committee on Health

Pete Delgado, Chief Executive Officer
LAC + USC Medical Center

Grace Floutsis, Medical Director
Clínica Msr. Oscar A. Romero Community Health Center

Paul Giboney, Associate Medical Director
Clínica Msr. Oscar A. Romero Community Health Center

Sharon Grigsby
Acting Chief Network Officer
Los Angeles County Department of Health Services

Melissa Stafford Jones
President and Chief Executive Officer
California Association of Public Hospitals

Alan M. Kurz, Medical Director
Los Angeles County Department of Public Health

Agnes Lee
Principal Consultant on Health
Senate Office of Research

Allen Miller
President and Chief Executive Officer
COPE Health Solutions

Mary O'Dell, President
UniHealth Foundation

Hanh Kim Quach
Health Care Policy Coordinator
Health Access

Nicole Ramos, Manager
Camino de Salud Networks
COPE Health Solutions

Michael Gregory Roybal
Medical Director, Ambulatory Services
LAC + USC Medical Center

Tim Smith, Policy Analyst
Governmental Relations
L.A. Care Health Plan

Deborah Villar
Director of Public Affairs
Clínica Msr. Oscar A. Romero Community Health Center

Deborah Ward, Vice President
Governmental Affairs
Community Clinic Association of Los Angeles

Notes

1. Note: Number cited is people who were uninsured for all or some of 2005. UCLA Center for Health Policy Research. *2005 California Health Interview Survey*. Los Angeles, CA. Accessed at http://www.chis.ucla.edu.

2. Arnold Schwarzenegger, Governor, State of California. January 10, 2007. *Governor's Budget Summary 2007-08*. "Health and Human Services." "Figure HHS-02 Major Health and Human Services Program Caseloads." California Department of Finance. Sacramento, CA. Page 139. Accessed at http://www.dof.ca.gov/Budget/Historical_Documents.asp.

3. Note: The Governor's Budget includes $14.8 billion in General Fund expenditures for Medi-Cal, which is 14.4 percent of the total $103.1 billion General Fund. The only larger General Fund expenditure is for K-12 Education at $40.5 billion General Fund, or 39.3 percent. Arnold Schwarzenegger, Governor, State of California. January 10, 2007. *Governor's Budget 2007-08*. "Proposed Budget." "Department of Health Care Services." California Department of Finance. Sacramento, CA. Page HHS 1. Accessed at http://www.ebudget.ca.gov/StateAgencyBudgets/4000/4260/department.html and http://www.ebudget.ca.gov/pdf/GovernorsBudget/4000/4260.pdf. Also, Arnold Schwarzenegger, Governor, State of California. January 10, 2007. *Governor's Budget Summary 2007-08*. "Summary Chart: 2007-08 General Fund Expenditures," Page 18 and "Health and Human Services, Department of Health Care Services, 2007-08 Expenditures" Page 148. California Department of Finance. Sacramento, CA. Accessed at http://www.dof.ca.gov/Budget/Historical_Documents.asp. See endnote 2. Also, Legislative Analyst's Office. February 2005. *2005-2006 Budget Analysis*. www.lao.ca.gov/analysis_2005/Health_ss/hss_05_4260_anl05.htm. Cited in California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. "State Budget Distribution. State FY 2005-2006." Oakland, CA. Page 43. Accessed at http://www.chcf.org/.

4. Arnold Schwarzenegger, Governor, State of California. January 10, 2007. *Governor's Budget 2007-08*. "Proposed Budget." "Department of Health Care Services." California Department of Finance. Sacramento, CA. Page HHS 1. Accessed at http://www.ebudget.ca.gov/StateAgencyBudgets/4000/4260/department.html and http://www.ebudget.ca.gov/pdf/GovernorsBudget/4000/4260.pdf. See endnote 3. Note: Pursuant to Chapter 241, Statutes of 2006 (SB 162), effective July 1, 2007, specific programs and public health responsibilities vested within the former California Department of Health Services will transfer to the newly established California Department of Public Health, and the California Department of Health Services will be renamed the California Department of Health Care Services (CDHCS). This report refers to the Department of Health Care Services, although at the time of publication, the split had not yet occurred.

5. California HealthCare Foundation. 2006. *Health Care Costs 101. Snapshot: California Addendum.* Oakland, CA. Pages 8 and 18. Compilation of data from the Centers for Medicare and Medicaid Services, Office of the Actuary and the California Division of Labor Statistics and Research.

6. Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services. September 28, 2006. Written testimony to the Little Hoover Commission. Page 16. Summary of findings from Thomas MaCurdy, Raymond Chan, Rodney Chun, Hans Johnson and Margaret O'Brien-Strain. June 2005.

Medi-Cal Expenditures: Historical Growth and Long Term Forecasts. Public Policy Institute of California. San Francisco, CA. Also, Arnold Schwarzenegger, Governor, State of California. January 10, 2007. *Governor's Budget 2007-08*. "Proposed Budget." "Department of Health Care Services." California Department of Finance. Sacramento, CA. Pages HHS 9 and 10. Accessed at http://www.ebudget.ca.gov/StateAgencyBudgets/4000/4260/department.html and http://www.ebudget.ca.gov/pdf/GovernorsBudget/4000/4260.pdf. See endnote 3.

7. Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services. September 28, 2006. Written testimony to the Little Hoover Commission. Page 16. Summary of findings from Thomas MaCurdy, Raymond Chan, Rodney Chun, Hans Johnson and Margaret O'Brien-Strain. June 2005. *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts*. Public Policy Institute of California. See endnote 6.

8. Department of Health Services. January 12, 2005. "Medi-Cal Redesign Fact Sheet." On file.

9. Department of Health Services. August 2005. Medstat analysis of Medi-Cal MIS/DSS. Cited in California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. "Delivery Systems." Oakland, CA. Page 25. Accessed at http://www.chcf.org/. See endnote 3.

10. Arnold Schwarzenegger, Governor, State of California. March 14, 2007. "Executive Order S-06-07." Office of the Governor. Sacramento, CA. Accessed at http://gov.ca.gov.

11. Note: Medi-Cal is California's version of the federal Medicaid program which was established in 1965 by Title XIX of the Social Security Act. Medi-Cal was created in 1966. U.S. Code Title 42, Chapter 7, Subchapter XIX, Sections 1396-1396v. Accessed at http://www.gpo.access.gov/uscode/index.html and http://www.ssa.gov/OP_Home/ssact/title19/1902.htm. Also, Janet D. Perloff. "Medicare and Medicaid: Health Policy." *Encyclopedia of Social Work*. 2003 Supplement. Washington, DC: National Association of Social Workers.

12. Department of Health Services. August 2005. Medstat analysis of Medi-Cal MIS/DSS. Cited in California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. "Delivery Systems." Oakland, CA. Page 25. Accessed at http://www.chcf.org/. See endnote 3.

13. Medi-Cal Policy Institute. September 2001. *Understanding Medi-Cal: The Basics*. California HealthCare Foundation. Oakland, CA. Accessed at http://www.medi-cal.org.

14. Jennifer Kent, Deputy Director, Legislative and Governmental Affairs. February 27, 2007. Personal communication.

15. Note: The move to managed care began when the Knox Keene act authorized managed care in 1975. California Health and Safety Code Section 1340 et. seq. "Knox-Keene Health Care Service Plan Act of 1975."

16. Department of Health Services. May 2005. Medstat analysis of Medi-Cal MIS/DSS enrollment data. Cited in California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. "Managed Care Models by County." Oakland, CA. Page 28. Accessed at http://www.chcf.org/. See endnote 3.

17. Department of Health Services. "Medi-Cal Beneficiaries by Managed Care Plan Files." HCP0203 and HCP0505. Cited in California HealthCare Foundation.

January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. "Managed Care Enrollment Trends." Oakland, CA. Page 29. Accessed at http://www.chcf.org/. See endnote 3.

18. Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services. September 28, 2006. Testimony to the Little Hoover Commission. See endnote 6.

19. California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. Oakland, CA. Page 28. Accessed at http://www.chcf.org/. See endnote 3.

20. Note: Ninety percent of Medi-Cal managed care enrollees are children and parents. Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services. September 28, 2006. Written testimony to the Little Hoover Commission. See endnote 6.

21. Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services. September 28, 2006. Written testimony to the Little Hoover Commission. See endnote 6. Also, California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. Oakland, CA. Page 28. Accessed at http://www.chcf.org/. See endnote 3.

22. California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. "About Medi-Cal." Oakland, CA. Page 3. Accessed at http://www.chcf.org/. See endnote 3.

23. Kaiser Family Foundation. 2004. *State Health Facts*. Federal FY2004 expenditures. June 2004 enrollment. Cited in Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services. September 28, 2006. Written testimony to the Little Hoover Commission. See endnote 6. Also cited in California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. "Delivery Systems." Oakland, CA. Page 37. Accessed at http://www.chcf.org/. See endnote 3.

24. Sandra Shewry, Director, Department of Health Care Services. October 24, 2006. Personal communication.

25. Office of the Actuary, Centers for Medicare and Medicaid Services. *National Health Care Expenditures Projections: 2004-2014*. "Table 1: National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Selected Calendar Years 1998-2014." Accessed at http://new.cms.hhs.gov/NationalHealthExpendData/downloads/nheprojections2004-2014.pdf. Also, Stephen Heffler, Sheila Smith, Sean Keehan, Christine Borger, M. Kent Clemens and Christopher Truffer. February 23, 2005. "Trends: U.S. Health Spending Projections For 2004-2014." *Health Affairs – Web Exclusive*. Accessed at http://www.healthaffairs.org/. Also, California HealthCare Foundation. 2006. *Health Care Costs 101. Snapshot: California Addendum.* Oakland, CA. Pages 8 and 18. Compilation of data from the Centers for Medicare and Medicaid Services, Office of the Actuary and the California Division of Labor Statistics and Research. Accessed at http://www.chcf.org/. See endnote 5.

26. Note: Nearly one in five Californians will be 65 or older by 2030. Seniors compose 12 percent of Medi-Cal beneficiaries, but consume 28 percent of Medi-Cal expenditures. Department of Aging, Statistics and Demographics. "Facts About California's Elderly." Accessed at http://www.aging.ca.gov/html/stats/fact_about_elderly.html. Also, Department of Finance. May 2004. Population Projections by Race/Ethnicity for California and Its Counties 2000-2050." Report 03 P-3. Accessed at http://www.dof.ca.gov.

Also, California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. "Beneficiaries and Cost" and "Spending Trends. Average Annual Growth, 2000-2005." Oakland, CA. Pages 32 and 35. Accessed at http://www.chcf.org/. See endnote 3.

27. Note: The Governor's 2007-08 Budget projects that the federal government will contribute $260,750,000 to Medi-Cal state operations and $20,672,925,000 to Medi-Cal local assistance. Arnold Schwarzenegger, Governor, State of California. January 10, 2007. *Governor's Budget 2007-08*. "Proposed Budget." "Department of Health Care Services." California Department of Finance. Sacramento, CA. Pages HHS 9 and 10. Accessed at http://www.ebudget.ca.gov/StateAgencyBudgets/4000/4260/department.html and http://www.ebudget.ca.gov/pdf/GovernorsBudget/4000/4260.pdf. See endnote 3. Also, Centers for Medicare and Medicaid Services. "CMS Quality Improvement Roadmap." Washington, DC. Accessed at http://www.cms.hhs.gov/CouncilonTechInnov/downloads/qualityroadmap.pdf. Also, Centers for Medicare and Medicaid Services, Office of Public Affairs. July 25, 2006. "CMS to Fund State Plans for Transforming Medicaid to Increase Quality and Lower Costs." Accessed at http://www.cms.hhs.gov/.

28. Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services. September 28, 2006. Written testimony to the Little Hoover Commission. Page 16. Summary of findings from Thomas MaCurdy, Stanford University and The SPHERE Institute; Raymond Chan, The SPHERE Institute; Rodney Chun, The SPHERE Institute; Hans Johnson, Public Policy Institute of California; and, Margaret O'Brien-Strain, The SPHERE Institute. June 2005. *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts*. Public Policy Institute of California. San Francisco, CA. See endnote 6. Also, Elizabeth G. Hill, Legislative Analyst. November 2006. *California's Fiscal Outlook: LAO Projections 2006-07 Through 2001-12*. Legislative Analyst's Office. Sacramento, CA. Page 22. Accessed at http://www.lao.ca.gov/2006/fiscal_outlook/fiscal_outlook_06.pdf. Note: The California Budget Project published a critique of the SPHERE/PPIC report, *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts*. The California Budget Project states that the PPIC may have overstated California's long-term Medi-Cal spending growth rate. Scott Graves, Senior Policy Analyst, California Budget Project. August 2005. "PPIC Report Projecting Long-Term Medi-Cal Spending Should Be Used With Caution." California Budget Project. Sacramento, CA. On file.

29. Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services. September 28, 2006. Written testimony to the Little Hoover Commission. Page 16. Summary of findings from Thomas MaCurdy, Stanford University and The SPHERE Institute; Raymond Chan, The SPHERE Institute; Rodney Chun, The SPHERE Institute; Hans Johnson, Public Policy Institute of California; and, Margaret O'Brien-Strain, The SPHERE Institute. June 2005. *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts*. Public Policy Institute of California. San Francisco, CA. See endnote 6.

30. Thomas MaCurdy, Stanford University and The SPHERE Institute; Raymond Chan, The SPHERE Institute; Rodney Chun, The SPHERE Institute; Hans Johnson, Public Policy Institute of California; and, Margaret O'Brien-Strain, The SPHERE Institute. June 2005. *Medi-Cal Expenditures: Historical Growth and Long Term Forecasts*. Public Policy Institute of California. San Francisco, CA. See endnote 6.

31. Department of Health Services. January 12, 2005. "Medi-Cal Redesign Fact Sheet." See endnote 8.

32. Mark Baldassare and Ellen Hanak. 2005. *CA2025 It's Your Choice*. Public Policy Institute of California. San Francisco, CA. Accessed at http://www.ppic.org/content/pubs/report/R_605MB1R.pdf.

33. Department of Health Services. August 2005. Medstat analysis of Medi-Cal MIS/DSS data, updated through October 2005. Cited in California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. "State Budget Distribution. State FY 2005-2006." Oakland, CA. Page 33. Accessed at http://www.chcf.org/. See endnote 3.

34. Department of Health Services. August 2005. Medstat analysis of Medi-Cal MIS/DSS data, updated through August 2005. Based on analysis of fee-for-service population and payments in state fiscal years 1999-2000 and 2004-2005. Cited in California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. "State Budget Distribution. State FY 2005-2006." Oakland, CA. Page 35. Accessed at http://www.chcf.org/. See endnote 3.

35. Congressional Budget Office. March 2007. "Fact Sheet for CBO's March 2007 Baseline: MEDICARE" and "Fact Sheet for CBO's March 2007 Baseline: Medicaid." Washington, DC. Accessed at http://www.cbo.gov/budget/factsheets/factsheets2007b.shtml. Also, The Kaiser Commission on Medicaid and the Uninsured. Feburary 2006. "Deficit Reduction Act of 2006: Implications for Medicaid." Accessed at www.kff.org/kcmu.

36. Jeff Flick, Regional Administrator, Centers for Medicare and Medicaid Services. January 25, 2007. Testimony to the Little Hoover Commission. Also, Public Law 109-171. February 8, 2006. "Deficit Reduction Act of 2005." On file. Also, Congressional Budget Office. January 27, 2006. "Cost Estimate: S. 1932, Deficit Reduction Act of 2005." On file.

37. Jeff Flick, Regional Administrator, Centers for Medicare and Medicaid Services. January 25, 2007. Testimony to the Little Hoover Commission. See endnote 36. Also, George W. Bush, President, United States of America. April 27, 2004. "Executive Order: Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator." The White House. Washington, DC. Accessed at http://www.whitehouse.gov/news /releases/2004/04/print/20040427-4.html. Also, George W. Bush, President, United States of America. August 22, 2006. "Executive Order: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs." The White House. Washington, DC. Accessed at http://www.whitehouse.gov/news/releases/2006/08/print/20060822-2.html. Also, Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services. Undated. *Better Care, Lower Costs: You deserve to know… Health Care Transparency*. On file. Also, U.S. Department of Health and Human Services. "Value-Driven Health Care." Washington, DC. Accessed at http://www.hhs.gov/transparency/index.html. On file.

38. Institute of Medicine. March 1, 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy of Sciences. Washington, DC. Accessed at http://www.iom.edu/?id=12736.

39. U.S. Department of Health and Human Services. "Value-Driven Health Care." Washington, DC. Accessed at http://www.hhs.gov/transparency/index.html. See endnote 37.

40. George W. Bush, President, United States of America. April 27, 2004. "Executive Order: Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator." The White House. Washington, DC. Accessed at http://www.whitehouse.gov/news/releases/2004/04/print/20040427-4.html. See endnote 37.

41. Also, George W. Bush, President, United States of America. August 22, 2006. "Executive Order: Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs." The White House. Washington, DC. Accessed at http://www.whitehouse.gov/news/releases/2006/08/print/20060822-2.html. See endnote 37.

42. Centers for Medicare and Medicaid Services. "CMS Quality Improvement Roadmap." Washington, DC. Accessed at http://www.cms.hhs.gov/CouncilonTechInnov/downloads/qualityroadmap.pdf. See endnote 27.

43. Public Law 109-171. February 8, 2006. "Deficit Reduction Act of 2005." Section 6081. On file. See endnote 36.

44. Center for Medicaid and State Operations. August 2005. "Value-Based…Results-Driven…Healthcare: The Medicaid/SCHIP Quality Initiative." Centers for Medicare and Medicaid Services. Accessed at http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/Downloads/qualitystrategy.pdf. Also, Division of Quality, Evaluation and Health Outcomes; Centers for Medicare and Medicaid Services. Undated. "Value Based Purchasing." On file. Also, Centers for Medicare and Medicaid Services. February 7, 2007. "Medicaid and SCHIP Quality Practices." Accessed at http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/.

45. Jeff Flick, Regional Administrator, Centers for Medicare and Medicaid Services. January 25, 2007. Testimony to the Little Hoover Commission. See endnote 36.

46. Arnold Schwarzenegger, Governor, State of California. July 24, 2006. "Executive Order S-12-06." Office of the Governor. Sacramento, CA. Accessed at http://gov.ca.gov. Also, Arnold Schwarzenegger, Governor, State of California. January 2007. "Governor's Health Care Proposal." Office of the Governor. Sacramento, CA. On file. Also, Arnold Schwarzenegger, Governor, State of California. March 14, 2007. "Executive Order S-06-07." Office of the Governor. Sacramento, CA. Accessed at http://gov.ca.gov. See endnote 10.

47. Sophia Chang, Director, Chronic Disease Care Programs, California HealthCare Foundation. January 25, 2007. Written Testimony to the Little Hoover Commission and February 15, 2007. Personal communication. Also, Andrew M. Wiesenthal, Associate Executive Director, The Permanente Federation. January 25, 2007. Written Testimony to the Little Hoover Commission and February 15, 2007. Personal communication. Also, Andrew B. Bindman, Professor of Medicine, Health Policy, Epidemiology & Biostatistics, University of California, San Francisco; and, Chief, Division of General Internal Medicine, San Francisco General Hospital. October 20, 2006. Personal communication and January 25, 2007. Testimony to the Little Hoover Commission.

48. SB 162 (Ortiz), Chapter 241, Statutes of 2006. On file. See endnote 4.

49. Rene Mollow, Associate Director for Health Policy, Department of Health Services. January 17, 2007. Personal communication.

50. Department of Health Services. October 2, 2006. *Medicaid Transformation Grant Application*. Sacramento, CA. On file.

51. Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services. October 11, 2006. Personal communication.

52. Jean Fraser, Director, San Francisco Health Plan. September 11, 2006. Little Hoover Commission Advisory Panel Meeting.

53. Eclipse Solutions. July 10, 2006. *California Medicaid Management Information System (CA-MMIS) Assessment Report – Final*. California Department of Health Services, Payment Systems Division. Sacramento, CA. On file.

54. Clea Benson. December 15, 2006. "Encore for key health official: State Medi-Cal chief is persuaded to stay on while big reform plans are debated." *The Sacramento Bee*. On file.

55. Little Hoover Commission. June 2005. *Serving the Public: Managing the State Workforce to Improve Outcomes*. Sacramento, CA. On file.

56. Gary J. Young, Senior Researcher Management Decision and Research Center, Veterans Affairs Health Services Research and Development Service and Associate Professor of Health Services, School of Public Health, Boston University. June 2000. "Transforming Government: The Revitalization of the Veterans Health Administration." *2000 Presidential Transition Series*. The PricewaterhouseCoopers Endowment for The Business of Government. Arlington, VA. Accessed at http://endowment.pwcglobal.com. On file.

57. See endnote 56.

58. See endnote 56.

59. Sheldon Greenfield and Sherrie H. Kaplan. August 17, 2004. "Creating a Culture of Quality: The Remarkable Transformation of the Department of Veterans Affairs Health Care System." *Annals of Internal Medicine*. Volume 141, Issue 4. Pages 316-318. On file.

60. Ashish K. Jha, Jonathan B. Perlin, Kenneth W. Kizer and R. Adams Dudley. May 29, 2003. "Effect of the Transformation of the Veterans Affairs Health Care System on the Quality of Care." *The New England Journal of Medicine*. Volume 348:2218-2227, Number 22. On file.

61. Gilbert M. Gaul. August 22, 2005. "Revamped Veterans' Health Care Now a Model." *The Washington Post*. On file.

62. California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. "Beneficiaries and Cost" Page 32 and "Spending Trends, Average Annual Growth, 2000-2005" Page 35. Accessed at http://www.chcf.org. See endnote 3.

63. Stan Rosenstein, Deputy Director, Medical Care Services, California Department of Health Services. September 28, 2006. Testimony to the Little Hoover Commission. See endnote 6. Also, Sophia Chang, Director, Chronic Disease Care Programs, California HealthCare Foundation. January 25, 2007. Testimony to the Little Hoover Commission. See endnote 47.

64. California HealthCare Foundation. 2006. *Chronic Disease in California: Facts and Figures*. Oakland, CA. Accessed at www.chcf.org.

65. See endnote 64.

66. Sue Holtby, MPH, Elaine Zahnd, PhD, Nicole Lordi, Christy McCain, MPH, Y. Jenny Chia, PhD, John Kurata, PhD. May 2006. *Health of California's Adults, Adolescents and Children: Findings from CHIS 2003 and CHIS 2001*. California

Health Interview Survey. UCLA Center for Health Policy Research. Los Angeles, CA. Accessed at http://www.chis.ucla.edu.

67. Note: Diabetes is one disease area where the state has a dedicated project, the California Diabetes Program, aimed at prevention through education and research. California Diabetes Program, Department of Health Services. "About the California Diabetes Program." Accessed at http://www.caldiabetes.org/about.cfm. Also, American Association of Clinical Endocrinologists. April 10, 2007. *State of Diabetes Complications in America*. The Association. Jacksonville, FL.

68. Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services. September 28, 2006. Written testimony to the Little Hoover Commission. See endnote 6. Also, California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. Oakland, CA. Page 28. Accessed at http://www.chcf.org/. See endnote 3.

69. California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. "Spending Trends, Average Annual Growth, 2000-2005" Page 35. Accessed at http://www.chcf.org. See endnote 3.

70. Note: Of the non-elderly Medi-Cal enrollees, the rate of avoidable hospitalizations was a third lower in managed care, which the researchers said suggested that managed care was associated with 7,000 fewer hospitalizations a year, accounting for $66 million in avoided hospitalization costs. Andrew B. Bindman, Arpita Chattopadhyay, Dennis Osmond, William Huen and Peter Bacchetti. February 2004. *Preventing Unnecessary Hospitalizations in Medi-Cal: Comparing Fee-for-Service with Managed Care*. Primary Care Research Center, University of California, San Francisco. Prepared for the California HealthCare Foundation.

71. Robert J. Nordyke and Ellen Wu. October 2004. "Policy Implications of Racial and Ethnic Differences in Managed Care vs. Fee-For-Service Utilization Disparities in California." California Program on Access to Care/California Policy Research Center, University of California Office of the President. Project #CNN16K. Note: Based on data from the 2001 California Health Interview Survey.

72. The Lewin Group. July 2004. *Medicaid Managed Care Cost Savings – A Synthesis of Fourteen Studies*. Prepared for America's Health Insurance Plans.

73. California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. Accessed at http://www.chcf.org. See endnote 3.

74. Stan Rosenstein, Deputy Director, Medical Care Services, California Department of Health Services. September 28, 2006. Written Testimony to the Little Hoover Commission. Page 7. See endnote 6.

75. Note: Ten percent of the Medi-Cal managed care population are seniors or people with disabilities. Stan Rosenstein, Deputy Director, Medical Care Services, California Department of Health Services. September 28, 2006. Written testimony to the Little Hoover Commission. See endnote 6. Also, Medical Care Statistics Section. January 2005. *Medi-Cal Managed Care Expansion—Aged, Blind, Disabled, and Long-Term Care Populations*. Department of Health Services. Sacramento, CA. On file.

76. Kaiser Commission on Medicaid and the Uninsured. "Medicaid and Managed Care." *Key Facts*. Kaiser Family Foundation. On file. Also, California HealthCare Foundation estimates using 2004 data from Kaiser Family Foundation (www.statehealthfacts.org) cited in California HealthCare Foundation. January

2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. Accessed at http://www.chcf.org. See endnote 3.

77. Department of Health Services. January 12, 2005. Medi-Cal Redesign Fact Sheet. On file. See endnote 8.

78. Department of Health Services. August 2, 2005. *Updated Medi-Cal Redesign Fact Sheet*. On file.

79. California Department of Health Services. January 12, 2005. *Medi-Cal Redesign*. "Fiscal Savings." Page 11. Sacramento, CA. On file.

80. Robert E. Hurley, Mercer Government Human Services Consulting, and Cheri Rice. May 2004. *An S.O.S. for the COHS: Preserving County Organized Health Systems*. Pacific Health Consulting Group. San Anselmo, CA. On file. Also, Arnold Schwarzenegger, Governor, State of California; S. Kimberly Belshé, Secretary, California Health and Human Services Agency; and, Sandra Shewry, Director, California Department of Health Services. May 12, 2006. "2006-07 Governor's May Revision. Highlights. California Department of Health Services." Sacramento, CA. Page 8. On file.

81. Note: CalOptima, an Orange County Organized Health System, was one such health plan. C. Perkes. February 8, 2006. "Health plan for poor gets extra funding." *The Orange County Register*. Accessed at http://infoweb.newsband.com. Also, Don Gilbert, Edelstein and Gilbert; and Margaret Tatar, CalOptima. January 22, 2007. Personal communication.

82. Sara Rosenbaum, Sara Wilensky and Peter Shin, George Washington University, School of Public Health and Health Services, Department of Health Policy. August 2005. *Achieving "Readiness" in Medi-Cal's Managed Care Expansion for Persons with Disabilities: Issues and Process*. Funded by The California Endowment. Washington, DC.

83. The Center for Disability Issues and the Health Professions; The Center for Health Care Strategies; and, The Lewin Group. November 2005. *Performance Standards for Medi-Cal Managed Care Organizations Serving People with Disabilities and Chronic Conditions*. Prepared for the California HealthCare Foundation. Accessed at http://www.chcf.org/documents/Medi-CalPerfStandardsRecommendationn112205.pdf.

84. Stan Rosenstein, Deputy Director, Medical Care Services, California Department of Health Services. Received September 28, 2006. Letter to Ms. Brenda Premo, Center for Disability Issues and the Health Professions.

85. California HealthCare Foundation. April 2006. *Examining the 2005 Medi-Cal Hospital Waiver*. Issue Brief. Accessed at http://www.chcf.org. Also, Peter Harbage, Harbage Consulting and Jennifer Ryan, National Health Policy Forum. Undated. *"Questions and Answers About the 2005 Medi-Cal Hospital Waiver."* Prepared for the California HealthCare Foundation. On file. Also, Peter Harbage. February 2006. *The 2005 Hospital Waiver Coverage Initiative: Discussion and Analysis of 22 Key Questions to Launching the CI*. The California Endowment. On file.

86. Rene Mollow, Associate Director for Health Policy, Department of Health Services. November 21, 2006. Personal communication.

87. Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services. October 11, 2006. Personal communication. Also, Bailit Health Purchasing, LLC. May 2006. "Putting Quality to Work: Rewarding Plan

Performance in Medi-Cal Managed Care." California HealthCare Assocation. Oakland, CA. On file.

88. Little Hoover Commission. October 17, 2006. Site Visit to the LAC + USC Medical Center and the Clínica Msr. Oscar A. Romero Community Health Center, Los Angeles County.

89. Little Hoover Commission. September 11, 2006. Site Visit to the Pittsburg Health Center, the La Clínica Pittsburg Medical Center and the Contra Costa Regional Medical Center, Contra Costa County.

90. Phillip R. Crandall, Director, Humboldt County Department of Health and Human Services. September 5, 2006. Written testimony to the Little Hoover Commission.

91. California HealthCare Foundation. October 2006. "Overuse of Emergency Departments Among Insured Californians." Issue Brief. Oakland, CA. Accessed at http://www.chcf.org.

92. L.A. Care Health Plan. Undated. L.A. Care Health Plan's Community Health Investment Fund." Los Angeles, CA. On file. Also, L.A. Care Health Plan Web site. Accessed at http://www.lacare.org/opencms/opencms/en/about/index.html. Also, Medi-Cal Policy Institute. March 2000. "Medi-Cal Facts: Medi-Cal Managed Care." Number 8. On file.

93. Little Hoover Commission. October 17, 2006. Site Visit to the LAC + USC Medical Center and the Clínica Msr. Oscar A. Romero Community Health Center, Los Angeles County. See endnote 88.

94. Little Hoover Commission. September 11, 2006. Site Visit to the Pittsburg Health Center, the La Clínica Pittsburg Medical Center and the Contra Costa Regional Medical Center, Contra Costa County. See endnote 89.

95. California HealthCare Foundation. May 2004. *Public Programs: Access to Physicians in California's Public Insurance Programs*. Issue Brief. Oakland, CA. Accessed at http://www.chcf.org.

96. Phillip R. Crandall, Director, Humboldt County Department of Health and Human Services. 2005-2009 AB 1881 Phase II Strategic Plan: *Transformation Towards An Excellence Based System*. On file. See endnote 90.

97. Phillip R. Crandall, Director, Humboldt County Department of Health and Human Services. September 5, 2006. Written testimony to the Little Hoover Commission. See endnote 90. Also, Thadeau Greenson. April 3, 2007. "Getting Better Care." The Times-Standard. Eureka, CA. On file.

98. B.C. Duggar, et al. 1994. *Health Services Utilization and Costs to Medicaid of AFDC Recipients in California Served and Not Served by Community Health Centers*. Center for Health Policy Studies.

99. See endnote 98.

100. Note: Cal CARE, the Senate Republican Caucus health plan proposal, includes provisions to use safety-net money to open community clinics and allow hospitals to shift their safety-net funds to open on-site primary care clinics. California State Senate Republican Caucus. 2007. "Cal CARE Overview." Accessed at http://republican.sen.ca.gov/calcare/overview.asp.

101. Athena Philis-Tsimikas, Chris Walker, Lisa Rivard, Gregory Talavera, Joachim O.F. Reimann, Michelle Salmon and Rachel Araujo. January 2004. "Improvement in Diabetes Care of Underinsured Patients Enrolled in Project Dulce." *Diabetes Care*. Volume 27, Number 1.

102. Note: Medi-Cal provides two-thirds of the revenues for California's safety-net hospitals. Dr. Guterman's successes produced the unintended side-effect of cutting into the hospital's Medi-Cal revenues by reducing the number of admissions. Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services. September 28, 2006. Written testimony to the Little Hoover Commission. See endnote 6. Also, California HealthCare Foundation. January 2006. *Medi-Cal Facts and Figures: A Look at California's Medicaid Program*. Oakland, CA. Accessed at http://www.chcf.org/. Also, Jeff Guterman, Medical Director, Los Angeles County, Department of Health Services and Professor of Medicine, UCLA School of Medicine. March 16, 2007. Presentation at the California Health Policy Forum. California State Capitol. Sacramento, CA.

103. Chris Cammisa, Medical Director, Partnership Health Plan of California. April 10, 2007. Personal communication. Also, Partnership Health Plan of California. *Annual Report 2005-06*. Accessed at http://www.partnershiphp.org. Note: Researchers debate whether disease management results in cost savings. Bruce Fireman, Joan Bartlett and Joe Selby. November/December 2004. "Can Disease Management Reduce Health Care Costs By Improving Quality?" *Health Affairs*. Volume 23, Number 6. Also, Francis J. Crosson and Philip Madvig. November/December 2004. "Perspective: Does Population Management of Chronic Disease Lead To Lower Costs of Care?" *Health Affairs*. Volume 23, Number 6.

104. Melanie Bella, Claudia William, Lindsay Palmer and Stephen A. Somers. November 2006. *Seeking Higher Value in Medicaid: A National Scan of State Purchasers*. Center for Health Care Strategies, Inc.

105. Sophia Chang, Director, Chronic Disease Care Programs, California HealthCare Foundation. January 25, 2007. Written testimony to the Little Hoover Commission and February 15, 2007. Personal communication. See endnote 47.

106. On Lok SeniorHealth Web site. http://www.onlok.org.

107. Note: It isn't clear, however, how successful care coordination programs can be for large populations outside the more structured environment of a managed care plan. A major demonstration project commissioned by the Centers for Medicare and Medicaid Services run by Mathematica Policy Research Inc. showed promise for high cost Medicare beneficiaries. Preliminary results from the ongoing demonstration in 15 markets showed that none of the programs were successful in changing dietary and exercise behavior, improving quality, reducing hospitalizations or costs. Mathematica, however, said it was too early to expect impacts on some of the outcomes and that sample sizes in some programs were small. Randall Brown, Deborah Peikes, Arnold Chen, Judy Ng, Jennifer Schore, and Clara Soh. "The Evaluation of the Medicare Coordinated Care Demonstration: Findings for the First Two Years." March 2007. Mathematica Policy Research Inc. Princeton, NJ. Accessed at http://www.mathematica-mpr.com/publications/PDFs/mccdfirsttwoyrs.pdf.

108. Roberta Kelley, Bureau Chief, Health Systems Development, Florida Agency for Health Care Administration. January 26, 2005. *The Florida Medicaid Disease Management Experience*. Presented to the House Health Care Committee. Florida Medicaid, Florida Agency for Health Care Administration.

109. Claudia Williams, AZA Consulting. September 2004. "Medicaid Disease Management: Issues and Promises." Kaiser Commission on Medicaid and the Uninsured. Washington, DC. On file.

110. Bruce Fireman, Joan Bartlett and Joe Selby. November/December 2004. "Can Disease Management Reduce Health Care Costs By Improving Quality?" *Health Affairs*. Volume 23, Number 6. See endnote 103.

111. Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi. November/December 2001. "Improving Chronic Illness Care: Translating Evidence into Action." *Health Affairs*. Volume 20, Number 6. On file.

112. Claudia Williams, AZA Consulting. September 2004. "Medicaid Disease Management: Issues and Promises." Kaiser Commission on Medicaid and the Uninsured. Washington, DC. On file. See endnote 109.

113. Stan Rosenstein, Deputy Director, Medical Care Services, Department of Health Services. October 11, 2006. Personal communication.

114. Sandeep Wadhwa, Vice President of Care Management, McKesson Health Solutions. February 2, 2007. Personal communication.

115. John Hsu, Scientist, Division of Research, Kaiser Permanente Institute of Health Policy. November 4, 2006. Personal communication.

116. California HealthCare Foundation. January 2006. *Medi-Cal Budget and Cost Drivers*. "Prevalence of Chronic Conditions." Page 14. Oakland, CA. Accessed at http://www.chcf.org.

117. California HealthCare Foundation. January 2006. *Medi-Cal Budget and Cost Drivers*. "Monthly Cost per Beneficiary." Page 13. Oakland, CA. Accessed at http://www.chcf.org. See endnote 116. Also, Sophia Chang, Director, Chronic Disease Care Programs, California HealthCare Foundation. January 25, 2007. Written Testimony to the Little Hoover Commission. See endnote 47.

118. Sophia Chang, Director, Chronic Disease Care Programs, California HealthCare Foundation. January 25, 2007. Written Testimony to the Little Hoover Commission and February 15, 2007. Personal communication. See endnote 47.

119. Elizabeth A. McGlynn, Steven M. Asch, John Adams, Joan Keesey, Jennifer Hicks, Alison DeCristofaro and Eve A. Kerr. June 26, 2003. "The Quality of Health Care Delivered to Adults in the United States." *The New England Journal of Medicine*. 348; 26.

120. Sophia Chang, Director, Chronic Disease Care Program, California HealthCare Foundation. January 25, 2007. Written testimony to the Little Hoover Commission. See endnote 47.

121. Centers for Disease Control and Prevention. 2004. "National Diabetes Fact Sheet, United States, 2003." U.S. Department of Health and Human Services. Atlanta, GA. Accessed at www.cdc.gov/diabetes.

122. Arnold Schwarzenegger, Governor, State of California. January 2007. "Governor's Health Care Proposal." Office of the Governor. Sacramento, CA. On file. See endnote 46.

123. Diabetes Control Program. Undated. "Fast Facts." Department of Health Services. Accessed at http://www.dhs.ca.gov/opa/FactSheets/PDF/ps8.pdf.

124. Andrew B. Bindman, Professor of Medicine, Health Policy, Epidemiology & Biostatistics, University of California, San Francisco; and, Chief, Division of General Internal Medicine, San Francisco General Hospital. October 20, 2006. Personal communication and January 25, 2007. Testimony to the Little Hoover Commission. See endnote 47.

125. Sophia Chang, Director, Chronic Disease Care Programs, California HealthCare Foundation. January 25, 2007. Written Testimony to the Little Hoover Commission and February 15, 2007. Personal communication. See endnote 47. Also, Andrew M. Wiesenthal, Associate Executive Director, The Permanente Federation. January 25, 2007. Written Testimony to the Little Hoover Commission and February 15, 2007. Personal communication. See endnote 47.

126. Peter Juhn, Neil Solomon and Helen Pettay. Spring 1998. "Care Management: The Next Level of Innovation for Kaiser Permanente." *The Permanente Journal*. Accessed at http://xnet.kp.org/permanentejournal/spring98pj.cmi.html. Also, Kaiser Permanente Care Management Institute Web site. http://www.kpcmi.org/.

127. Sophia Chang, Director, Chronic Disease Care Programs, California HealthCare Foundation. January 25, 2007. Written testimony to the Little Hoover Commission and February 15, 2007. Personal communication. See endnote 47. Also, Andrew B. Bindman, Professor of Medicine, Health Policy, Epidemiology & Biostatistics, University of California, San Francisco; and, Chief, Division of General Internal Medicine, San Francisco General Hospital. October 20, 2006. Personal communication and January 25, 2007. Testimony to the Little Hoover Commission. See endnote 47.

128. David M. Carlisle, Director, Office of Statewide Health Planning and Development. February 13, 2007. Personal communication. Also, Andrew B. Bindman, Professor of Medicine, Health Policy, Epidemiology & Biostatistics, University of California, San Francisco; and, Chief, Division of General Internal Medicine, San Francisco General Hospital. October 20, 2006. Personal communication and January 25, 2007. Testimony to the Little Hoover Commission. See endnote 47. Also, Chris Perrone, Senior Program Officer, Public Financing and Policy, California HealthCare Foundation. August 21, 2006; October 4, 2006; and, December 12, 2006. Personal communications. Also, Toby Douglas, Assistant Deputy Director, Medical Care Services, Department of Health Services. January 17, 2007. Personal communication. Also, Kim Ortiz, Chief, Office of Medi-Cal Payment Systems, Department of Health Services. November 3, 2006. Personal communication.

129. Andrew B. Bindman, Arpita Chattopadhyay, Dennis Osmond, William Huen and Peter Bacchetti. February 2004. *Preventing Unnecessary Hospitalizations in Medi-Cal: Comparing Fee-for-Service with Managed Care*. Primary Care Research Center, University of California, San Francisco. Prepared for the California HealthCare Foundation. See endnote 70.

130. Note: The Governor, in his health system reform proposals and in a follow-up executive order, has called for the state to use its data warehouses to make the California's health care system more transparent and allow consumers to be able to make more informed choices. The Governor called for collaborating with private and public entities to develop a quality reporting mechanism through the Office of the Patient Advocate. His plan also seeks to strengthen the ability of the OSHPD to collect, integrate and distribute data on health outcomes, costs, utilization and pricing. This data could then be used by purchasers, health plans, other providers and consumers to inform and drive decision-making. Arnold Schwarzenegger, Governor, State of California. January 2007. "Governor's Health Care Proposal." Office of the Governor. Sacramento, CA. On file. See endnote 46.

131. Andrew B. Bindman, Professor of Medicine, Health Policy, Epidemiology & Biostatistics, University of California, San Francisco; and, Chief, Division of General Internal Medicine, San Francisco General Hospital. October 20, 2006. Personal communication. See endnote 47. Also, Stan Rosenstein, Deputy

Director, Medical Care Services, California Department of Health Services. October 11, 2006. Personal communication. See endnote 51.

132. Andrew B. Bindman, Professor of Medicine, Health Policy, Epidemiology & Biostatistics, University of California, San Francisco; and, Chief, Division of General Internal Medicine, San Francisco General Hospital. October 20, 2006. Personal communication. See endnote 47.

133. Little Hoover Commission. June 2005. *Serving the Public: Managing the State Workforce to Improve Outcomes*. See endnote 55.

134. Sandra Shewry, Director, Department of Health Care Services. October 24, 2006. Personal communication. See endnote 24.

135. Note: One result is that few data analysts entering the workforce now are being trained to use COBAL. To meet its data analysis needs for running the existing Medi-Cal claims payment operation, the state has supplemented its staff with retired annuitants and taken on the job of teaching COBAL to new programmers who are well-versed in modern software programming. Jerry Stanger, Chief, Payment Systems Division, Department of Health Services. February 21, 2007. Personal communication.

136. See endnote 53.

137. See endnote 53.

138. Jerry Stanger, Chief, Payment Systems Division, Department of Health Services. February 21, 2007. Personal communication. See endnote 135.

139. See endnote 53.

140. Note: Replacing a system of the size and complexity of CaMMIS will require several years and several phases, including extracting the existing business rules from the 4 million lines of code in the current system, which preserve the list of what CaMMIS is supposed to accomplish. Paradoxically, replacing CaMMIS also would require modernizing the existing system to reduce the risk of its collapse before it is replaced. See endnote 53. Also, Department of Health Care Services. January 9, 2007. "Budget Change Proposal 071/MC-27: Medi-Cal Claims Processing Systems and Policy Management – Planning and Development for a Replacement CA-MMIS." Sacramento, CA. On file.

141. See endnote 53.

142. Bill Lockyer, Attorney General, State of California. December 2006. *Attorney General's Medi-Cal Task Force Report*. Sacramento, CA. On file.

143. Stan Rosenstein, Deputy Director, Medical Care Services, California Department of Health Services. September 28, 2006. Testimony to the Little Hoover Commission.

144. See endnote 142.

145. See endnote 142.

146. "California Health Plans Pay Over $55 Million to Physician Groups For Reaching IHA Pay For Performance Measures." February 14, 2007. News Release. Integrated Healthcare Association. Oakland, CA. Also, Integrated Healthcare Association. February 2006. "Advancing Quality Through Collaboration: The California Pay for Performance Program." Oakland, CA. On file.

147. The Leapfrog Group. February 2007. "Fact Sheet." Washington, DC. Accessed at http://www.leapfroggroup.org/about_us/leapfrog-fact sheet.

148. Emma Hoo, Director, Value-Based Purchasing, Pacific Business Group on Health. January 25, 2007. Testimony to the Little Hoover Commission.

149. Note: An additional 297,000 children are eligible for either Healthy Families or Healthy Kids but still lack health insurance of any kind. Garrison Frost, Director of Communications, UCLA Center for Health Policy Research. March 8, 2007. Personal communication.

150. Lisa Chimento, Moira Forbes, Joel Menges, and Anna Theisen; The Lewin Group; and, Nalini Pande, Medi-Cal Policy Institue. June 2003. *Simplifying Medi-Cal Enrollment: Technical Report on the Assets and Income Test*. Medi-Cal Policy Institute. Oakland, CA. Accessed at http://www.chcf.org/documents/policy/MediCalSimpTechRpt.pdf. Also, The Lewin Group. May 9, 2003. "Simplifying Medi-Cal Enrollment: Summary Presentation." Medi-Cal Policy Institute. Page 3. On file.

151. See endnote 150.

152. SB 87 (Escutia), Chapter 1088, Statutes of 2000.

153. SB X1 26 (Committee on Budget and Fiscal Review), Chapter 9, Statutes of 2003.

154. Note: Federal law requires that Medicaid eligibility be determined in a manner consistent with simplicity of administration and in the best interests of recipients. Social Security Act, Section 1902(a)(4) and (19). U.S. Code Title 42, Chapter 7, Subchapter XIX, Section 1396a. Accessed at http://www.gpo.access.gov/uscode/index.html and http://www.ssa.gov/OP_Home/ssact/title19/1902.htm. See endnote 11. Also, Centers for Medicare and Medicaid Services. August 2001. *Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage*. CMS Pub. No. 11000. U.S. Department of Health and Human Services. Baltimore, MD. On file. Also, Western Center on Law and Poverty. Received March 19, 2007. "Streamlining the Medi-Cal Program: A Critical Component of Health Coverage Reform." Sacramento, CA. On file.

155. Note: There are approximately 164 aid codes in the Medi-Cal Eligibility Data System (MEDS), although not all of those aid codes are for Medi-Cal programs. Some programs, such as the California Children's Services (CCS), have aid codes in MEDS even though they are not Medi-Cal programs. Anna Pearson and Jennene Newby, Medi-Cal Eligibility Branch, Department of Health Services. April 27, 2007. Personal communications. Also, Department of Health Services. May 2006. "Aid Codes Master Chart." Sacramento, CA. Accessed at http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part1/aidcodes_z01c00.doc.

156. Gerry Fairbrother and Amy Cassedy, Cincinnati Children's Hospital Medical Center. November 2006. "Churning and Racial Disparities in Medi-Cal: Effect of Churning on Eligible Uninsured." Cover California's Kids. The California Endowment. Los Angeles, CA. Accessed at www.covercaliforniaskids.org.

157. Cathy Senderling-McDonald, Senior Legislative Advocate, County Welfare Directors Association of California. April 16, 2007. Personal communication.

158. County Welfare Directors Association of California. February 1, 2007. "Medi-Cal Eligibility Primer." Sacramento, CA. On file. Also, Department of Health Services. "Medi-Cal Eligibility Procedures Manual." Accessed at http://www.dhs.ca.gov/mcs/mcpd/meb/Medi-CalEligibilityProceduresManual/default.htm. Also, Ben Crittenden, Eligibility Supervisor, Sacramento Department of Human Assistance. April 5. 2007. Personal communication.

159. County Welfare Directors Association of California. February 1, 2007. "Medi-Cal Eligibility Primer." Sacramento, CA. On file. See endnote 158. Also, Ben Crittenden, Eligibility Supervisor, Sacramento Department of Human Assistance. April 5. 2007. Personal communication. See endnote 158.

160. Katie Murphy, Health Attorney, Western Center on Law and Poverty. Spring 2007. *Medi-Cal Lost: How Overly Complex Rules End Health Coverage for Low-Income Consumers*. Health Consumer Alliance. Los Angeles, CA. On file. Also, Elizabeth Landsberg, Legislative Advocate, Western Center on Law and Poverty. April 4, 2007. Personal communication.

161. See endnote 156.

162. Katie Murphy, Health Attorney, Western Center on Law and Poverty. Spring 2007. *Medi-Cal Lost: How Overly Complex Rules End Health Coverage for Low-Income Consumers*. Health Consumer Alliance. Los Angeles, CA. On file. See endnote 160.

163. Katie Murphy, Health Attorney, Western Center on Law and Poverty. Spring 2007. *Medi-Cal Lost: How Overly Complex Rules End Health Coverage for Low-Income Consumers*. Health Consumer Alliance. Los Angeles, CA. On file. See endnote 160. Also, Katie Murphy, Health Attorney, Western Center on Law and Poverty. April 18, 2007. Personal communication.

164. Laura Summer and Cindy Mann, Georgetown University Health Policy Institute. June 2006. *Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies*. The Commonwealth Fund. Accessed at www.cmwf.org on April 18, 2007.

165. Note: Separately, former CalWORKs recipients who receive transitional Medi-Cal benefits are required to submit quarterly status reports for the first year of their transitional status. SB X1 26 (Committee on Budget and Fiscal Review), Chapter 9, Statutes of 2003. See endnote 153.

166. Dana Hughes, UCSF Institute for Health Policy Solutions and Letitia Brewster, Brewster Consulting. October 2004. *Keeping Eligible Families Enrolled in Medi-Cal: Results of a Survey of California Counties*. Prepared for the California HealthCare Foundation. Oakland, CA. Accessed at http://www.chcf.org.

167. See endnote 166.

168. Social Security Act, Section 1902(a)(4) and (19). U.S. Code Title 42, Chapter 7, Subchapter XIX, Section 1396a. Accessed at http://www.gpo.access.gov/uscode/index.html and http://www.ssa.gov/OP_Home/ssact/title19/1902.htm. See endnote 11. Also, Centers for Medicare and Medicaid Services. August 2001. *Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health Care Coverage*. CMS Pub. No. 11000. U.S. Department of Health and Human Services. Baltimore, MD. On file. See endnote 154. Also, Western Center on Law and Poverty. Received March 19, 2007. "Streamlining the Medi-Cal Program: A Critical Component of Health Coverage Reform." Sacramento, CA. On file. See endnote 154.

169. SB X1 26 (Committee on Budget and Fiscal Review), Chapter 9, Statutes of 2003. See endnote 153.

170. California Welfare and Institutions Code Section 14012.5, enacted by SB 437 (Escutia), Chapter 328, Statutes of 2006.

171. Centers for Medicare and Medicaid Services. August 2001. *Continuing the Progress: Enrolling and Retaining Low-Income Families and Children in Health*

Care Coverage. CMS Pub. No. 11000. U.S. Department of Health and Human Services. Baltimore, MD. On file. See endnote 154.

172. See endnote 150.

173. See endnote 150.

174. Vernon K. Smith, Eileen Ellis and Christina Chang. April 2001. *Eliminating the Medicaid Asset Test for Families: A Review of State Experiences*. The Kaiser Commission on Medicaid and the Uninsured. Washington, DC. Accessed at www.kff.org on April 4, 2007.

175. See endnote 150.

176. Sam Karp, Vice President of Programs, California HealthCare Foundation. February 21, 2007. Personal communication.

177. Note: California's Medicaid State Plan requires that Medi-Cal policies operate uniformly statewide. See endnote 166.

178. See endnote 166.

179. County Welfare Directors Association of California. February 1, 2007. "Medi-Cal Eligibility Primer." Sacramento, CA. On file. See endnote 158. Also, Christy Quinlan, Deputy Director, Information Technology Services, Department of Health Services. March 2, 2007. Personal communication.

180. Michael Manekin, San Jose Mercury News. February 27, 2007. "Medicare glitch prompts lawsuit." Accessed at http://www.mercurynews.com/. Also, "Snag in Computer System Trips Up California Medicare Benefits." February 27, 2007. I-Health-Beat. Accessed at http://www.ihealthbeat.org/.

181. Sophia Chang, Director, Chronic Disease Care Programs, California HealthCare Foundation. February 15, 2007. Personal communication. See endnote 47. Also, Claudia Page, Director, One-e-App. April 24, 2007. Personal communication. Also, One-e-App. March 5, 2007. Overview and Implementation Status. On file.

Sources to the Health Information Technology text box on pages 40 and 41: Elizabeth A. McGlynn, Steven M. Asch, John Adams, Joan Keesey, Jennifer Hicks, Alison DeCristofaro and Eve A. Kerr. June 26, 2003. "The Quality of Health Care Delivered to Adults in the United States." *The New England Journal of Medicine*. 348; 26. Also, George W. Bush, President, United States of America. April 27, 2004. "Executive Order: Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator." The White House. Washington, DC. Accessed at http://www.whitehouse.gov/news /releases/2004/04/print/20040427-4.html. Also, Arnold Schwarzenegger, Governor, State of California. March 14, 2007. "Executive Order S-06-07." Office of the Governor. Sacramento, CA. Accessed at http://gov.ca.gov. Also, Sophia Chang, Director, Chronic Disease Care Programs, California HealthCare Foundation. February 15, 2007. Personal communication. Also, Andrew M. Wiesenthal, Associate Executive Director, The Permanente Federation. February 15, 2007. Personal communication. Also, Lori L. Hack.