STATE OF CALIFORNIA

EDMUND G. BROWN JR., *Governor*

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

11th & L Building, Suite 550, (916) 445-2125
Sacramento 95814

Chairman
NATHAN SHAPELL
Beverly Hills

Vice-Chairman
DONALD G. LIVINGSTON
Los Angeles

ALFRED E. ALQUIST
Senator, San Jose

MAURICE RENE CHEZ
Los Angeles

JACK R. FENTON
Assemblyman, Montebello

RICHARD D. HAYDEN
Assemblyman, Cupertino

N. BROOKE KNAPP
Los Angeles

MILTON MARKS
Senator, San Francisco

JAMES F. MULVANEY
San Diego

MANNING J. POST
Los Angeles

PHILIP J. REILLY
Mission Viejo

JEAN KINDY WALKER
Modesto

L. H. HALCOMB
Executive Director

THE STATUS OF HEALTH PLANNING IN CALIFORNIA

SUPPLEMENTARY REPORT

STATE OF

CALIFORNIA

February 1979

STATE OF CALIFORNIA

EDMUND G. BROWN JR., *Governor*

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

11th & L Building, Suite 550, (916) 445-2125
Sacramento 95814

Chairman
NATHAN SHAPELL
Beverly Hills

Vice-Chairman
DONALD G. LIVINGSTON
Los Angeles

ALFRED E. ALQUIST
Senator, San Jose

MAURICE RENE CHEZ
Los Angeles

JACK R. FENTON
Assemblyman, Montebello

RICHARD D. HAYDEN
Assemblyman, Cupertino

N. BROOKE KNAPP
Los Angeles

MILTON MARKS
Senator, San Francisco

JAMES F. MULVANEY
San Diego

MANNING J. POST
Los Angeles

PHILIP J. REILLY
Mission Viejo

JEAN KINDY WALKER
Modesto

L. H. HALCOMB
Executive Director

February 1979

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

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

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

As you well know, this Commission has long been concerned with the alarming increases in health care costs in California. Time and again, the Commission has issued recommendations for improving the quality of health care and reducing its cost to the consumer and government.

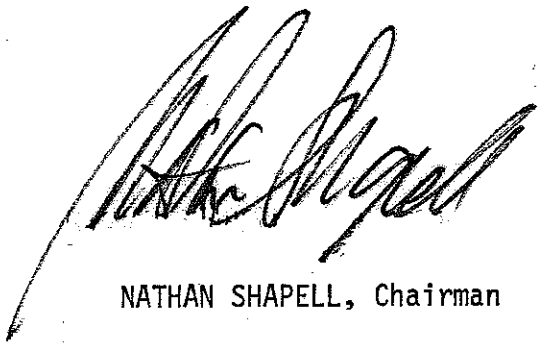
However, we continue to be distressed by the fact that precious little progress has been made toward improving the health care delivery system, in line with recommendations from our Commission and numerous other public and private bodies. Considerable lip-service has been paid to these needs. But in the long run, political realities, intense lobbying by self-interested groups and general bureaucratic apathy has left the health care system in a state of disarray. And the ones suffering most from this chaos are the ones who need care the most--the poor, the frail, the elderly, the minorities.

We are encouraged by the Administration's recently proposed 19-point program for holding the line on health care costs. Some of its features, such as negotiating hospital payment rates in advance and reviewing health facility rates and budgets, are completely in accord with our past recommendations.

In order to focus on these and other health planning issues, the Commission held a hearing December 6, 1978 in Sacramento. Transmitted herewith are our findings and recommendations which emerged from the hearing.

Our Commission sincerely hopes that the Administration, Legislature, health care providers and consumers can work together with renewed effort to make 1979 the year in which significant progress is achieved toward putting together an efficient health care system which meets the needs of our State.

Respectfully,



NATHAN SHAPELL, Chairman

Donald G. Livingston, Vice Chairman
Senator Alfred E. Alquist
Maurice Rene Chez
Assemblyman Jack R. Fenton
Assemblyman Richard D. Hayden
Nancie Brooke Knapp
Senator Milton Marks
*James F. Mulvaney
Manning J. Post
*Philip J. Reilly
Jean Kindy Walker

*Commissioners James F. Mulvaney and Philip J. Reilly were appointed to the Commission on January 18, 1979, consequently they did not participate in the Commission study of health care costs.

February 1979

THE STATUS OF HEALTH PLANNING IN CALIFORNIA
SUPPLEMENTARY REPORT

I. Background

As far back as 1967, this Commission has had a serious and increasing concern over the operation of health care delivery systems in California. Spiraling costs, fragmentation of services, and inadequate care for the poor and other disadvantaged residents have been among the prime concerns. A central issue is the state's inability to adopt legislation to assure effective statewide health planning or to install mandatory cost-containment for hospital expenditures.

Because the Commission is charged with overseeing state government operations its studies and recommendations have dealt with the administration of state health programs in general, and the leviathan Medi-Cal program in particular. But inasmuch as the state is deeply involved in a planning and regulatory function over the private sector, this Commission's scope has, of necessity, been broadened to consider all health care programs, public and private. Isolating either segment is neither possible nor desirable in these days of complex interrelation of resources.

The Commission's major work concerning the health care delivery system is its January 1976 report, entitled 'A Study of the Administration of State Health Programs,' together with several supplemental reports since that time. Although the 1976 report is specifically concerned with the structure and operation of state programs, its overall objective could well be summed up in this comment from the report:

> 'The overriding issue is the provision of quality care at a reasonable cost without regard to sponsorship--public or private. The public system of direct services must not be sacrificed to a poorly organized and uncontrolled private sector.' (page 23)

Some of the Commission's key 1976 recommendations concerning the overall health care system in California were:

1. The Governor should enunciate clear health goals and policy initiatives for California, and commit the Administration to build competence and confidence in state health programs.

2. A State Board of Health should be established to review major health policies and possess final authority for statewide health planning.

3. Steps should be taken to halt the rapid growth in hospital and nursing home facilities as a prime move in cost-containment.

4. An end should be put to fragmentation, such as separation of preventive services from treatment; separation of primary mental health care from general medical care; isolation of nursing home care from general hospital services, extended care and in-home health services; and isolation of services to treat particular disorders (such as drug abuse, mental disability and alcoholism).

5. Non-medical approaches to health status should be enhanced, including health education, environmental standards and job-related hazard control.

In the three years which have elapsed since this report, there has been some progress toward implementing its many recommendations, but clearly no adequate overall momentum for these sorely needed reforms.

Lack of effective laws to limit facilities construction and to contain the cost of health services threatens the financial security of the average citizen and the fiscal integrity of local and state government. Cutbacks generated by Proposition 13 impair the ability of state and local government to provide essential health services to the poor and disadvantaged who must rely on government programs.

In an effort to focus attention once again on these issues, and to develop recommendations designed to achieve some progress, the Commission held a hearing in Sacramento on December 6, 1978, concerning the status of health planning in California.

Witnesses who testified at that hearing included representatives of the California Association of Health Systems Agencies, local health systems agencies themselves, health law specialists, the California Health Facilities Commission, the legislative consultant to the Senate Health and Welfare Committee, the Office of Statewide Health Planning and Development, the California Medical Association and the U.S. Department of Health, Education and Welfare.

This report presents the Commission's findings and recommendations from that hearing and other independent studies.

II. Recommendations

1. Legislation should be enacted to bring California into compliance with the administrative requirements of PL 93-641 by creation of a State Health Coordinating Council.

2. Legislation should be enacted to revamp AB 4001 by elimination of Certificates of Exemption and bringing under Certificate of Need (CON) procedures all expensive equipment located in non-hospital settings, such as physicians' offices, dialysis units, CAT scanners, surgi-centers and in-home health services. All modernization projects should also require CON review.

3. The California Health Facilities Commission should be restructured to consist of five full-time public members and should possess authority to implement a mandatory program of hospital budget and rate review. Failing this goal, the Commission should be abolished and its technical staff and functions transferred to the Office of Statewide Health Planning and Development.

4. Legislation should be enacted to reduce the number of licensed hospital beds in California, including cancellation of licensure for 'phantom' beds not in use and decertification of excess beds.

5. Legislation should be enacted to grant the Office of Statewide Health Planning and Development the authority to review and approve all plans by tax-supported health programs which involve facilities construction, renovation or development of new direct service programs. Such programs would include, but not be limited to Medi-Cal, mental health services, developmental disability programs, public health services, and drug and alcohol abuse programs.

III. Statewide Planning Deficiencies

Public Law 93-641, the National Health Planning and Resources Act, was initiated in 1975. As yet, California has not implemented this statute and our Certificate of Need (CON) law is not in compliance with federal requirements. A long list of exemptions has permitted approval without local review of $3 billion of capital investment since 1976, adding to an already bloated excess capacity statewide.

In order to comply with federal law, the Legislature must create a State Health Coordinating Council and a CON Appeals Board. In addition, AB 4001's variances from federal requirements will have to be removed from state law.

Legislation introduced in the last legislative session would have created a State Health Coordinating Council. Although the Administration clearly supported the bill on its way through the Legislature, the Governor vetoed it without consulting the bill's author, Senator Arlen Gregorio. Future legislative action on this topic is uncertain.

Sheridan Weinstein, M.D., Region 9, U.S. Department of Health, Education and Welfare alluded to a letter sent November 20, 1978, to Mario Obledo, Secretary of the State Health and Welfare Agency. In it, HEW warned that no extension or conditional designation would be granted to the Agency and that $2.6 million in federal funds now in use would be withdrawn in October 1, 1979, unless the state enacts legislation which conforms to federal requirements under PL 93-641.

The letter warned that failure to comply by October 1, 1980, would result in a collective forfeit of federal assistance to support a wide variety of

community health programs funded under the Public Health Service Act, the Community Mental Health Act, and the comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act of 1970. Examples of such problems include neighborhood health centers, nurse training programs, migrant health grants, HMO grants, drug abuse community service programs and community mental health programs. In 1976, this assistance exceeded $200 million; for 1979, estimates range from $300 million to $500 million.

PL 93-641 amendments which failed to clear the last Congress are expected to be reintroduced next year. These amendments strengthen the role of the states by giving the Governor power to disapprove the state health plan if it does not effectively meet the needs established by the state planning agency and to appoint the chairman of the State Health Coordinating Council. Another amendment would strengthen the control over health systems agencies budget and the appointment or removal of their governing body members when HSAs are also public bodies.

This Commission agrees with the testimony of the Executive Director of the California Association of Health Systems Agencies that health care is a public matter, and society has the obligation to plan to assure that comprehensive services are available to everyone on an equal basis. Accordingly, the state can't afford not to plan. The present individualistic development of health services is duplicative, ineffective, and wasteful.

Dr. Henry Zaretsky, Director of the Office of Statewide Health Planning and Development, solicited the cooperation of the Commission and freely acknowledged that he agreed the present situation is a 'mess' and that all of the critical testimony presented by other witnesses had a great deal of merit. He told the Commission that the administration will again support legislation to bring California into conformity with all federal requirements under PL 93-641.

IV. Reforms in the Certificate of Need Program

Under both federal and state law, health institutions must obtain a Certificate of Need (CON) in order to build new or expanded health facilities. However, one significant loophole which hampers this program's effectiveness is that it does not cover expensive capital expenditures made in non-institutional settings, such as in physicians' offices, dialysis units and home health agencies.

Local health systems agencies are now processing CON applications under two conflicting standards, one in compliance with state law and the other in compliance with federal regulation. A vast majority of applications denied by local health systems agencies have been overturned when challenged in the courts. Large legal expenditures are being made by hospitals to fight denials of applications for expansion.

Attorney Stanton Price, a specialist in health law, described to the Commission the legal dilemma of health systems agencies when a CON application is processed. The applicant, in anticipation of the possibility of denial, hires a law firm specializing in hospital law and the CON process. These firms are growing rapidly, and are skillful in representing their clients. Since legal costs are reimbursable as a legitimate cost of operation under both the Medicaid and Medicare programs, no restraint on legal costs is exercised; they are passed on to consumers and government programs. By contract, HSAs have minimal budgets for legal services to effectively defend their decisions in court. So far, legal challenges to HSAs on CON denials have generally been successful, thus frustrating the goal of controlling excess capitalization.

Local health systems agency representatives also testified that hearing procedures must be streamlined, especially to assure that HSA testimony obtained at public hearings is automatically recorded officially at state hearings. State hearings should be conducted only when there is a challenge to the CON recommendation of the HSA. In addition, they maintained that state guidelines now in use for CON are outmoded and simplistic, and do not address many complex factors which must be taken into account in developing standards for acute, long-term and special services.

Dr. Zaretsky of the Office of Statewide Health Planning and Development, pledged the administration's support in this area, too, by backing legislation to bring physicians' offices under CON procedures and to establish a statewide dollar limit on CON approvals.

The Commission feels that revision of state CON law, plugging loopholes and removing certificates of exemption will do much to strengthen the HSAs so they are more effective and less vulnerable to legal challenge.

V. Cost-containment Programs

Nationally, health costs have risen from 4.6 percent of the Gross National Product in 1950 to 8.8 percent in 1977. Today, 42 percent of the health dollar is spent on hospital services.

Inflation in the cost of hospital services in California has risen 18% per year over the last five years. Approximately $7 billion was expended in 1977. By 1985, this will rise to $24 billion unless costs are contained.

Fifty-four percent of hospital costs are underwritten by tax-supported health programs in California. The Medi-Cal program alone will spend $3.8 billion this fiscal year. Without control of costs, this program is expected to consume $5 billion in 1983, or 25 percent of the state budget.

There has been a breakdown in the traditional supply and demand controls existent in other markets. Two components explain this breakdown--dominance by physicians over both hospitals and patients, and the structure of the payment system.

Physicians control 70 percent to 80 percent of health expenditures by guiding patients through the health care maze, ordering tests, demanding the beds, and in general using hospitals as rent-free workshops.

Third-party payers reimburse hospitals retrospectively--increasing costs rather than containing them--without regard to efficiency. Voluntary efforts by hospitals to contain their costs are not working. The CON concept alone, without other cost-containment measures, will not make a major impact on costs. The Commission thus urges prospective budgeting and rate setting to control health care inflation.

Nine states which have undertaken such mandatory cost-containment programs have held the hospital care inflation rate to 12 percent. This has resulted in significant savings to those states for government-purchased hospital services. California, in contrast, does not have a mandatory program of hospital budget and rate review, and its inflation rate is 18 percent.

In 1972, the newly created California Health Facilities Commission was to make technical preparations for a rational and equitable system of mandatory hospital cost-containment. Much of the thrust of our own Commission's January 1976 report was in the same direction. But for the past four years, mandatory rate budget review proposals for hospitals have been defeated in the Legislature in the face of a heavily financed lobbying effort by the health industry and despite recent support by the administration.

The Commission feels that a mandatory program of hospital cost-control is long overdue in California and should be enacted in the next session of the Legislature. This Commission is acutely aware of the demands of the electorate to streamline and diminish government. We are charged as a Commission to improve government organization and efficiency. Therefore, it is with some reluctance that we recommend that state government undertake more regulation in the field of health care. We do so because of the essential character of health services and the overwhelming evidence that, without regulation its costs will endanger the security of the average working family and the fiscal integrity of state government.

By reviewing and approving budgets and rates in advance (without retroactive adjustments except for specifically defined exceptions), the program should maximize managerial discretion and create incentives for cost-effectiveness.

Another possible approach is to establish an aggregate annual expenditure target covering all hospitals in the state and in each region in California. This would establish an objective public judgment on the balance between projected needed services and their production on an efficient basis. Health services of all hospitals and the estimated cost on an efficient basis should be projected against this target.

Any mandatory cost-containment regulations should naturally be established under fair ground rules involving due process, public notice and hearings.

This is imperative in establishing a strong program which compels more effective distribution of services. Otherwise, the program would be inequitable, confiscatory and perhaps illegal.

When hospitals are able to document and justify their cost of operation, equal rates should be paid by both government and private sources of payment.

A spokesman for the California Medical Association stressed their record of cooperation with the health planning process. He observed that the Certificate of Need process is expensive and marked by an elongated and complex method of processing. He blamed hearing officers and state attorneys for delaying tactics and acknowledged that delays can also be attributed to attorneys representing applicants. He quoted Professors Salkever (Johns Hopkins) and Bice (Washington University) as saying: 'CON controls have contributed to cost-inflation, thus they tend to produce the very results which they intended to prevent.'

In an exchange with various Commissioners, the CMA was critized for the failure of voluntary hospital cost-containment; the control of choice of hospital by physicians, not patients; and their inference that there is a direct correlation between the cost of an episode of hospitalization and the quality of care provided.

The Commissioners emphasized the peculiarity of the hospital industry in terms of market-type price competition, in that the consumer is not aware of hospital charging practices, does not make decisions on what services are provided to him and is rarely aware of the high charges paid by health insurance companies for hospital services.

One Commissioner expressed his concern about the survival of organized medicine as an independent profession, if consumers cannot rely on the principle of marketplace competition to reduce cost escalation. He indicated that the handwriting is on the wall and that CMA needs to be doing more to contain costs or face the demise of its status as an independent profession. He also indicated concern for CMA's apparent lack of concern that more specialists are still being trained than the number needed, and their proclivity to locate in parts of the state now already oversupplied with specialists. This factor tends to encourage both proliferation of specialized hospital units and excess provision of services. (The California Hospital Association was invited to testify at the hearing, but failed to appear.)

VI. Excess Bed Capacity

One reason California's per-patient hospital costs are so much higher than in other states is that facilities continue to maintain an excess number of beds. This Commission's 1976 report noted that the average occupancy of 58 percent at that time was less than in most other states. This means there are more than 25,000 vacant beds. These vacant beds are costing

California consumers approximately $1 billion a year. The excess is ironic in view of the 1960 report of the Governor's Committee on Medical Aid and Health which recommended reducing the number of beds. Instead of turning downward, the construction trend is still going upward.

Therefore, the Commission feels that a program of incentives for actually closing or converting unnecessary facilities should be undertaken this year. Licensed beds which are now 'mothballed' should be eliminated immediately in order to reduce excess capacity. Ultimately, a change in hospital reimbursement practices must be made so that maintenance of excess capacity and provision of unnecessary services are not rewarded financially.

VII. California Health Facilities Commission

Victor Garlin, former Chair of the California Health Facilities Commission, testified that the present composition of the commission, with eight public and seven industry seats, is not effective in the protection of the public interest in the health care cost-containment effort. With industry holding nearly half the seats, the industry is, in effect, engaged in self-regulation under the auspices of an 'independent' commission. The influence of the industry, he states, is dominant.

The Health Facilities Commission is on record as supporting its own reconstitution to consist of five full-time public members, with power to implement a mandatory program of hospital budget and rate review.

Unless this is accomplished, the health industry will continue to behave in its own interest, and rising costs will remain unabated.

In response to a question, Dr. Garlin stated that the CHFC should be abolished unless it is reconstituted as a public body with regulatory powers.

Our Commission in 1976 recommended the outright abolishment of the California Health Facilities Commission. However, because we see in it the desire and potential for becoming an effective contributor toward the goal of hospital cost-containment and improved quality of care, we recommend that it be restructured to consist of five full-time public members, and also be empowered to mandate hospital budget and cost reviews. But if these reforms are not implemented, our Commission stands on its original recommendation that the California Health Facilities Commission should be abolished. Its current limited functions then should be transferred to the Office of Statewide Health Planning and Development.