

COMMISSION ON CALIFORNIA STATE GOVERNMENT ORGANIZATION AND ECONOMY

11th & L BUILDING, SUITE 550, (916) 445-2125
SACRAMENTO 95814



March 15, 1983

The Honorable George Deukmejian
Governor of California

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

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

The Honorable Diane Watson, Chairperson
Senate Health and Welfare Committee

The Honorable Curtis R. Tucker, Chairman
Assembly Health Committee

The Honorable Bill Green, Chairman
Senate Finance Subcommittee #3

Chairman
Assembly Ways & Means Committee on Health

Dear Governor and Members of the Legislature:

On January 20, 1983, our Commission conducted the second in a series of public hearings on the progress and problems associated with the State's new Office of Special Health Care Negotiations. This hearing focused on questions about the negotiation process employed thus far, the current plans for implementing the final contracts, and the actual quality of care Medi-Cal patients may receive from hospitals contracting with the State.

During our hearing, government, industry, and consumer advocacy representatives presented testimony which confirms that the Medi-Cal hospital contracting program will not achieve its original objectives for cost savings during either fiscal year 1982-83 or 1983-84. Moreover, this new system for purchasing hospital inpatient services for Medi-Cal beneficiaries may unleash significant new problems for the Medi-Cal program not ever anticipated by the Legislature or the Governor at the time they enacted this system. Specifically, our hearing determined the following:

- The Office of Special Health Care Negotiations estimates that hospital contracts will save the Medi-Cal program only \$13 million in fiscal year 1982-83 and \$127 million on an annual basis. This is significantly less than the original estimates of \$200 million.
- The current requirement that all terms and conditions of most hospital contracts be kept confidential creates administrative problems and circumvents all forms of public oversight.
- The State may not be adequately prepared to implement the final contracts. The State's fiscal intermediary has not yet modified its claims processing system to enable it to process claims

Chairman - Nathan Shapell • Vice-Chairman - Senator Milton Marks

*Senator Alfred E. Alquist • James M. Bouskos • Mary Anne Chalker • Benjamin Felton • Albert Gersten, Jr. • Brooke Knapp
Manning J. Post • Richard S. Trugman • Assemblyman Frank Vicencia • Jean Kindy Walker • Assemblyman Phillip D. Wyman*

Executive Director - Richard C. Mahan

submitted under the new hospital contracts. Additionally, certain groups of Medi-Cal beneficiaries may not be receiving sufficient or appropriate instructions for treatment by contracting hospitals. Consequently, significant problems may occur as a result of excessive confusion.

- The State may face serious quality of care problems. Under the new contracts, hospitals have an incentive to avoid providing Medi-Cal patients with all the services they require.

We believe the potential problems discussed in this letter report are significant. Therefore, we request that the Legislature and the Administration consider our findings and recommendations, further investigate these problems, and closely monitor this program as it evolves during the next twelve months. Below is a detailed discussion of each of the issues mentioned above.

Projected Cost Savings

In the closing days of the 1981-82 legislative session, the Legislature enacted major changes in the Medi-Cal program including the institution of the competitive contracting system for providing hospital inpatient services. At that time, the proponents of hospital contracting estimated that the State would save approximately \$200 million in fiscal year 1982-83 under the new system.

However, the Office of Special Health Care Negotiations has not completed negotiations with as many hospitals as originally planned. This has occurred due to delays in receiving waivers from the Federal government, because of untimely resolution of disagreements with hospitals concerning specific services to be included or excluded, and from difficulties in coordinating with the Department of Health Services.

Consequently, Mr. William Guy testified during our hearing that contracts negotiated in San Francisco, Long Beach, and San Diego will save the State approximately \$31 million on an annualized basis. This estimated savings does not take into account approximately \$4 million in potential losses from emergency cases being treated at non-contracting hospitals. Based on these completed contracts, Mr. Guy projects that after all contract negotiations are completed this year the State will save approximately \$127 million annually -- approximately \$73 million less than originally anticipated. However, these estimates represent annual savings only. During fiscal year 1982-83, hospital contracts will probably not save the State more than \$13 million.^{1/}

We believe the Legislature and Administration must carefully consider whether the reduced level of cost savings sufficiently offsets the problems this program may create. Other methods of purchasing inpatient services might provide equal or greater savings without some of the problems. For example, Federal officials have informed this Commission that the method of limiting cost reimbursement through use of hospital peer groups would save more money than the hospital contracting system in some health planning areas. Utilization

^{1/} These figures are approximations and will be further refined by the Department of Health Services Fiscal Forecasting Section during the budget development process.

monitoring and control procedures under this method would not require significant changes in the Department's established procedures. Finally, because the peer group reimbursement methodology is based on median rates per discharge, it prevents problems associated with negotiated per diem rates.

Confidentiality Provisions of Contracts

Under the legislation implementing the hospital contracting system, the Office of Special Health Care Negotiations was empowered to negotiate contracts which are excluded from the Public Records Act. The Commission recognizes that maintaining confidentiality during contract negotiations provides the State with an important advantage. However, we believe the confidentiality provisions also result in at least three serious disadvantages to the State.

First, holding the contracts confidential after they are officially signed would result in the State expenditure of hundreds of millions of dollars without any public oversight. In essence, the public would be told to simply trust that the negotiator and the Department of Health Services had neither abused the process nor negotiated a poor contract. Second, it could be very difficult to maintain confidentiality after the contracts were signed. Within a short amount of time, most hospitals would probably discover which rate each other had negotiated. Finally, the confidentiality provisions significantly complicate the processing of Medi-Cal claims by the fiscal intermediary. During our hearing, a representative of Computer Sciences Corporation testified that contract confidentiality would complicate its responsibilities. Specifically, CSC Provider Relations Representatives will be unable to effectively respond to inquiries from hospitals since the representatives will not have access to the terms and conditions of the contracts.

As a result of these problems, we believe that the Legislature and the Executive Branch should consider amending the current statutes to require that the contracts become part of the public record after all negotiations have been completed.

Potential Contract Implementation Problems

Once the Medi-Cal contracts are officially signed, the Department of Health Services becomes responsible for ensuring that the contracts are efficiently and effectively implemented. Included in its responsibilities are notifying Medi-Cal beneficiaries and providers of the provisions of the contracts and any associated regulations, and modifying the department's own operations.

Testimony received during our hearing indicated that the Department of Health Services may not be adequately prepared to implement the new contracts. Specifically, the Computer Sciences Corporation and the Department of Health Services have not yet reached agreement on the contract amendments necessary to authorize the CSC to modify its claims processing system to handle the claims which contracting hospitals will submit. According to CSC officials, once agreement has been reached, they will require approximately thirty working days to modify and test all computer software programs necessary to process the new claims. This estimate assumes that there would be no further contract amendments and that contracts become effective without further delays.

Moreover, CSC estimates that approximately six months will pass before hospital claims are properly prepared and flowing through the system smoothly. In the meantime, the State will experience a higher than normal level of suspended claims and abnormal delays in payments to hospitals.

Contract implementation may be further complicated if Medi-Cal beneficiaries do not receive timely and accurate notification regarding contracting hospitals. The Department of Health Services must still make critical decisions about how various beneficiary groups will be treated and ensure that each one is properly notified.

For example, the department must decide whether women who are pregnant and have been receiving treatment from a particular doctor at a specific hospital must now deliver their babies at a different hospital. If they must change hospitals, they may also be required to change doctors if their attending physician does not yet have staffing privileges at the contracting hospital.

We believe it is imperative that beneficiaries as well as providers receive timely and considerate notification before contracts take effect. Failure to effectively notify beneficiaries and providers will result in significant confusion in the form of patients reporting to unauthorized hospitals, doctors not knowing to which hospitals to refer patients, and even patients' health being endangered in some cases.

Potential Quality of Care Problems

The most serious problem hospital contracting may generate is a decline in the quality of inpatient care some Medi-Cal beneficiaries receive. During the Commission hearing, an attorney with the National Health Law Program and the Medical Director of a Southern California Professional Standards Review Organization testified that quality of care issues did not receive adequate attention during the negotiation process. These witnesses testified that there are at least three major potential quality problems: contracting with hospitals providing poor services; not ensuring access to care; and hospitals not providing all necessary services to the detriment of patients.

Witnesses testifying at our hearing stated that State negotiators did not assign sufficient priority to a hospital's past performance when deciding who would receive a contract. According to Mr. Lucien Wulsin of the National Health Law Program, the contracting agency "should have exercised due caution and denied contracts altogether or required special assurances of quality before it entered into contracts with hospitals with poor quality records." According to Mr. Wulsin, three out of the eleven hospitals in the Long Beach and South Bay Area of Los Angeles have serious quality problems. These quality concerns are not trivial: no registered nurse in the Intensive Care Unit; outdated sterile supplies; rodent infestation in the linen closet; no registered nurse in the infant nursery; no records of drug therapy; operation of an uncertified emergency room; etc. Additionally, it appears that one facility may be in the process of being decertified for Medicare and Medi-Cal reimbursement. Similarly, in the San Francisco area, Mr. Wulsin reported that one out of the nine hospitals receiving contracts has serious quality problems.

However, Mr. Guy states that his office had no choice but to negotiate with any hospital that had a license to operate. According to Mr. Guy, he did not

believe he had the authority to exclude any hospital because of allegations of quality of care problems. On the other hand, Mr. Guy believes that the contracts provide the State with an effective tool to terminate those hospitals from the Medi-Cal program simply by cancelling the contract. Consequently, we believe the State must develop adequate criteria to ensure such actions are taken when quality problems are identified. Additionally, we recommend that the Governor and the Legislature direct the department to obtain a legal opinion on whether the State must negotiate with any licensed hospital.

The Federal law under which the State received a waiver to negotiate contracts with hospitals requires the State to assure access of Medi-Cal beneficiaries to hospital services. One of the critical barriers to access in California has always been the unwillingness of most private physicians to see Medi-Cal beneficiaries. The disruption by the selective contracting program of the patient treatment patterns which exist between hospital inpatient and outpatient departments, and any reduction in the number of hospital staff physicians who continue to see Medi-Cal beneficiaries may exacerbate access to inpatient hospital care for Medi-Cal beneficiaries. It is questionable as to whether or not physicians who treat only a few Medi-Cal patients will submit to the process of applying for staffing privileges at contracting hospitals. Rather, they may choose to drop the Medi-Cal patient and no longer participate in the program.

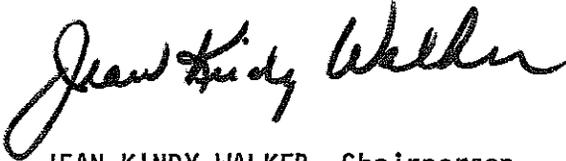
Finally, the testimony we received during our hearing has left us with serious concerns regarding how the State will ensure that hospitals do not underutilize services or, in other words, provide less than sufficient services. Historically, the State has been concerned that a hospital would overutilize services; that is, conduct unnecessary procedures such as X-rays, surgeries, and lengthy stays in a hospital.

However, according to Dr. Jack Wasserman, the Medical Director of PSRO #23 in Torrance, it is very difficult to detect and evaluate underutilization because there is very little to measure. When a patient receives too many X-rays, or is held in a hospital too many days, a trained individual can detect the abuse. However, there are few indications of medically necessary tests which were not provided. Dr. Wasserman does believe that the hospitals which abused the system by continuously overutilizing services will now abuse the system by underutilizing services. Consequently, we believe it is imperative that the Legislature ensure that the Department of Health Services develops an adequate system to effectively monitor underutilization.

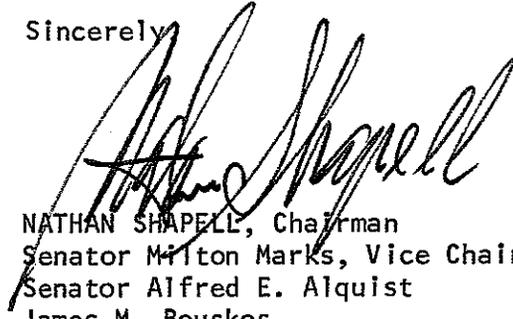
In conclusion, our Commission believes that the Office of Special Health Care Negotiations has accomplished a great deal in implementing a new program in a very compressed time frame. And we recognize that any new program faces

problems during its implementation. However, we believe that this program could result in a significant deterioration in the quality of care many Medi-Cal patients receive. Moreover, the State will face this problem and others while generating a cost savings which is much lower than the Legislature and the Governor originally anticipated. Therefore, we believe it is imperative that the Legislature and the Governor closely monitor the development of this program and effectively correct these potential problem areas which face the Medi-Cal program.

Sincerely,



JEAN KINDY WALKER, Chairperson
Subcommittee on Health
Member: Richard S. Trugman



NATHAN SHAPELL, Chairman
Senator Milton Marks, Vice Chairman
Senator Alfred E. Alquist
James M. Bouskos
Mary Anne Chalker
Albert Gersten, Jr.
Michael Kassan*
Brooke Knapp
Mark Nathanson
Assemblyman Phillip D. Wyman
Assemblyman Bruce Young*

cc: Mr. William Guy,
State Medi-Cal Negotiator

William D. Dawson, Interim Director
Department of Health Services

*Assemblyman Young and Michael Kassan were appointed to the Commission on February 8, 1983. Accordingly, they did not participate in the Commission's public hearings on this study.