COVER SHEET

SUBJECT:	Health
ISSUE:	Medi-Cal Reform Plan (MRP)
ASSIGNED TO:	Department of Health
TITLE:	William Mayer, M.D., Acting Director of Health
PHONE NO:	5-1248
WHEN ISSUED:	December 7, 1973
EXPECTED COMPLETION DATE:	January 11, 1974

ASSIGNED TO:	Jerry W. Green, Deputy Director, Health Financing System
PHONE NO:	5-0260
WHEN ASSIGNED:	December 13, 1973

WORKSHEET

SUBJECT: Health

ISSUE: Medi-Cal Reform Plan (MRP)

THEORETICAL POSITIONS:

1. MRP established uniform, statewide standards and brought all needy Californians within the scope of medical care available to other citizens.

2. MRP increased benefits but still resolved an escalating fiscal problem by deterring overuse of benefits and abuse by providers.

3. MRP is cost-effective with savings far exceeding the cost of administering the utilization controls.

4. MRP enhanced the potential for prepaid health plans and encouraged experimentation with new health care delivery systems and controls.

5. MRP discouraged possible fraud through legislation and by expanding the Medi-Cal surveillance capability.

THE SUCCESS OF

MEDI-CAL REFORM PLAN (MRP)

*

A POSITION PAPER

TABLE OF CONTENTS

DISCUSSION SECTION

Introduction

The purpose of this report is to reexamine the Medi-Cal Reform Plan (MRP) which was implemented in October 1971, and to stress the positive aspects of the Plan. In the following discussion, five theoretical positions supporting MRP are explored and upheld. These positions are:

1. MRP established uniform, statewide standards and brought all needy Californians within the scope of medical care available to other citizens.

2. MRP increased the scope of benefits but still resolved an escalating fiscal problem by deterring overuse of benefits and abuse by providers.

3. MRP is cost-effective with savings far exceeding the cost of administering the utilization controls.

4. MRP discouraged possible fraud through legislation and by expanding the Medi-Cal surveillance capability.

5. MRP enhanced the potential for prepaid health plans and encouraged experimentation with new health care delivery systems and controls.

Background

Medi-Cal began in 1966 as a dramatic State health care program, which was a sharp departure from the past. Before Medi-Cal, welfare recipients received limited medical care. Almost all medically indigent persons had

to use the county hospitals for inpatient care. Medi-Cal changed all this. Overnight, welfare recipients became eligible for a scope of care generally available only to the more affluent.

Medi-Cal also extended coverage to certain "medically needy" persons not previously covered by existing programs. These persons were linked to the federal categorical aid groups; i.e., the blind, the permanently and totally disabled, the aged and families with dependent children. However, the income and/or property of these "medically needy" persons was sufficient to preclude them from receiving cash grants under the welfare programs.

Health care for the medically indigent still contained gaps. Approximately 800,000 poor California residents received unequal treatment; their care depended on the policies of the county in which they resided and the health care program of that county. Eligibility for health care services was based on varying county standards and was determined by county medical facility staff. While Medi-Cal eligibles could receive services from their choice of providers, county health programs provided only selective services to these medically indigent persons based on available county facilities and funds. (See Data Section for specific coverage.)

There was also unequal treatment provided to the two groups covered by Medi-Cal. Group I beneficiaries (welfare cash grant recipients) received the full range of services with practically unlimited utilization. Often their benefits far exceeded those available to the average citizen. Group II beneficiaries (medically needy) received very minimal services limited to (1) physician visits, (2) hospital outpatient and emergency services, (3)

laboratory and X-ray, and (4) follow-up care for 90 days after discharge from an acute care hospital. In addition, these beneficiaries were required to share the cost of these services. (See Data Section for comparison.)

By 1969 it became apparent that the Medi-Cal program was in financial distress and needed reform. The program had been hastily enacted and was loose in many areas, particularly in regard to administrative controls. The scope of available medical benefits encompassed practically all services rendered by legitimate health care providers with virtually no utilization controls. Patient responsibility was not encouraged. Spending increased until nearly one-fifth of the State budget was used to fund the program. These inherent defects, coupled with the inflationary impact of health care spending at the national level and increasing abuses of the Medi-Cal program itself, drew the attention of the Governor and the State Legislature.

In August 1970, a 16-member commission was appointed to study the Medi-Cal program and to recommend a better and more economical means of providing health care services. From this came the Medi-Cal Reform Act of 1971, which represented a synthesis of the views of the Administration, State Legislature, county government, welfare rights organizations, and the physicians, hospitals and other provider groups in California.

Section 14000.1 of the Welfare and Institutions Code, added by the Medi-Cal Reform Act of 1971, states: "It is the intent of the Legislature that the health care services available under this Chapter shall be at least equivalent to the level provided in 1970-71." By any reasonable standard, it seemed to be an impossible task to expect the Administration to curtail runaway program

spending and still maintain the level of services as prescribed. Nevertheless, the Medi-Cal Reform Plan (MRP) accomplished this mandated objective even while extending Medi-Cal coverage to about 800,000 poor Californians previously excluded.

After the implementation of MRP, one basic comprehensive schedule of benefits and a supplemental schedule of benefits applied to all. Services to those who had been in Group I were limited by utilization controls at a level commensurate with those services available to the average citizen. Funds saved through this means enabled the program to expand services to those who had been in Group II. Services provided to the medically indigent in the few counties that had very liberal benefits and eligibility standards were reduced. However, most persons in the medically indigent group received better care than before MRP. Because both private providers and county health facilities treated Medi-Cal patients, the medically indigent now could select the provider of his choice. Thus, California became almost unique among the Medicaid states in providing such comprehensive, uniform health care services to welfare recipients, medically needy and medically indigent persons.

The primary objectives of MRP were: (1) to bring program costs under control and improve the Medi-Cal financing system, and (2) to ensure that necessary health care continued to be available to the State's poor. MRP set out to accomplish these objectives by: (1) issuing service labels with each Medi-Cal identification card to impose a limit on services and deter excessive use of the program, (2) requiring prior authorization; i.e., a

Medi-Cal provider had to obtain approval from a State professional consultant (physician, dentist, pharmacist, or optometrist) before specified nonemergency treatment of services for a fee were reimbursable, (3) introducing an element of beneficiary restraint on those able to pay by requiring them to pay up to $1 of the fee (copayment), and (4) obtaining matching federal funds, for the first time, to cover the cost of care for unmarried persons under 21 years of age.

MRP also: (1) strengthened the law which requires the payment by Medicare or any other insurance coverage to which Medi-Cal patients are entitled, prior to the expenditure of Medi-Cal money, (2) directed counties to enforce the provisions of the law requiring specified relatives of Medi-Cal beneficiaries to contribute toward the cost of their care, (3) encouraged the establishment of fixed-fee prepaid health plans by providing incentives such as predictable income and freedom from utilization controls, and (4) brought an expansion of program surveillance activities by the State to ensure compliance with program laws, rules and regulations.

Incentives for Reform

As with any new program, close scrutiny was required to determine whether the original objectives of MRP had been and were continuing to be met. The first objective was achieved in 1972 when the skyrocketing costs of the Medi-Cal program showed a sharp reduction. (See item 2 in Data Section for details.) However, since this was accomplished primarily by imposing government restrictions in the form of utilization controls on the State's

health care providers, California achieved this goal at a price. That price was physician and other health provider alienation or lack of cooperation.[1/] The decision to control providers was unpopular, and perhaps could prove to be unwise in the long run since their participation is crucial in any health care delivery system. Recognizing this fact, the element of reform accompanied other factors which provided the incentive for California to redesign its Medi-Cal program in 1971:

1. Demand for medical care had increased to match or exceed the dollars available for payment. This "Parkinson's Law of Medical Care" stemmed from a lack of patient responsibility, and little evidence that health care providers were attempting to discourage or curb overtreatment. For example, a 15 percent reduction in acute care hospital admissions was achieved by requiring physicians to state why nonemergency patients required acute care hospitalization. Nearly all of the $30 million saved annually by this control resulted from deterance; only a few admission requests were denied.[2/]

2. Unrestricted health care became extremely expensive but did not lead to quality medical care. In some areas of the State, medical care was woefully inadequate. Many of California's medically indigent were not eligible. The inequity of too much care for too few persons diluted available services and wasted resources.

3. While expecting that abuses of the program could be counteracted by the imposition of strict utilization controls such as limiting the

---

1/ H & WA News Release #73-66, dated 12/13/73

2/ Ibid.

number of monthly visits to a physician and requiring prior authorizations of treatment, the imprudence of more permanent government controls on doctors was also an important consideration. Consequently, the major thrust of MRP was to encourage prepaid group health plans. Hence, the combination of visit limitation, prior authorizations, and prepaid health plans.

To quote Earl Brian, M.D., Secretary of the Health and Welfare Agency,

> "I was concerned that doctors would find it difficult to provide proper care under those first regulations but immediate action was required to restrain Medi-Cal expenditures, which were tracking toward a potential $50 million deficit. Since California's Medi-Cal program is funded by a closed-end budget, exceeding the budget would have caused an illegal fiscal crisis. I knew doctors wouldn't like the control system. But I believed it would give them the incentive to reach out for new forms of practice freed of controls. This seems to be happening."3/

There are other equally important incentives for new and innovative forms of health care delivery systems. Increasing costs of conventional fee-for-service medicine were causing private patients to turn to a more efficient health care delivery system. Over the decade of the 1960's, hospital charges rose four times as fast as other items in the Consumer Price Index; physician fees rose twice as fast. And that increase was heavily concentrated in the brief period after the introduction of Medicare and Medicaid in 1965.4/

3/ Sheridan, Bart, "State Medicine, Conservative Style - Still a Hassle", Medical Economics, September 3, 1973, pg. 185.

4/ Hodgson, Godfrey, "The Politics of American Health Care", the Atlantic, October 1973, pg. 51.

"The important weakness of the American health care system which the crisis of the late 1960's revealed was the entrepreneurial concept of the doctor's social role, the intimate relationship between healing and monetary reward, which has prevented a real, indeed a brilliant, improvement in medical technique from being translated into commensurate improvement in medical care."5/

In one study, Dr. John Bunker found that twice as much surgery was performed, in proportion to population, in the United States as in England and Wales. He also found that surgery rates in American group health plans was half those reported for Blue Shield fee-for-service practice.6/ In other words, when American surgeons had a financial incentive to operate, they did so twice as often as when they had no incentive.

The Alternative -- Group Health Plans

Prepaid health plans (PHPs) are health care delivery systems which are financed by capitation payment generally to provide a full scope of medical and dental benefits to Medi-Cal beneficiaries who voluntarily enroll in them. To ensure that all enrollees have access to comprehensive health care in PHPs, the Department of Health specifies services which must be made available and sets ratios for key services. A PHP must provide health care services at a level equal to or greater than the level of benefits provided under the Medi-Cal fee-for-service system. Incentives to plan providers include lower cost of administration, faster payment, predictable income and freedom from most Medi-Cal controls. PHPs also have a financial incentive to practice preventive medicine.

5/ Ibid., pg. 61.

6/ New England Journal of Medicine, 1970.

The Medi-Cal program entered into its first PHP contract in May 1972. Currently, more than 60 PHPs are under contract; 48 are operational, serving over 200,000 beneficiaries. For the month of September 1973 the average cost to the State for each beneficiary enrolled in a PHP was $27.27; as compared to an average of $48.59 for each beneficiary covered by fee-for-service. See Item 5 in the Data Section for other advantages of PHPs.

Since a PHP is paid a fixed fee for each enrollee, the healthier it can keep its enrollees the greater its profits. An office visit or an education class in preventive medicine is considerably less expensive than a hospital bed. For example, one plan in Central Los Angeles determined which enrollees have a tendency toward diabetes. They have even gone shopping with the beneficiary to teach him how to properly eat to keep from developing the disease. This was less costly than trying to treat diabetes and to relieve the suffering caused by the disease.

Under Section 14000 (F) of the Welfare and Institutions Code, the Department of Health is authorized to conduct studies to improve the Medi-Cal program's overall efficiency and quality of care. Presently, six such pilot projects are being conducted.

A major revision of the law relating to PHPs was enacted by the Waxman-Duffy Prepaid Health Plan Act, Chapter 1366 Statutes of 1972 (effective July 1, 1973). It establishes a separate chapter in the Welfare and Institutions Code relating to PHPs which:

1. Specified administrative powers and duties of the Department,

2. Established guidelines for determining per capita payment rates, approval of contracts, and general regulations of the plans,

3. Authorized the Department to establish the scope and duration of services provided, and

4. Established standards of participation for plans.

Service Controls -- A Hindrance to Health Care?

The second objective of MRP has also been achieved, but is one which constantly needs monitoring and evaluation in view of changing needs. In particular, imposition of utilization controls, if they are not well designed, may discourage needed care.

Prior authorization is a key control procedure of MRP and serves two important functions. First, it provides a formal utilization control through denial of particular services which had been found to be subject to abuse. However, most of the savings attributed to prior authorization are due to a greater awareness of the medical necessity for these services on the part of the Medi-Cal providers.

The second critical function of prior authorization is to ensure sufficient program flexibility to allow for all necessary services. When unusual procedures or services beyond the normal limitations are required, prior authorization enables these services to be given in a manner which is consistent with good health care practice and good program administration.

MRP has made recipients more selective in their utilization of benefits and providers more sensitive to the need for particular treatment patterns.

However, no evidence has been found that necessary health care has been denied. On January 27, 1973, the San Francisco Chronicle quoted from a report issued by the Bay Area Comprehensive Health Planning Council which concluded that MRP had succeeded in detecting abuses but in the process had hindered health care. No solid evidence to support this allegation has been found, although undoubtedly there have been individual hardships due to high workloads and human frailty. It should be noted, however, that in 1972 less than five percent of all requests for services were denied. Four of five medical patients received necessary care through the standard limitation of two physician visits a month without prior authorization. Two of three patients similarly had their drug requirements fulfilled under the two-per-month limitation.7/ In terms of cost, MRP's utilization controls are cost-effective, with savings far exceeding the cost of administering the controls. Results of medical visit, drug, and dental service studies show $4.23 million per month saved in service costs at a monthly control cost of $159,000.8/

During the period January 1, 1972 to June 30, 1973, about one-third of the Medi-Cal population paid $1 for each of the first two monthly visits to physicians, and $.50 for each of the first two prescriptions per month. This experimental copayment program was authorized by the U.S. Department of Health, Education, and Welfare. The purpose of copayment was not to discourage needed services, but to deter overutilization and inappropriate utilization. Results of this program are now being studied and are being

---

7/ 1972 Annual Report to the Governor and the Legislature, by the Department of Health Care Services.

8/ Crane, M. A., Ph.D., and Morey, R. C., Ph.D., "The Cost Effectiveness of Medi-Cal's Program Utilization Controls: A Summary", Control Analysis Corporation, November 1972.

compared with data developed before MRP. Copayment is an outgrowth of the deductible feature found in most private insurance company policies to deter nuisance claims. The deterrent value of copayment was shown in Great Britain from 1952-1965 when each increase in the copay amount produced a decrease in the use of drug benefits. Copay ended in 1966, but had to be renewed in 1968 to deter abuse.[9/] North Carolina experienced a significant increase in drug utilization when copay was removed in 1970.[10/] Other experiences with copay have shown similar results with no evidence that needed service has been denied.

MRP utilization controls were coupled with investigative activities to deter fraud and questionable activities by beneficiaries and providers. Substantiated allegations involving criminal and administrative violation of the Medi-Cal program or Medical Practices Act have been submitted to district attorneys and the State attorney general's office for appropriate action. During 1972, investigative activity increased significantly. The identification of recoverable funds also increased significantly during 1972. In the five-year period prior to the establishment of the Department of Health's Investigation Section, recoverable funds totaled $462,644. During 1972, this amount increased 500 percent.[11/]

Some bewail the moneys assigned to investigate, arguing that such sums could be spent more fruitfully on health care services. Others advocate peer review

---

9/ Dunlap, Sir Frederick M., "Drug Control and the British Health Service", Annals of Internal Medicine, August 1969, pg. 238.

10/ Caskill, Lillian L., Assistant Director, Division of Medical Services, Department of Social Services, Raleigh, N.C., September 30, 1970.

11/ op. cit., 1972 Annual Report.

by members of the professional medical and dental societies. Yet others propose review boards or insurance companies perform the investigation. Nonetheless, with the expenditure of billions of dollars in public funds in the health care industry -- a behemoth that has become the largest employer of American manpower -- government has no recourse except to move into such areas.[12/]

Outlook -- Next Five Years

The short-term goal of MRP was to bring fiscal stability through utilization controls. This has been done. Utilization controls which cracked down on skyrocketing health care spending have served their purpose. The Medi-Cal program cannot, at this time, discard these controls in the fee-for-service program for obvious reasons. Refinement and minimization of these controls, however, is possible through the use of computer modeling techniques and improved systems which will alleviate some of the paperwork burden.

California is currently negotiating a statewide contract whereby one fiscal intermediary will administer the major portion of the Medi-Cal payment system. In addition, an agreement went into effect on January 1, 1974, between California Dental Service (CDS) and the State, whereby the former provides a comprehensive dental program to all Medi-Cal beneficiaries. Under the CDS agreement, the requirement of prior authorization for basic services has been minimized for both adults and children.

Gradually the fundamental goal which has been to foster growth of prepaid group plans, or health maintenance organizations (HMOs) as they are also

---

12/ Bellin, Lowell E., M.D., Medical Audit: The Bitter Pill is Here and Now, Medical Opinion, December 1971.

known, will make the issue of utilization controls moot. HMOs meld together the financial risk responsibility with the providers of health care -- thus shifting the responsibility for quality health care from the government to the provider.

On December 29, 1973, this evolutionary approach to transform the economic structure of medicine was reaffirmed at the national level.[13/] The new health legislation signed by the President is intended to demonstrate the feasibility of the prepaid health maintenance organization concept during the next five years. California has judiciously attempted to retain a pluralistic approach to HMOs since no one structure or formula for an HMO can be applied universally at this time. This experience with a variety of approaches is essential to allow the best prepaid mode of health care delivery to emerge alongside the traditional fee-for-service system in this State.

13/ Sacramento Union, December 30, 1973, pg.3.

DATA SECTION

1. MRP established uniform, statewide standards and brought all needy Californians within the scope of medical care available to other citizens.

MEDI-CAL SYSTEM PRIOR TO MRP[1/]				MEDI-CAL SYSTEM, January, 1974[2/]			
	Federal	State	County		Federal	State	County
ELIGIBILITY				**ELIGIBILITY**			
Aged, Blind, Disabled, AFDC — Group I		Established Standards.	Determined Case Eligibility. Issued I.D. Cards	Aged, Blind, Disabled	Establishes standards. Determines case eligibility.	Issues I.D. Cards	
Medically Needy — Group II				AFDC, Medically Needy, Medically Indigent		Establishes standards. Issues I.D. Cards.	Determines case eligibility.
Not Medi-Cal Medically Indigent			Established Standards. Determined Eligibility.				
SERVICES				**SERVICES**			
Group I		Practically unlimited		All categories		Administers Basic and Supplemental Schedule of benefits on a fee-for-service or prepaid plan basis.	
Group II		Limited to inpatient care, physicians services, Hospital outpatient & emergency, Lab & X-ray, others if related to and within 90 days after hospitalization					
Not Medi-Cal Medically Indigent			Selective services based on particular county facilities.				

1/ Title 22 – 1969/70

2/ Title 22 – 1974

2. MRP increased the scope of benefits but still resolved an escalating fiscal problem by deterring overuse of benefits and abuse by providers.

Costs

Average cost per beneficiary before MRP $522 Fiscal Bureau Rp't 112#2r 5-5-71

Average cost per beneficiary in Fiscal 71-72 $267 PASS Bulletin 19-1 12-20-3

Medi-Cal Program Costs:	Fiscal 66-67	Fiscal 70-71	Fiscal 71-72	Fiscal 72-73
	$500 mil	$1.02 bil[1]/	$1.3 bil*[2]/	$1.5 bil*est.[2]/
State Funds		$592 mil[1]/	$509 mil[2]/	$609 mil[2]/est.

* Administrative costs represent about 6 percent of totals

1/ Meeting the Challenge: A Responsible Program for Welfare and Medi-Cal Reform, 3-3-71, page 142.

2/ 1972 Annual Report to the Governor and Legislature.

Financing[1]/

Before MRP (Title XIX)

Federal	50%
State	40%
County	10%

County Health Programs

17%	State
83%	County

After MRP (Title XIX)

Federal	50%

All Other Costs

70%	State
30%	County

1/ Meeting the Challenge: A Responsible Program for Welfare and Medi-Cal Reform, 3-3-71, page 142.

Coverage

Medi-Cal beneficiaries are served by approximately 80,000 providers of health care services. During the 1971-72 fiscal year, approximately four million individuals received medical services: 3.2 million were public assistance recipients; 433,000 were medically needy; and approximately 100,000 were medically indigent persons. The medically indigent category was added by MRP.

Through MRP, for the first time California was able to obtain matching funds for the cost of care for unmarried persons under 21 years of age. These poor youths represented approximately four percent of covered individuals in the 1971-72 fiscal year.

Source: PASS Bulletin, 19-1, 12-20-3.

Utilization Controls

MRP controls save approximately $5.2 million monthly. The net saving is approximately $5.05 million. Source: An Evaluation of the Medi-Cal Reform Plan Utilization Controls, 12-8-72, page 10.

1. Medi-Cal identification cards with service labels

   a. About 2.5 million cards mailed monthly

   b. Each card contains 10 peel-off labels

      (1) 2 MEDI (2) 2 DRUG (3) 6 POE (Proof of Eligibility)
      MEDI -- outpatient physician visits; DRUG -- outpatient prescriptions; POE -- other medical services.

   c. MEDI labels under MRP reduced monthly payments 10 percent, or $2.3 million. Source: An Evaluation of the Medi-Cal Reform Plan Utilization Controls, 12-8-72, Page 5.

2. Treatment Authorization Requests (TAR)

   a. Ninety-eight percent of physician services in 1972 were provided without prior authorization. Source: 1972 Report to Governor and Legislature, page 14.

   b. Three million TARs issued annually. Source: 1972 Report to Governor and Legislature, page 17.

   c. Eighty-one percent approved without question in 1972.

      Forty-one percent of those approved involved dental services which were not controlled before MRP. This alone produced savings of $112,000 monthly. Source: A Summary of the Medi-Cal Utilization Review Plan, 12-15-72.

   d. One percent of monthly savings due to (1) MEDI label requirements and (2) prior authorization (TAR) denials; 99 percent accrues from the deterrent effect of the prior authorization requirement. Source: An Evaluation of the Medi-Cal Reform Plan Utilization Control, 12-8-72, page 5.

   e. Of the total savings due to MRP, less than 10 percent resulted from the denial of services requested on TARs. Source: An Evaluation of the Medi-Cal Reform Plan Utilization Controls, 12-8-72, page 10.

3. Beneficiary Copayment*

   a. Thirty percent of beneficiaries (medically needy) had a "spenddown" or copayment commitment before becoming eligible for Medi-Cal benefits. Source: 1972 Annual Report to Governor and Legislature.

   b. Temporary experiment allowed by the U. S. Department of Health, Education, and Welfare from January 1, 1972 through June 30, 1973.

   c. In 1967, North Carolina instituted a prescription copayment of $1.00 and reduced drug costs approximately one-third. Conversely, in 1970, the copayment was removed and North Carolina experienced an increase in drug costs in excess of the 1967 decrease. Source: Gaskill, Lillian L., Assistant Director -- Division of Medical Services, Department of Social Services, 9-30-70.

   d. During 13 years of experience with prescription copayment, Great Britain experienced a decrease in the number of prescriptions with each increase in the copayment amount. When copay was removed in 1965, a dramatic increase in the number and total costs of prescriptions followed. Thus, in 1968, a 30-cent copayment fee on drugs was reinstituted. Source: Dunlop, Sir Derrick, M.D., "Drug Control and the British Health Service", Annuals of Internal Medicine, August 1969.

   * Evaluation statistics are not available until released by the Health and Welfare Agency.

3. <u>MRP is cost-effective with savings far exceeding the cost of administering the utilization controls</u>.

The cost-effectiveness analysis of MRP utilization controls disclosed the following:

-- MRP produces a total monthly savings in expenditures for medical services of $1.31 million at an administrative cost of $39,000 or a saving of $34 for every $1 spent on utilization controls.

-- Of the $1.31 million in monthly savings for medical services, only approximately $20,000 or two percent, results from prior authorization denials of requested services. The balance of the savings is attributed to increased provider sensitivity to the medical necessity of particular treatment patterns.

-- Of the $10.3 million average monthly payment for physician and outpatient services under MRP, only three percent involved prior authorization for the service provided while 97 percent were paid under the Basic Schedule of Benefits.

-- MRP produces total monthly savings in expenditures for prescription services of $2 million with an administrative cost of $111,000.

-- Of the $2 million in monthly drug savings, only about $21,000 or one percent, results from the prior authorization denials of requested prescriptions. The remaining 99 percent of the savings is attributed to the physician's ability to provide quality treatment without the need for the high cost pharmaceuticals that were routinely used before MRP.

-- MRP produces total monthly savings in expenditures for dental services of $923,000 with an administrative cost of $9,000.

-- Of this $923,000 savings, $811,000 resulted from a decreased frequency in the utilization of particular diagnostic services and prosthetic devices. Diagnostic visits under MRP are limited to one per year without prior authorization, and the fitting of prosthetic devices is limited to once every five years.

-- The remaining $112,000 in savings is attributed to the effects of requiring treatment authorization for dental services costing less than $35. Prior to MRP, no controls were exercised on these services.

-- Only $4,000 of the $112,000 in savings, or 3.5 percent, is due to denials of prior authorization of treatment. The remaining savings are attributed to a more critical analysis of the need for these services by health care providers.

-- Considerable administrative cost savings also were realized under MRP due to the reduction in the volume of claims for services. Although estimiations of this reduction, in terms of claims for medical and dental services are not available, it is estimated that drug service claims were reduced by approximately 500,000 per month. Unexpended processing costs for this volume amounted to approximately $112,000 per month.

In summary, MRP is cost-effective, with savings far exceeding the cost of administering the controls. Results of the medical visit, drug, and dental service studies show $4.23 million per month saved in service costs, with monthly administrative controls costing approximately $159,000. Source: Crane, M.A. and Morey, R. C., "The Cost Effectiveness of Medi-Cal Controls Relating to Medical Visits", November 1972. Published in 1972 Annual Report to Governor and Legislature.

4. MRP discouraged possible fraud through legislation and by expanding the Medi-Cal surveillance capability.

In 1972, 50 criminal actions were filed against professional providers resulting in 22 convictions. As of October 31, 1973, there were 32 criminal actions pending.

Fifty-eight criminal actions were filed against Medi-Cal beneficiaries in 1972. This compares with two in preceding five years. As of October 31, 1973, there are 101 pending.

Nineteen nursing homes were suspended from the program during 1972 for Medi-Cal violations.

977 fraud allegations against beneficiaries and 1,003 against providers were under investigation as of February 1973.

The Department's Audit Section reported recoveries of $38.4 million resulting from field audits and additional recoveries of $1.3 million due to desk reviews.

The Program Surveillance Division which performed the detection activities noted above was formed in 1971 to ensure compliance with Medi-Cal program laws and regulations.

Source: 1972 Annual Report of the Governor and the Legislature, Department of Health Director's monthly report for October 1973

5. MRP enhanced the potential for prepaid health plans and encouraged experimentation with new health care delivery systems and controls.

Advantages of PHPs1/

TO THE BENEFICIARY:

-- 24-hour emergency service

-- Assurance of access to and availability of comprehensive health care service through one source

-- No restrictions for prescriptions or doctor visits

-- Possibility of additional services; i.e., free transportation, preventive care programs, baby-sitting service, etc.

-- No copayment

-- Personal identification for health care services in lieu of Medi-Cal card

---

1/ "Facts About Prepaid Health Plans", Brochure published by the Department of Health.

TO THE STATE:

-- The PHP is at risk to provide all necessary health care services covered by contract

-- Potential annual savings to taxpayer of 10 to 20 percent of current Medi-Cal costs

TO THE CARRIER:

-- No prior treatment authorizations required by the State

-- No DRUG or MEDI labels or proof of eligibility stickers required

-- The carrier manages his own PHP and his activities are monitored by the State; minimal intrusion into traditional doctor-patient relationship

-- Faster payments to providers

-- No reimbursement problems

-- No copayment collection

-- Guaranteed monthly cash flow to PHP in advance of services to be rendered

(This monthly fixed payment is based on the number of enrolled beneficiaries and the rates agreed upon by the carrier and the State; a separate rate is established for each of the four cash grant categories.)

-- Centralized administration -- records, billing, reception, etc.

-- No physician profile fee system

-- No emergency cuts to services or payments

Disadvantages2/ of PHPs

-- Cash grant recipients only are eligible

-- Some plans may discourage patients from use of services

-- Poor communication and less personalized care

-- Assembly-line treatment

2/ Leyhe, Dixie L. and Donald M. Procter, "Medi-Cal Patient Satisfaction Under a Prepaid Group Practice and Individual Fee-For-Service Practice", School of Public Health, U.C.L.A., Medi-Cal Project Report No. 3, June 1971.

Growth of PHPs[3/]

	PHP Contracts	Actual Enrollees	Maximum Enrollees Allowed
December 1971	-0-	-0-	-0-
December 1972	22	132,688	429,406
December 1973	48	201,879	814,584

	Enrollment or Eligibles	Cost to State	Average Cost Per Beneficiary
PHP (September 1973)	196,715	$5,365,157	$27.27
Fee-for-Service (September 1973)	2,036,590	$ 98,960,205	$48.59

3/ "Services and Expenditure Report, Computer Report, July-August-September 1973", Program Analysis Section, Department of Health and Michelotti, Carlo, "Medi-Cal: Some Background and Remarks about MRP, Payment Systems and PHP Pilot Projects", California Pharmacist, December 1973.

Legislation

1971 -- AB 949 -- Chapter 577, Statutes of 1971

1972 -- Waxman-Duffy Prepaid Health Plan Act, Chapter 1366, Statutes of 1972

QUOTATION SECTION

Lowell E. Bellin, M.D., M.P.H., "MEDICAL AUDIT; The Bitter Pill is Here and Now", MEDICAL OPINION, December 1971, Volume 7, No. 12.

1. "The catalyst for quality control in health care must come not only from government, but also from leaders within the medical profession."

2. "No matter how motivated a professional medical society may be it cannot dispassionately audit the activities of its peer members."

3. "From our own experience in the New York City Health Department, I can tell you that every dollar spent in uncovering practices of fraud, over-utilization, and incompetence, two to three dollars come back."

Robert D. Eilers, Ph.D., Leonard Davis Institute of Health Economics, University of Pennsylvania, Philadelphia, Address to American Sociological Association, Washington, D.C., September 3, 1970. (Reprinted in the April 22, 1971 issue of The New England Journal of Medicine.)

4. "The fragmented organization of health delivery, including the array of specialists with no apparent linkages, delays experienced in receiving care and problems in obtaining primary care, seem to be perceived by an increasing proportion of the populace as evidence of a self-serving and nonconsumer-oriented system. Although rising costs are probably the principal motivation for some kind of national

health insurance, dissatisfaction with health delivery could be the ultimate force that determines the specific type of national health insurance that will be enacted."

Peter Behr, ROSS VALLEY REPORTER, San Anselmo, California, August 16, 1972.

5. The sole justification for the prior authorization program, and the one seldom mentioned, has been its application as a lever to force needed changes in the medical care delivery system of our state, particularly by encouraging the formation of prepaid medical plans. For according to the law, any group of doctors may escape prior authorization requirements by forming a prepaid plan and delivering their services at ten percent below the average cost.

Dr. Paul Ellwood, Jr., "The Health Maintenance Strategy", AMERICAN REHABILITATION FOUNDATION, Minneapolis.

6. HMOs would "align the physician's economic interests with those of the consumer."

Godfrey Hodgson, "The Politics of American Health Care", THE ATLANTIC, October 1973.

7. ...by pouring money into the medical system on a cost reimbursement basis, Medicare and Medicaid set off a wild inflation in costs. Medicare and Medicaid went into effect in 1966. Within two years, cost inflation had reached the proportion of a crisis. That steep, sudden inflation exposed other weaknesses in the health system and triggered a general reassessment of long accepted assumptions and values.

8. "The whole group health idea has long been anathema to organized medicine. For one thing, it turns the rugged, individualist, fee-for-service, small businessman physician into an employee. Secondly, with the specific incentive of fee-for-service removed, group health schemes have shown consistently lower rates of utilization of advanced medical technology, thus stimulating a passionate debate among medical academics as to whether group health did too little, or fee-for-service doctors did too much."

James Tills, Ph.D., Summer Intern, Bay Area Planning Council, Medi-Cal Reform in California, September 19, 1972.

9. "The common stereotype given of physicians and selective other health professionals is that of persons seeking to make a large amount of money. However, this stereotype is far too exaggerated. Most physicians are genuinely concerned about the health and welfare of their patients. They see Medi-Cal as practiced in the Medi-Cal Reform Act as detrimental to the well being of their patients."

Sir Derrick M. Dunlop, M.D., "Drug Control and the British Health Service", ANNUALS OF INTERNAL MEDICINE, August 1969.

10. "When these (medicine) surcharges were abolished by Mr. Wilson's government in 1964 a fantastic increase occurred, necessitating last year the reimposition, even by a Labour government, of a charge of 30 cents on every prescription with the exception of those for old age pensioners, those on national assistance, children under 15, and those suffering from certain chronic disorders."

BIBLIOGRAPHY

Martin, Nancy, "Surprise: An H.M.O. that Pleases Almost Everybody", MEDICAL ECONOMICS, October 15, 1973.

Sheridan, Bart, "State Medicine, Conservative Style - Still a Hassle", MEDICAL ECONOMICS, September 3, 1973.

California Legislative Analyst, A REVIEW OF THE REGULATION OF PREPAID HEALTH PLANS BY THE STATE DEPARTMENT OF HEALTH, State of California, November 15, 1973.

Bellin, Lowell E., M.D., M.P.H., "Medical Audit: The Bitter Pill is Here and Now", MEDICAL OPINION, Volume 7, No. 12, December 1971.

Hodgson, Godfrey, "The Politics of American Health Care", THE ATLANTIC, October 1973.

Tills, James, Ph.D., "Medi-Cal Reform in California", Summer Intern, Bay Area Health Planning Council, September 18, 1972.

Behr, Peter, "Medi-Cal Reform - Part Two", ROSS VALLEY REPORTER, August 16, 1972.

Brian, Earl W., M.D., "The Medi-Cal Reform Law", CALIFORNIA'S HEALTH, Volume 29, No. 10, April 1972.

Brian, Earl W., M.D., "Foundation for Medical Care Control of Hospital Utilization: CHAP - A PSRO Prototype", NEW ENGLAND JOURNAL OF MEDICINE, April 26, 1973.

Management Analysis Bureau, "An Evaluation of the Medi-Cal Reform Plan Utilization Controls", Department of Health Care Services, December 8, 1972.

Michelotti, Carlo, "Medi-Cal: Some Background and Remarks about MRP, Payment Systems and PHP Pilot Projects", CALIFORNIA PHARMACIST, December 1973.

Crane, Michael A., Ph.D., and Richard C. Morey, Ph.D., "The Cost Effectiveness of Medi-Cal's Program Utilization Controls: A Summary", CONTROL ANALYSIS CORPORATION, November 1972.

Welter, Jack, "$50 Million Saved on Medi-Cal: 1971 Reforms Reverse Rise", San Francisco Examiner and Chronicle, March 18, 1973.

Department of Health Care Services, "A Summary of the Medi-Cal Utilization Review Plan", December 15, 1972.

Health Management Systems, "Six Month Evaluation Report of the PAID Prescriptions Four-County Prepaid Medi-Cal Drug Program", December 1972-May 1973.

Department of Health Care Services, "1972 Annual Report to the Governor and To the Legislature", February 1973.

Leyhe, Dixie L. and Donald M. Procter, "Medi-Cal Patient Satisfaction Under A Prepaid Group Practice and Individual Fee-For-Service Practice", School of Public Health, UCLA, Medi-Cal Project Report No. 3, June 1971.

Reagan, Ronald, "A Responsible Program for Welfare and Medi-Cal Reform", transmitted to the California Legislature, March 3, 1971.

Eilers, Robert D., Ph.D., Leonard Davis Institute of Health Economics, University of Pennsylvania, Philadelphia - An Address to American Sociological Association, Washington, D.C., September 3, 1970.

Dunlop, Sir Derrick M., M.D., "Drug Control and the British Health Service", ANNUALS OF INTERNAL MEDICINE, August 1969.