From:

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FOR IMMEDIATE RELEASE

Sacramento, California, January 15, 1971 -

CAL/CARE

Cal/Care, a new system of health care for needy Californians and a new and positive alternative to Medi-Cal, was proposed today by the County Supervisors Association of California (CSAC).

The Cal/Care plan will provide for a county-administered and county-centered program to provide Health Care for the needy.

Major Points of the Proposal:

--The county shall determine the entry point into the health care services system, regardless of who provides the services.

--The state and counties will be jointly responsible for providing health care services to all needy. This also means sharing the total cost of services. Now the counties are charged by law with providing for medically indigent not covered by Medi-Cal. This new concept would create a single system for all indigent patients.

--A family or individual will be required to pay for services if adequate income or other resources are available.

---A State Health Care Commission would be established to govern the program.

"It's no secret that the economic burden carried by the counties under Medi-Cal has been tremendous," said CSAC President Ralph P. Thiel. "Recent administrative cost shifts from the state to the county taxpayers have meant near fiscal disaster for county government.

"This proposal culminates a two-month effort by our association. It is an innovative approach that is reasonable and flexible and that the taxpayers of California can afford.

"Medi-Cal is a fragmented program that has defied cost controls. Through a single system centered in the counties, California can provide health care for the needy but still keep the program within budgetary limits."

Under the Cal/Care plan, each county would annually prepare and submit a program and budget to provide the scope of services and standards of care for the needy which are generally available for other persons in that county. Medi-Cal has been criticized for providing better and more comprehensive medical care to the indigent than the average citizen can afford.

The program would also provide counties with the flexibility to provide care to persons above the upper limits of financial eligibility or the community standard of care.

The program continues to assure freedom of choice to the needy by permitting those who are eligible to select from approved services and facilities included in the county program. However, those services provided by the private sector will be reimbursed according to a fee schedule established by the State Health Care Commission.

"'Cal/Care' will be able to curb many of the abuses of the current Medi-Cal system," Thiel continued. "With a county system close to the people, California should be able to control expenditures in the program and excessive uses of it."

The CSAC proposal was developed primarily by administrators of county health care systems and reviewed and approved by the CSAC Welfare/Medi-Cal/Hospitals Committee and the CSAC Board of Directors. County hospitals are the usual means of fulfilling the state mandate that counties provide health care services to the indigent, and to the extent that state subventions and other sources of revenue are inadequate, property taxpayers supply the actual cost needs.

The proposal will be part of legislation to be sponsored by the association.

In a related action, the association called for emergency legislation for a deficiency appropriation for the "Option" portion of Medi-Cal for this fiscal year. The association estimates that option costs may be as much as one-third short of counties' needs.

# # # #

County Supervisors Association of California

CSAC POSITIVE HEALTH CARE PROPOSAL

January 14, 1971

MEDICAL CARE POLICY RECOMMENDATIONS
CSAC HOSPITAL ADVISORY COMMITTEE

CSAC Hospital Advisory Committee of the County Supervisors Association of California recommends: 1) that CSAC seek emergency legislation for a deficiency appropriation of $_____for the "Option" portion of the California Medical Assistance Program (Medi-Cal) which was not funded for fiscal year 1970-71; 2) that CSAC seek legislative and/or judicial relief from Medi-Cal regulations that shift costs from the state to the counties; and 3) that CSAC sponsor legislation in the 1971 Session of the California Legislature to create a new single system for meeting the health care needs of medically needy Californians.

The new system will:

1) Make the state and the counties jointly responsible for providing health care services, through a single system, to all persons unable to provide their own.

2) Require the state and the counties to share in the total cost of health care for the needy in the future in the same ratio as they did in 1969-70 for persons on welfare, those "just like" welfare persons now known as Group 2 and all others such as needy children and all persons who rely on county sources for care.

3) There shall be established a sliding scale of income and resources relative to the cost of episodic care requirements

which are in the nature of a financial catastrophy for the affected family or individual with provision for the program to pay the immediate costs and be reimbursed for the beneficiary share over time.

4) Each county will annually prepare and submit a program and budget to provide the scope of services and standards of care for the medically needy which are generally available for all other persons in that county. Such program and budget are to be reviewed and approved by the State Commission on Health Care (see Item #8).

5) Permit counties which desire to provide care to persons above the upper limits of financial eligibility or to augment the approved scope of services or standards of care to assume responsibility for the full cost of such additional care.

6) Provide for administration of the system at the county level with the county having the responsibility to provide its approved program.

7) To insure the availability of funds for payment of medical care costs, the state will advance its estimated share of such costs to the respective counties monthly, subject to regular reconcilation of over or under advances and county compliance with its approved program and budget.

8) There shall be a State Health Care Commission composed of seven members which include the following: 1) The Director of the State Department of Health, who shall serve as Chairman of the Commission; 2) two public members appointed by the Governor; 3) two legislative members, one senator appointed by the Senate Rules Committee and one assemblyman appointed by the Speaker of the Assembly; 4) one county supervisor appointed by the Governor from a list of three submitted by the County Supervisors Association of California and 5) one County Health Care Administrator appointed by the Governor from a list of three submitted by the County Supervisors Association of California

This Commission shall have authority to set financial eligibility criteria; review and approve submitted county programs and budgets; make rules and regulations governing the administration of this program. The Commission will establish fee for service schedules as appropriate to be used as the basis for payment of any services provided by the private sector. The Commission shall exercise its authority so as to insure federal conformity and maximize federal sharing.

9) Freedom of choice will be assured by permitting applicants, whose eligibility and medical need have been confirmed, to select from approved services and facilities included within the approved county program. The county will be the entry point into the system regardless of who provides the service.

State of California

Memorandum

To : SENIOR STAFF
CABINET

file

Date : December 7, 1970

Subject: Medi-Cal Table

From : Jerry Martin

Attached is a table showing (Medi-Cal Scope) the type of service and the amount of benefit financed by Medi-Cal. This is compared across the page with the types of health insurance plans offered by typical major group programs (in this case, the three major state employee health plans).

The last three columns are two union and one private company group health plan and the benefits they offer. This whole package was printed in a series on Medi-Cal uses in the Sacramento Union, September 20, 1970.

Comparison of Benefits: SACRAMENTO UNION 9/20/70

Medi-Cal vs. private plans

SERVICE-GROUP 1 SCOPE	MEDI-CAL SCOPE	BLUE CROSS BLUE SHIELD	CAL/WEST/ OCCIDENTAL	KAISER NORTH & SOUTH	CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA	LOCKHEED MISSILES AND SPACE COMPANY UNDERWRITTEN	LABORERS HEALTH AND WELFARE TRUST FUND
Hospital Inpatient (F)	Yes/100%	Yes/70 days/3 Bed W/d. Rate Co-Pay	Yes/70 days/ $40.00 per day maximum	Yes/100% 111 days/year North Yes/100% 125 days/year South	Yes/70 days/3 Bed Wd Rate/Co-Pay For Private Room	Yes/365 days/ $50.00 per day maximum	Yes/100%/120 days/ Semi-private Room
Hospital Outpatient (F)	Yes/100%	Yes/Limited/Co-Pay	Yes/Limited/Co-Pay	Yes/100%	Yes/Limited/Co-Pay	Yes/Limited/Co-Pay	Yes/10% Co-Pay
Lab and X-ray (F)	Yes/100%	Yes/Limited Co-Pay	Yes/Limited/Co-Pay	Yes/100%	Yes/Limited/Co-Pay	Yes/Limited/Co-Pay	Yes/10% Co-Pay
Nursing Home (F)	Yes/100%	None	None	None	None	None	Yes/100%/120 days
Physician Services (F)	Yes/100%	Yes/Limited/Co-Pay	Yes/Limited/Co-Pay	Yes/100%	Yes/Limited/Co-Pay	Yes/Limited/Co-Pay	Yes/10% Co-Pay
Home Health Agencies (F)	Yes/100%	None	None	Minimal	None	None	None
Medical Transportation (F)	Yes/100%	Yes/Co-Pay	Yes/Co-Pay	Yes/when auth'd	Yes/Limited/Co-Pay	Yes/Limited/Co-Pay	Yes/10% Co-Pay
Pharmacy (Drugs)	Yes/100%	None	None	Yes/Co-pmt	Yes/Co-Pay	None	Yes/20% Co-Pay
Dental Care	Yes/100%	None	None	None	None	Yes/Limited/Co-Pay	Minimal
State Hospitals	Yes/100%	Yes/30 days/Co-Pay	Yes/70 days/Co-Pay	None	None	Yes/365 days/Co-Pay	Yes/20% Co-Pay
Optometrists	Yes/100%	None	None	Yes/100%	None	None	None
Chiropractors	Yes/100%	None	None	None	Yes/Limited/Co-Pay	None	None
Podiatrists (Foot Doctor)	Yes/100%	Yes/Limited/Co-Pay	Yes/Limited/Co-Pay	None	Yes/Limited/Co-Pay	Yes/Limited/Co-Pay	Yes/10% Co-Pay
Special Duty Nursing	Yes/100%	None	None	Minimal	None	Yes/Limited/Co-Pay	Yes/10% Co-Pay
Dispensing Opticians	Yes/100%	None	None	Yes Kaiser Staff/Full Co-Pay	None	None	None
Prosthetic & Orthotic	Yes/100%	None	Yes/Limited/Co-Pay	None	None	None	Yes/10% Co-Pay
Psychology (CPC)	Yes/100%	None	None	None	None	None	None
Occupational Therapy	Yes/100%	None	None	None	None	None	Yes/10% Co-Pay
Physical Therapy	Yes/100%	None	None	None	None	None	Yes/10% Co-Pay
Speech Therapy	Yes/100%	None	None	None	None	None	None
Hearing Aids	Yes/100%	None	None	None	None	None	None
Durable Medical Equipment	Yes/100%	None	Minimal	None	None	Minimal	Yes/10% Co-Pay
Christian Science Service	Yes/100%	None	Yes/Co-Pay	None	None	None	None

(F) — Federally mandated.

Co-pay—patient pays part of cost under private plans, but co-payment by Medi-Cal recipients is prohibited by federal government.

State of California

Memorandum

Medi-Cal

~~EJG~~ → WAS

fyi

To : SENIOR STAFF
CABINET

Date : December 22, 1970

Subject:

From : Jerry Martin

Attached is a package of factual material of the 1970-71 Medi-Cal reductions. It includes a background report on the nursing home situation and a chart comparing Medi-Cal services offered free to welfare recipients with six major health plans offered to public and private employees.

The main point is that the average citizen finances medical benefits to welfare recipients far beyond those which he receives.

EXPLANATION CODE:

Listed below are a selected number of large group health insurance plans available to public and private employees and the health care services each plan provides compared with the services offered under Medi-Cal to welfare recipients.

1. Column 1, (Medi-Cal Scope) is the authorized range of health care services, which the Medi-Cal program provides for welfare recipients.

2. Columns 2 through 4 are health plans available to state employees.

3. Column 5 is the health plan offered by the Carpenters Health and Welfare Trust.

4. Column 6 is the Lockheed Company Health Insurance Plan.

5. Column 7 is the Laborers Health and Welfare Trust Fund Plan.

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES

COMPARISON OF BENEFITS — MEDI-CAL WITH PRIVATE PLANS

SERVICE - GROUP 1 SCOPE	MEDI-CAL SCOPE	BLUE CROSS, BLUE SHIELD FREE CHOICE/SERVICE PLAN	CAL/WEST/ OCCIDENTAL - FREE CHOICE/ INDEMNITY PLAN	KAISER NORTH & SOUTH CLOSED PANEL/GROUP PRACTICE	CARPENTERS HEALTH AND WELFARE TRUST FUND FOR CALIFORNIA HOSPITAL SERVICE OF CALIFORNIA (BLUE CROSS)	LOCKHEED MISSILES AND SPACE COMPANY UNDERWRITTEN BY TRAVELERS INSURANCE COMPANY	LABORERS HEALTH AND WELFARE TRUST FUND — SELF-ADMINISTERED PLAN PLAN
Hospital Inpatient	Yes/100%	Yes/70 days/ 3 Bed Wd Rate Co-pmt/Higher Accd. Required	Yes/70 days/ $40.00 per day maximum	Yes/100% 111 days North Yes/100% 125 days South (South has 240 more days at ½ cost)	Yes/70 days/3 Bed Wd Rate/ Co-pmt if Higher Accom's Required	Yes/365 days/ $50.00 per day maximum	Yes/100%/120 days/ Semi-private Room
Hospital Outpatient	Yes/100%	Yes/Limited / Co-pmt	Yes/Limited / Co-pmt	Yes/100%	Yes/Limited/Co-pmt	Yes/Limited/Co-pmt	Yes/10% Co-pmt/ $15,000 Max
Lab and X-ray	Yes/100%	Yes/Limited/ Co-pmt	Yes/Limited/ Co-pmt	Yes/100%	Yes/Limited/Co-pmt	Yes/Limited/Co-pmt	Yes/10% Co-pmt/ $15,000 Max
Nursing Home	Yes/100%	None	None	None	None	None	Yes/100%/120 days (2 for 1) ECF Care
Physician Services	Yes/100%	Yes/Limited// Co-pmt	Yes/Limited/ Co-pmt	Yes/100%	Yes/Limited/Co-pmt	Yes/Limited/Co-pmt	Yes/10% Co-pmt/ $15,000 Max
Home Health Agencies	Yes/100%	None	None	Minimal	None	None	None
Medical Transportation	Yes/100%	Yes/Co-pmt	Yes/Co-pmt	Yes/when auth'd	Yes/Limited/Co-pmt	Yes/Limited/Co-pmt	Yes/10% Co-pmt/ $15,000 Max
Pharmacy (Drugs)	Yes/100%	None	None	Yes/Co-pmt	Yes/Co-pmt	None	Yes/20% Co-pmt/ $15,000 Max
Dental Care	Yes/100%	None	None	None	None	Yes/Limited/Co-pmt	Minimal
State Hospitals	Yes/100%	Yes/30 days/ Co-pmt	Yes/70 days/ Co-pmt	None	None	Yes/365 days/Co-pmt	Yes/20% Co-pmt/ 120 days
Optometrists	Yes/100%	None	None	Yes/100%	None	None	None
Chiropractors	Yes/100%	None	None	None	Yes/Limited/Co-pmt	None	None
Podiatrists	Yes/100%	Yes/Limited/ Co-pmt	Yes/Limited/ Co-pmt	None	Yes/Limited/Co-pmt	Yes/Limited/Co-pmt	Yes/10% Co-pmt/ $15,000 Max
Special Duty Nursing	Yes/100% Within Require.	None	None	Minimal	None	Yes/Limited/Co-pmt	Yes/10% Co-pmt/ $15,000 Max
Dispensing Opticians	Yes/100%	None	None	Yes/Kaiser Staff/ Full Co-pmt	None	None	None
Prosthetic & Orthotic	Yes/100%	None	Yes/Limited/ Co-pmt	None	None	None	Yes/10% Co-pmt/ $15,000 Max
Psychology (OPC)	Yes/100%	None	None	None	None	None	None
Occupational Therapy	Yes/100%	None	None	None	None	None	Yes/10% Co-pmt $15,000 Max
Physical Therapy	Yes/100%	None	None	None	None	None	Yes/10% Co-pmt $15,000 Max
Speech Therapy	Yes/100%	None	None	None	None	None	None
Hearing Aids	Yes/100%	None	None	None	None	None	None
Durable Medical Equipment	Yes/100%	None	Minimal	None	None	Minimal	Yes/10% Co-pmt $15,000 Max
Christian Science Service	Yes/100%	None	Yes/Co-pmt	None	None	None	None

7/24/70

COST COMPARISON

1. Medi-Cal cost about $517 per capita in 1970. During the same fiscal year, the per capita cost for health care in the United States was about $312, according to the latest available federal statistics.**

2. The average citizen is helping finance (through his taxes) a program of medical benefits and services for welfare recipients that is far more extensive than many private health insurance plans and costs about $205 a year more than the per capita cost of health care in the United States.

3. One newspaper (Sacramento Union, Sept. 20, 1970) estimated that to obtain comparable health care benefits from private insurance, a family of four would have to pay a premium of $2,000 a year!

MEDI-CAL BENEFITS EXCEED PRIVATE HEALTH PLANS

1. Medi-Cal finances full-cost benefits for a list of 23 basic and optional medical and related health care services. Medi-Cal provides 23 of 23 services on the list.

By contrast:

One major group plan (Blue Cross, Blue Shield) provides benefits for only the 7 most basic categories of medical services. And it requires limited co-payment in six of those seven!

Another private plan (Kaiser Group Practice) offers benefits in 10 of the 23 service categories. BUT, it requires partial or full co-payment by the person receiving benefits in 4 of the 10 and imposes limitations of benefits in two others!

In short, many private citizens are being taxed to pay for welfare recipients' medical benefits that are more extensive than they themselves have under private insurance. And the cost of Medi-Cal is $517 a year versus the approximately $312 per capita that is spent on health care in U.S. (1970).

MEDI-CAL'S GENEROUS BENEFITS

1. In addition to the basic medical services, Medi-Cal also must pay for benefits such as occupational therapy, chiropractors, dental care, psychologists, speech therapy, physical therapy, optometrists, home health agency services, nursing home services and medical equipment. NONE of those benefits are offered under many major private health

*Group plan available to state employees.
**Health care cost estimate (national total) by Task Force on Medicaid and Related Programs, HEW, June 30, 1970; census data.

plans, the ones which cover most citizens who pay the taxes to finance Medi-Cal.

Yet all of these and most important, all basic health needs will still be offered by Medi-Cal under the December regulations. (Federal and state law prohibits eliminating any. The state is mandated to make across the board reductions, such as the 10% cut. It could not, for example, eliminate Dental care to provide more funds for some other benefit such as nursing home care).

Non-Elective Surgery

All surgery or other medical benefits necessary to prevent death or significant disability will CONTINUE TO BE OFFERED AND FINANCED TO the FULL EXTENT OF EXISTING BENEFIT SCHEDULES! Only non-essential services are affected by the new limitations.

An example of non-emergency, non-essential services that can be safely postponed for 90 days or more without causing significant disability include:

A "bunionectomy", or a hernia repair (non-emergency).

Why Trim Services?

The law requires the state administration to make a specific sequence of cost reductions when Medi-Cal exceeds its budget.

The first cut on the list is a 10% reduction of fees to physicians, chiropractors, nursing homes, and other health providers. Then the state must order a postponement of non-elective services under a sequence written into the law by the Legislature in 1967. Services cannot be eliminated and only a comparatively small number of persons, the "affluent poor", can be dropped from the program under emergency circumstances. These are the 230,000 medically needy who have too much income to qualify for a cash grant. There are no present plans to drop them. The law requires Medi-Cal to accept all welfare recipients on its rolls, too.

Why the Budget Squeeze?

The original 1970-71 budget included funds for a projected average monthly caseload of 2,119,600 (including all welfare categories). Now the number of Medi-Cal recipients is expected to average more than 2,400,000 a month for Fiscal 1970-71. The caseload growth in Medi-Cal is caused by the growth of the welfare rolls, including the impact of court decisions which liberalize benefits and add people to welfare.

MAINSTREAM MEDICAL CARE?

Q--Some critics have said the latest Medi-Cal restrictions means that the poor no longer will be in the "mainstream" of medical care.

A--On the contrary, the tightening up still leaves welfare recipients and the medically needy with a far more generous array of medical benefits than the average working taxpayer has for his own family. Most private plans offer one-half to two-thirds FEWER health services than Medi-Cal. And in many private plans, the person receiving the care must make at least a small co-payment for the service rendered. Medi-Cal recipients pay nothing. FURTHERMORE, ALL essential health services are still fully provided.

Q--The benefits offered free by Medi-Cal to welfare recipients must be more expensive than the health insurance the average citizen has for his own family since it provides so many more benefits. IS it more expensive?

A--It certainly is. During Fiscal 1970, the cost of Medi-Cal on a per capita basis was about $517. The Task Force on Medicaid and Related Programs, U.S. Department of Health, Education and Welfare, has reported that for Fiscal 1970, (June 30, 1970) the total expenditure for health care in the United States was about $64 billion. That means that the per capita (per person) expenditure for health care in the United States during Fiscal 1970 amounted to about $312 a year for 205 million American citizens, about $205 less than the Medi-Cal per capita cost.

NURSING HOME RATES

The subject of what constitutes "reasonable" reimbursement for nursing homes in the Medi-Cal program is a complex problem. A proper perspective for evaluating the situation requires some background into the whole history of the Medi-Cal nursing home program.

Immediately prior to the advent of Medi-Cal and Medicare in California, there were approximately 22,000 nursing home beds in the State of California. In the five years the two government health care programs have been in existence the number of nursing home beds has increased to approximately 100,000 beds at the present time.

Many homes, including those built as speculative investment ventures, rely heavily upon the Medi-Cal and Medicare programs for filling their beds. But the vacancy factor in California is relatively high--15 per cent--indicating an over-capacity which the industry itself created.

Eighty per cent of those beds which are filled are occupied by Medi-Cal and Medicare patients.

In effect, the Nursing home industry in California was largely built through the Medi-Cal program. There is nothing wrong in this. Private enterprises such as private nursing homes should be encouraged to help meet existing public needs (i.e. the need for nursing home facilities for the elderly).

But the Reagan administration does not believe that the taxpayers should be forced to pay excessive daily rates to make up for a high vacancy factor caused by over-capacity.

The Reagan administration does believe that nursing home operators participating in the Medi-Cal program are entitled to "reasonable" reimbursements. The attempt is being made now to define "reasonable".

The State really is caught in a bureaucratic cross fire in this situation. The Federal Government indicated after a survey that 45% of Medi-Cal nursing home patients should not be in this type of facility, but instead should be in an "intermediate care" program (one which doesn't require the higher degree of medical attention in nursing homes).

No such program existed. The State must develop standards for an intermediate care type facility from scratch. It is attempting to do this by cooperating with the nursing home operators and the Federal government.

But some nursing home operators have objected to the "intermediate care" concept because it would mean lower daily rates than they have been demanding from the State.

In brief, the dispute involves what constitutes a "reasonable" daily rate.

BACKGROUND OF NURSING HOME RATES

The California Association of Nursing Homes sued the State in November 1967, charging that nursing home rates under Medi-Cal were not reasonable. These rates were established by the Department of Finance at the direction of the former Governor in 1961.

An appeal upheld a trial court decision which said essentially that the court had no way to decide if the rate was reasonable because it did not go the State Administrative Procedure Act route. This course allows data (or regulations) establishing a base to be introduced as evidence at a public hearing. There it is open to challenge and contrary evidence may be introduced. Public hearing testimony in effect provides a body of evidence that sometimes obviates the need for a court to take evidence itself.

The legal route ran its course in late 1969 and the Department ordered that Ernst and Ernst, a national accounting firm, establish nursing home data from a valid statistical sample which proved to be 76 nursing homes chosen from about 1,300. Ernst and Ernst was advised not to chose a nursing home that had less than 65% occupancy nor one that had less than 35% Medi-Cal patients. This was to prevent "outlaw" statistics from distorting the present picture. Based on their data, the Department's analysis showed that the proposed rate should be $13.54 a day.

The December 15-16 public hearing for nursing home rates will result in the adoption of a rate on February 1, 1971. That rate--whatever it is-- will be subject to a 10% cut which is being levied against all until June 30, 1971. The current rates are also subject to the 10% cut until such time as the new rates are established.

INTERMEDIATE CARE FACILITIES

As of early December, approximately 300 beds have been approved for intermediate care in northeastern California by Comprehensive Health Planning. At that time, there were applications for another 300 beds awaiting CHP approval in the Los Angeles area. Ordinarily, this approval required a public hearing and CompHealth has yet to make a Southern California swing.

At the same time, the State Department of Health Care Services has medical-social review teams operating in the Sacramento and Los Angeles areas. These teams are surveying the medical and social needs

of every Medi-Cal patient in each nursing home to ascertain what level of care that patient needs. So far, their survey shows about 30% of the patients need some lesser level of care than nursing homes. The nursing home industry and the public have been assured that even though Medi-Cal patients are identified as requiring a lesser level of care, none will be moved until that care is available in the area. The accent on intermediate care is for social activity rather than medical care. For example, instead of a staffing requirement for 24 hour nursing care, 40 hours a week nursing standards are all that's necessary. On any given day, there are about 55,000 Medi-Cal patients in nursing homes. The Department will adopt emergency regulations governing standards for intermediate care on December 10. Nursing homes, convalescent hospitals, or hospitals already licensed by DPH do not have to go through Comprehensive Health Planning, nor be additionally licensed by DPH which will entail an on-site inspection by the Department's licensing agency. This will identify a wing or section in a licensed facility that could be used for intermediate care. This will sever a great deal of red tape that presently is inhibiting nursing home operators from applying for ICF. The rate for ICF, as proposed by Human Relations Agency (and also subject to public hearings later) is $305 per patient a calendar month.

There are, of course, avenues through which the nursing home operators may seek equitable adjustments in the rates. Both the Federal government and the State have established procedures for this purpose.

But both the Federal and State governments also have an obligation to make sure that taxpayers are not forced to pay an excessive nursing home rate for a facility built in the wrong place at the wrong time. Nor should taxpaying citizens who finance their own, less extensive medical care, be required to subsidize inefficiency to meet a payment level that a nursing home operator arbitrarily thinks if "fair".

If the state administration did not insist upon tight fiscal checks upon rates, nursing home expenses could be subject to the same type of massive cost over-runs that the Federal government has experienced with some of its large defense contracts.

PB

Medi-Cal

December 22, 1970

REPLY TO KCBS RADIO EDITORIAL

By Dr. Earl Brian
Director, Department of Health Care Services
State of California

Several weeks ago, when Governor Reagan announced temporary steps his administration was taking to help head off the financial crisis in the state's Medi-Cal program, he noted the public's confusion about the program. I'd like to clear up some of that confusion.

Medi-Cal was created by law in 1965, implemented in early 1966 and inherited by Governor Reagan in 1967. Since assuming office, the governor has warned repeatedly of the enormous difficulties of administering the program.

To get a Medi-Cal card, one need only get on welfare. The card provides the most complete array of health care services imaginable---all paid in full by the taxpayers---working men and women who cannot even afford such care for themselves or their families.

Today, one out of every nine Californians is on welfare and therefore a Medi-Cal recipient. That compares with one of every 15 citizens four years ago.

Despite the tremendous increase in those receiving Medi-Cal, the law---Section 14120 of the Welfare and Institutions Code---requires the Medi-Cal program to be operated within budgeted expenditures. The law says that if, at any time, we know the cost of Medi-Cal will exceed available funds, we must reduce by up to 10 percent the amounts the state pays for Medi-Cal services.

The governor's action was explicitly required by law. Had the temporary controls not gone into effect December 15, the Medi-Cal program would have run out of funds next April, two and one half months before the end of the fiscal year. And that is <u>against</u> California law.

I want to emphasize that the cuts we made were in fees paid to doctors, dentists and other providers. No essential services have been eliminated. The fact is: because the administration took the action <u>in time</u>, Medi-Cal recipients are now assured of receiving the necessary care they require.

In the meantime we are putting the finishing touches on a complete overhaul and reform of Medi-Cal---which Governor Reagan will be announcing in the coming months.

Time: 1:58

EJG:feb

Medi-Cal

From: 12/77

Chuck Broadhurst
County Supervisors Association of California
1100 Elks Building
Sacramento, California 95814
Telephone (916) 441-4011

FOR IMMEDIATE RELEASE

Sacramento, Dec. 17--The president of the County Supervisors Association of California today expressed alarm over the serious implications to local property taxpayers stemming from State efforts to overcome a $140 million deficit in California's Medi-Cal program.

In a statement issued from the Association's offices in Sacramento, Ralph P. Thiel, a Tuolumne County supervisor, declared:

"The State has simply told county hospitals to make their services available to Medi-Cal recipients at a multi-million dollar loss, whereas in the past they've provided them at cost. This regrettable move was ordered by the Director of the State Department of Health Care Services without even consulting the counties, and we are important financial partners in the Medi-Cal program. Specifically, the Department:

"One--ordered the counties to provide outpatient Medi-Cal services at below their actual cost. We estimate the direct impact of this order to be between $5 and $8 million on the county property taxpayer.

"Two--imposed a further 10% reduction in the amount the State will pay for county medical services. This adds another $2 million to the county property taxpayers' bill.

"Three--on top of this the State proposes to require the counties to provide long term care to the chronically ill at a loss. In Tuolumne County alone, this would cost real property taxpayers $161,280, which would mean an increase of 20.6 cents on our county's tax rate. Statewide, our preliminary estimates of the amount that would have to be raised locally is between $10 and $15 million. Again, it would be the county property taxpayer who would have to pick up the tab.

"And four--circumstances threaten to shift over 200,000 medically needy recipients to care in county hospitals. The cost implication of this move, if it occurs, is between $100 and $150 million.

"It is totally unreasonable to expect counties to absorb such massive costs. For one thing, this year most county tax rates jumped to all time highs. For another, county budgets for the current fiscal year have already been adopted and their tax rates established. There is positively no way for county boards of supervisors to go back to the property taxpayer and raise the 1970-71 tax rate. If the State prevails, it will mean the counties will have to cut such desperately needed services as law enforcement, fire protection, mental health, and probation. Most counties have no reserves whatever from which to bail the State out of its Medi-Cal financing crisis.

"Moreover, there is a serious question under the Medi-Cal law whether the State Director of Health Care Services has the authority to impose fees on counties at less than the cost of the services they provide. Counties are required, by law, to provide medical care services to the poor, whereas private hospitals are not. They cannot

close their doors to the poor. This principle has been recognized since the inception of the Medi-Cal program in 1965 and is due to the simple fact that county hospitals are supported by property tax revenues. Californians should realize that county health care is provided at cost, and that any fee schedules or reductions in payments by the State is nothing less than an outright cost-shift to the county property taxpayer. They should also realize that the property taxpayer is a heavy contributor to the funding of Medi-Cal. He supplies approximately $1 for every $2 that the State puts up.

"If doubt is now to be cast upon this State-county relationship, the counties believe they will have no other alternative but to secure judicial or legislative interpretation of the Medi-Cal law rather than relying upon the unilateral interpretation of the State Director of Health Care Services.

"Counties quite appropriately are alarmed, for the State's directives are clearly a breach of faith in the joint State-county partnership to deliver health care services to the poor."

# # #

State of California

Health and Welfare Agency

Memorandum

To : Edwin Meese, III
Executive Secretary
Governor's Office

Date : July 14, 1970

File No.: 21:38

Subject : Medi-Cal Management System

From : Office of the Administrator

In response to questions raised at staff meeting this morning, transmitted herewith are Earl Brian's explanations.

LUCIAN B. VANDEGRIFT
Secretary

Attachment

cc: Verne Orr, Director, Department of Finance)
James Crumpacker, Cabinet Secretary)
Governor's Office) with copy of
Paul J. Beck, Press Secretary) attachment
Governor's Office)

State of California — Human Relations Agency

Memorandum

hand delivered 4:30 7/14/70

JUL 14 1970

To : Lucian B. Vandegrift, Secretary
Human Relations Agency

Date : July 14, 1970

Subject :

From : **Department of Health Care Services**
Earl W. Brian, M.D., Director

This memorandum will summarize the events to date regarding the Medi-Cal Management System.

In 1967, the Governor's Survey on Efficiency and Cost Control recommended that the claims processing system for the Medi-Cal program be reviewed, with the idea that considerable revision in the system was needed.

In the Fall of 1968 Lockheed Corporation was awarded a contract for the study of the existing claims processing system and proposal of a new system, which is now called the Medi-Cal Management System. The Lockheed proposal was put out to bid, and finally two companies submitted bids to design, implement, and test the system on a prototype basis in two California counties. The final contract for $5.5 million was awarded to Health Care Systems Administrators (HCSA), a joint venture of Occidental, Pacific National, Pacific Mutual, and Cal-West insurance companies, in conjunction with IBM. After lengthy contract negotiations the final contract was signed on June 15, 1970, and since that time has been approved by the Department of General Services. HCSA is now working to implement the computerized claims processing system in two California counties -- San Diego and Santa Clara.

The system is quite complex in that there are many different factors involving the Medi-Cal program, which includes such things as eligibility determination, mechanics of claims processing, systems for duplicate payment checks, systems for utilization review, which will be built into the Medi-Cal Management System. The contract calls for an 18-month design and implementation period. If the system is as successful in the prototype counties as is anticipated, the state will have to give consideration to statewide implementation of the system.

The attached reports prepared by the Lockheed Corporation indicate what effect might be anticipated if a successful system can be implemented statewide. The last chart in the group projects a program saving of $172 million.

This may be somewhat optimistic, but it seems reasonable to assume that a system such as the Medi-Cal Management System can effect a 7% program savings (which in the Medi-Cal program would approximate $100 million).

There may be some concern that the conflict of interest question regarding Carel Mulder has some relationship to the Medi-Cal Management System. This is not the case. The question surrounding Carel Mulder arose out of a relationship between EDS-F of Dallas, Texas, and California Blue Shield. Neither of these two organizations have any relationship with the Medi-Cal Management System. (Furthermore, as you will recall, the Attorney General investigated the Mulder charge and found him to be "without conflict of interest".)

Earl W. Brian

Earl W. Brian, M.D.
Director

EWBdw
Attachments

cc: Verne Orr, Director
State Department of Finance

LOCKHEED PROJECT STARTUP COSTS

	Low Estimate	Per Claim	High Estimate	Per Claim
Cost to Start	$5,000,000		$6,000,000	
Amortized Over 3 Years	1,667,000	$0.56	2,000,000	$0.67
Claims Load*	3,000,000		3,000,000	
Operating Expense	3,000,000	$1.00	4,000,000	$1.33
Total Annual Expense (First 3 Years)	$4,667,000	$1.56	$6,000,000	$2.00

*To keep amortized cost at less than $1.00 per claim, and also have reasonable overall processing cost.

Estimated Monthly Claim Volume for Larger Foundation and Society Counties:

Foundation Counties	Medical	Dental	Drug	Total
Fresno	27,930	2,560	51,720	82,210
San Bernardino	27,260	2,210	43,590	73,060
Sacramento	25,610	2,490	41,180	69,280
San Diego	22,910	2,260	66,680	91,850
Santa Clara	22,910	2,060	37,690	62,660
Riverside	17,120	1,390	32,500	51,010
Kern	15,810	1,060	30,520	47,390
Tulare	13,760	930	25,690	40,380
Society Counties				
San Mateo	8,992	667	12,139	21,797
Ventura	7,030	610	10,678	18,319
Santa Barbara	6,553	567	8,585	15,704
Butte	5,034	411	9,116	14,560
San Luis Obispo	5,185	465	8,362	14,012
Solano	4,503	379	7,591	12,472
Marin	3,409	313	5,273	8,995

MEDI-CAL SYSTEM COST METHODOLOGY

- PROGRAM SAVINGS BASED ON EXPERIENCE IN FRESNO COUNTY ON MEDICARE CLAIMS

NATIONWIDE CLAIM REDUCTION	1½%
FRESNO CLAIM REDUCTION	14 %
DIFFERENCE ATTRIBUTED OF IMPROVED UTILIZATION CONTROL	12½%

- ADMINISTRATIVE SAVINGS BASED ON EXTENSION OF LOCKHEED WORK - USING A CONSTANT PERCENTAGE SAVING

ESTIMATED ANNUAL TOTAL

MEDI-CAL CASH FLOW

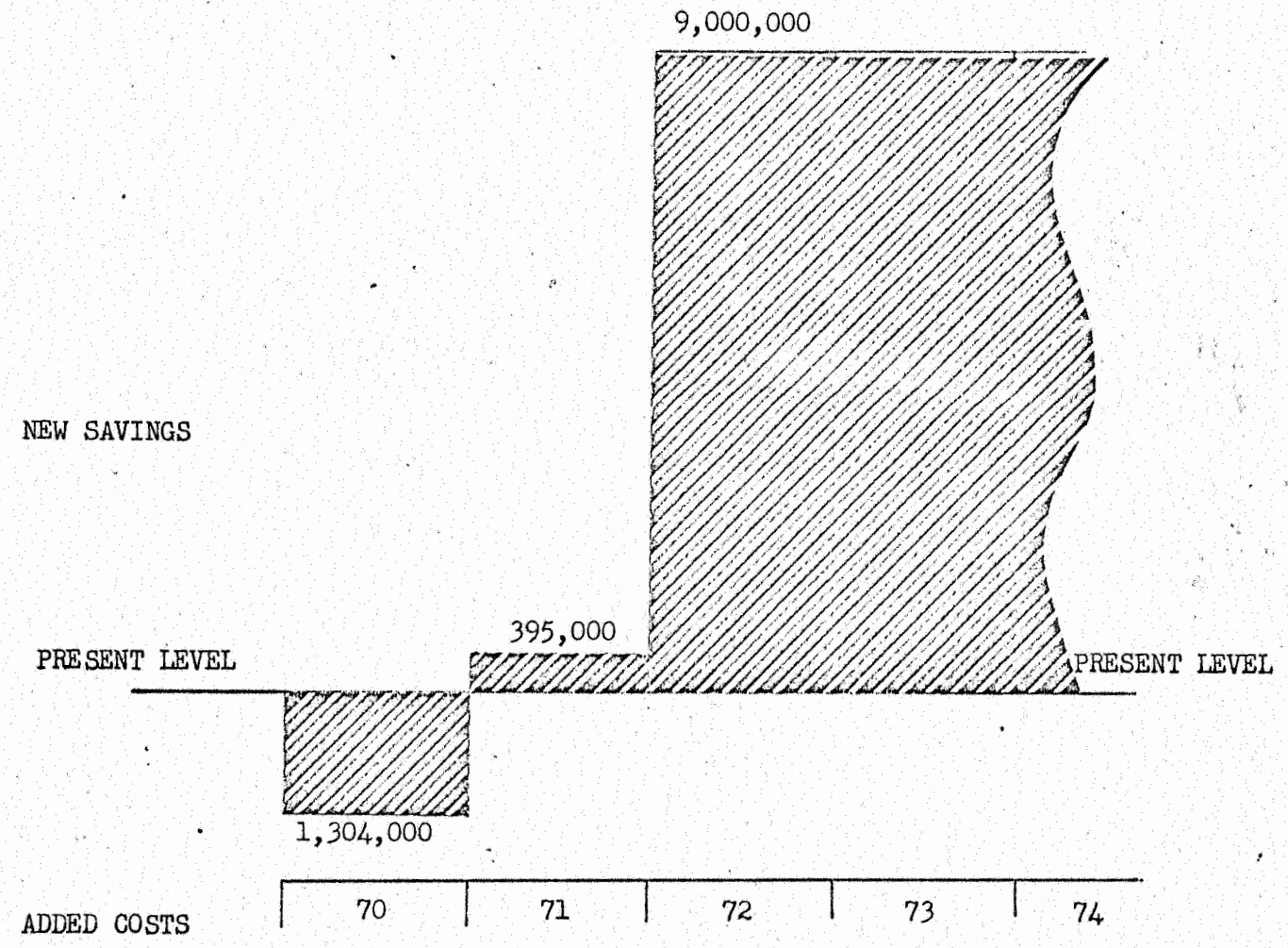
FISCAL YEAR	$	
1970	$484,000	ADDED COST
1971	$163,400,000	SAVINGS
1972 onward	$172,200,000	SAVINGS

MEDI-CAL COSTS: 1969/1970 ESTIMATED

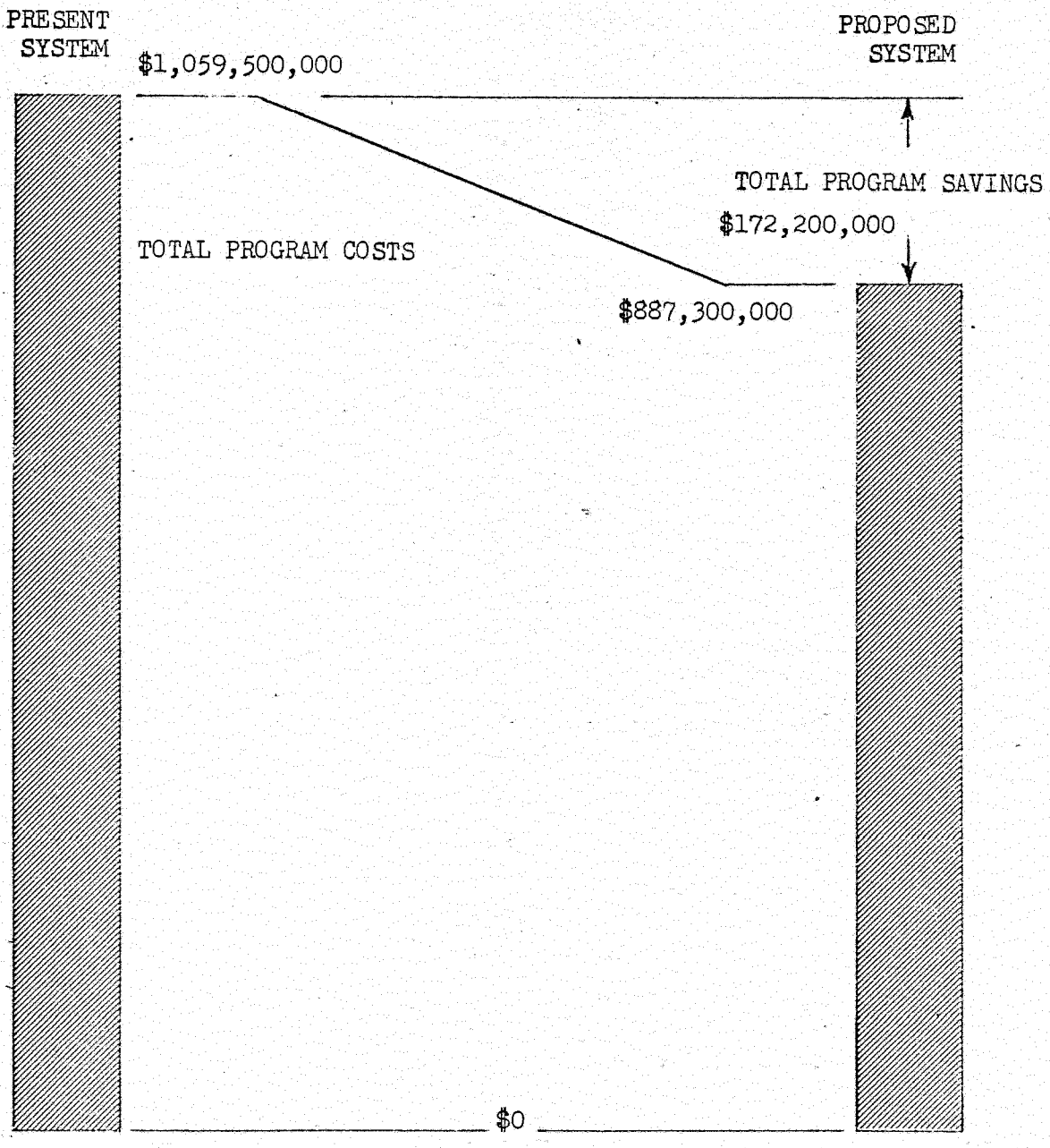
	PRESENT SYSTEM	FULLY OPERATIONAL PROPOSED SYSTEM	CHANGE
ADMINISTRATION	$39,500,000	$30,300,000	$9,200,000
APPLICANT PROCESSING			
CLAIMS PROCESSING			
FISCAL OPERATIONS			
PLANNING, ANALYSIS & CONTROL			
PROVISION OF SERVICE	$1,020,000,000	$857,000,000	$163,000,000
TOTALS	$1,059,500,000	$887,300,000	$172,200,000

ESTIMATED TOTAL MEDI-CAL SAVINGS

ESTIMATED ANNUAL CASH FLOW ADMINISTRATIVE COSTS ONLY



ESTIMATED
CHANGE IN MEDI-CAL
COSTS



HUMAN RELATIONS AGENCY
Sacramento, California
Contact: Walter Barkdull
Telephone: (916) 445-6951
April 17, 1970

FOR IMMEDIATE RELEASE

Plans to establish a new intermediate category of out-of home care for the aged or disabled were announced today by Lucian B. Vandegrift, Secretary of the Human Relations Agency, in a report to the Legislature.

"Intermediate care will fill the existing gap between homes that either provide no regular nursing care or provide it around the clock," Vandegrift said. "This new category will permit the aged or disabled to secure the combination of medical and social care best suited to their needs."

The new combination category will go into effect after hearings are held, standards officially adopted, and licenses are issued by the State Department of Public Health -- probably in September, 1970.

At the same time, State medical-social review teams will be formed which will place residents whose care is paid by the State Medi-Cal or welfare programs in the most appropriate type of program. The teams will review the placement of each resident annually to insure that his needs are being met. Teams will be under control of the Department of Health Care Services.

Vandegrift said that he expects most of the new intermediate care beds will come from conversion of distinct portions of existing nursing and residential care homes, minimizing the need to move residents.

The Agency proposes that the staffing of intermediate care homes include a licensed nurse on duty full-time for the day shift during the regular work week and another employee responsible for planning and directing social and recreational programs.

Nursing homes are now required to have licensed nursing personnel on duty 24-hours a day, every day, while the residential care homes require no nursing personnel.

On the basis of preliminary comparisons, the average intermediate care rate is expected to be approximately $300-$320 a month -- about $100 a month less than skilled nursing home care and $100 more than residential care.

The new category was developed under authority of legislation authored by Assemblyman Eugene Chappie (R-Cool) which was adopted in 1968.

A study conducted by the Agency showed that 35 percent of a sampling of Medi-Cal recipients in skilled nursing homes could be served more appropriately by a lower level of medical care together with a higher level of social care, a combination that does not now exist.

Vandegrift said that the cost of the review team operation would be paid by the savings from utilizing the less costly care during 1970-71. He said that in subsequent years savings to the State should be "substantial".

# # #

State of California

Memorandum

Human Relations Agency

cc Crumpacker
Beck
Walton
for info
file

To : Lucian Vandegrift, Secretary
HumanRelations Agency

Date : March 12, 1970

Subject :

From : Department of Health Care Services
Earl W. Brian, M.D., Director Designate

On March 11, 1970, I attended the California Hospital Association's Board of Trustees meeting, and during the course of that meeting I was forced into a position of having to speak for Governor Reagan in regard to a basic health concept. The conversation went something like this:

> The President of the California Hospital Association said, "Dr. Brian, we have heard from a reliable source that when told that needy patients would have to go to county hospitals (in lieu of private hospitals) if Medi-Cal funds were cut, Governor Reagan responded: 'What is wrong with that?'." The CHA President went on to say that this caused concern in their ranks about the Governor's position in regard to the "mainstream health care" concept under which the Medi-Cal program (theoretically) operates.
>
> I responded to the audience (of approximately 50 people) in the following manner: "I am certain that Governor Reagan's intent, if he made such a statement was to get at the crux of the subject rather than to take an unfavorable position in regard to the mainstream concept. The Governor is a pragmatic individual who keeps an open mind to the various possibilities. While I know for certain that he desires to help the truly needy members of our society who, for reasons beyond their control, are unable to help themselves, the Governor has some reservations about the manner in which this help is delivered to those persons. Generally I feel that he is interested in having me attempt to make this mainstream health care concept work efficiently and, in fact, has hired me to do that particular job. However, he would be willing to take a hard look at alternative methods for delivering health care to the needy members of our society."

Generally, my position in the discussion was one of leaving the door open for the Governor to proceed in either direction; but, since this and other related questions tend to crop up continuously, I believe it would be advisable for us to sit down with the Governor for a few minutes and review this subject.

Earl W. Brian

Earl W. Brian, M.D.
Director Designate

EWBdw

HUMAN RELATIONS AGENCY
Sacramento, California
Contact: Spencer Williams
November 7, 1968

FOR IMMEDIATE RELEASE

Spencer Williams, Secretary of the Human Relations Agency, issued the following statement in connection with the release by the Attorney General of the report on Medi-Cal:

"We join with the Attorney General in our mutual determination to eliminate fraud in the State's Medi-Cal program.

The suggestions contained in his report, aimed at reducing abuses in this important area, should contribute to creating additional safeguards in the program.

As this administration has said many times, Medi-Cal was hastily conceived in the closing days of the 1965 legislature, prior to the time Governor Reagan took office. In this connection, it is important to note that the Attorney General's report emphasizes that the necessary planning and research needed for the effective operation of Medi-Cal unfortunately did not accompany the initial enactment of the program.

We also echo his warning that the enactment of Federal legislation which requires immediate response from the states to take advantage of Federal funding is laden with peril. Certainly, as the report emphasizes, the formulation of programs without sufficient preparation and analysis is ill-considered.

We have not, and will not, tolerate fraudulent misuse of Medi-Cal funds by those who receive or provide services.

We have asked to meet with the staff of the Attorney General to secure specific cases of fraud and abuse which were uncovered. Further, we will continue to insist on prosecution in any case where there is evidence of wrong-doing.

Even though the 'illegal and unethical activities' identified in the report amount to only about one percent of program expenditures, the fact is that this still represents one percent more misuse of the taxpayers' money than is warranted. Every penny spent for Medi-Cal must be spent for those who require treatment, not for the benefit of cheaters.

We are continuing to improve the management of Medi-Cal and are making substantial progress in this regard.

As the report notes, 'efforts have already been made to remedy many of the problems' mentioned. For example, before the study was even contemplated we had tested and installed a new computerized billing system which resulted in the recovery of more than $1 million paid out prior to January, 1967. Since that time we have rejected duplicates at the rate of about $100,000 a month. Furthermore, the new multi-card identification system will make false billing even more difficult.

After many months of complex negotiation we awarded contracts last September to begin audits. We supported legislation months ago that will shortly become effective to place the Medi-Cal consultants under State control. We have a management systems study underway which will result in further improvements in the program."

# # #

State of California

Memorandum

To : Governor Reagan

Date : May 3, 1968

file

Subject : Suggested comments concerning press stories on Legislative Joint Committee Report on Medi-Cal

From : Spencer Williams

As to necessity to propose program reductions and postponement of non-essential services last August: This year's budget was prepared on the basis that carry-over debts were to be paid out of this year's appropriation. This position was made known to the Legislature at the time the budget was presented, and subsequently during June and July. The ability to pay off the Medi-Cal debts, however, out of prior-year resources from other programs made possible the Medi-Cal surplus which we will experience this year.

As to the comment in the report, "The Administration's response to (Supreme Court's) decision was to answer that 160,000 medically indigent people would be totally eliminated from the program unless the Legislature authorized the Administration to make the reductions in benefits the courts held to be illegal".: It was the court, not the Administration, which said the first step in reducing or postponing program services must be the elimination of the 160,000 medically indigent. The Administration rejected this concept as unfair and as requiring a shift of unreasonable expenses to the counties. It was for this reason that it sought legislative alternatives.

In general, the report gives the Administration proper credit for actions taken to control the program by tightening up in the administration of Medi-Cal. These total approximately 64.6 million General Fund savings. There will be no relaxation of these efforts to control program costs which result from over-utilization by both providers and patients.

As to statements alleged that future Medi-Cal cuts are unnecessary and that the program does not face fiscal problems next year, the question asked of Mr. Williams was that "if this year's surplus is carried over and added to next year's budget as mentioned in the report (page 20, last paragraph) can the current level of service be maintained?" The response was "assuming that the surplus is carried over it would seem that unless unforeseen circumstances arise, the program could be operated at current levels, however, in view of the broader overall General Fund problem that faces the state there can be no assumption of such carryover".

RR - prog. should be reduced in cost & all cmte did was postpone day of reckoning.

As to the need for the Sherman Bill: The Sherman Bill is necessary to establish sensible priorities for program controls in the event of fiscal problems whether they develop this year or any year. In a program affected by as many variables as Medi-Cal, such variables including changes in federal legislation and reductions in federal funding, the legislative establishment of such criteria is essential. Whether the program faces fiscal difficulties next year will depend upon these variables as well as whether the condition of the total General Fund allows or does not allow the application of this year's Medi-Cal surplus to next year's program.

Rough Draft

file

BACKGROUNDER - Medi-Cal/Proposed Prepaid Program

1/ Medi-Cal is one of our biggest fiscal headaches. The way it is now run, it will continue to be a headache.

It is draining the taxpayer. It is draining the state budget. It is building a bureaucracy. It is not answering the real needs for mainstream medicine for our needy. It is causing a deep rift between the medical community and the administration.

It must be overhauled.

2/ The California Medical Association (CMA) House of Delegates meet in state ~~conservation~~ convention in San Francisco March 23-27

It is reported that quite a few resolutions have already been submitted that deal with the Administration's proposals (Spencer Williams):

- (a) to cut the doctors fees under Medi-Cal (sixty percentile) and
- (b) the proposed doubling of the OHCS budget for Medi-Cal vender surveillance.

The medical association feels that these proposals are direct slaps at it. There will probably be hot debates, hard criticism, extensive press coverage -- all of which would be most embarrassing to the Governor. We must move to preempt this (to strike first as we did in the mental hospitals' report situation several weeks ago).

3/ The ground work for such a ~~crowd~~ coup has already been laid.

On February 14 a group of doctors met with the Governor and with Spencer Williams, Mike Deaver and myself. The doctors

previewed a concept for prepayment plan for Medi-Cal -- i.e. a giant prepaid insurance program through which Blue Shield would contract with the State of California to provide doctors' services for Medi-Cal recipients for a set annual contract fee. The California Physicians Service would agree to provide care for all recipients of Medi-Cal. If the costs of fulfilling such a contract exceed the amount of the contract Blue Shield would absorb the loss. If the costs did not total the dollar amount of the contract, the savings would be returned to the State for the next year's operation.

Reportedly, Spence has also been working with several other groups on a similar plan.

The Governor was most ~~perceptive~~ receptive to this concept.

It was agreed that this group of doctors would on March 15 present the Governor with a draft proposal for such a prepayment plan.

Therefore, we should schedule at least a half an hour for these doctors with the Governor on either March 14 or 15.

(The draft proposal has already been submitted to Spence on March 4. He is now reviewing it with people in his shop.)

4/ We should now schedule the release of such a concept at the Governor's news conference on March 19.

The Governor should outline the basic structure of the concept, point out that he and Spence Williams ~~has~~ have been working on it for sometime and that progress is being made and that this seems to be the proper role of state government in the overall Medi-Cal program.

(Also, reference to recent recommendation of Assembly Public Health Committee - 3/7/68.)

5/ Such a plan could put the Governor in a position of leadership (National overtones here).

It would help short circuit those resolutions now boiling for the CMA convention (our friends could say "the Governor is already working

to solve the problem"). Hopefully it will enable us to both avoid bad publicity and bad relations with the doctors and once again give us the positive ascendancy in a very important matter.

To : Paul Beck

file

Date : March 15, 1968

Subject: New York State's Medicaid Plan

From : Jim Gibson

Two years ago Governor Nelson Rockefeller fathered a program of state medical assistance which was the most liberal, in terms of benefits, in the nation. He has now signed legislation which becomes effective April 1, and which will eliminate 1.5 million possible recipients from the program.

The new legislation lowers the eligibility standards and denies practically all benefits to persons aged 21 through 64. Under the current program a family of four could qualify if its net annual income after taxes and other deductions didn't exceed $6,000.

The new law lowers this standard to $5,300 for this typical family. The parents, however, might be excluded under the age qualification.

This new legislation will cut New York State participation from $600 million to $300 million.

OJG:sjs

FOR IMMEDIATE RELEASE

STATEMENT OF SPENCER WILLIAMS
CONCERNING THE PRELIMINARY REPORT ON MEDI-CAL
BY THE ASSEMBLY COMMITTEE ON PUBLIC HEALTH

The preliminary report of the Assembly Committee on Public Health is comprehensive and constructive. I agree with the Committee that its recommendations will serve as a useful point of departure in stimulating solution to Medi-Cal problems and I will be pleased to work closely with Chairman Duffy and the members to that end. The Administration also will have proposals and I am confident the Committee will find them worthy of serious consideration. The Administration, like the Committee, is vitally concerned with making the present program efficient and economical while providing good health care for those who need it. With the assistance of the Governor's task force and the recently appointed advisory committee, the Administration has instituted a number of steps to improve the program.

I am gratified that the Committee recognizes that the Administrator must have the flexibility to make program adjustments in order to maintain essential services while keeping within the funds available.

We will present our detailed views concerning the Committee recommendations as the bills are heard. At this time, however, let me note that several pilot projects to develop prepaid contracts for comprehensive health care services are currently nearing the operational stage. These will give us a basis for evaluation of the proposal.

# # #

March 7, 1968

State of California
Office of Health Care Services

file

Program Cost Estimates Bureau
Report No. 400 #1.4
February 26, 1968

CALIFORNIA MEDICAL ASSISTANCE PROGRAM
Current Analysis of Preliminary Medi-Cal Expenditure Estimates
Fiscal 1968-69

(Not adjusted for effects of PL 90-248)

The attached tables present a comparison of the December 14, 1967, subvention budget estimates and current estimate revisions based on:

1. Modified Medically Needy caseload projections.
2. Elimination of Group II extension caseload increment and subsequent cost as a separate estimate component.
3. Reduction in estimated days of care for nursing homes, and revised per diem rates.
4. Revised State mental hospital estimate.
5. Elimination of Group II revised maintenance need adjustment.
6. Inclusion of the Short-Doyle program.

The following sections describe these changes in greater detail. As noted in the above head-note, revised 1968-69 expenditure estimates are not adjusted for the effect of PL 90-248, which is now being evaluated by OHCS staff.

Caseload

The Department of Social Welfare has not revised its Cash Grant caseload estimates; therefore, OHCS used these same caseload figures, as presented in the December 14 estimate package. The earlier Medically Needy caseload estimates were developed from a least squares regression line based on thirteen months' experience - August 1966 through August 1967. The growth rate of Medically Needy certified population declined significantly during May, June, and July, 1967. At the time caseload projections were developed for the December 14 budget estimates, caseload experience was available only through the month of September, thus the continuing effect of the reduced rate of growth was beyond prediction. The revised Medically Needy caseload projections were developed from November 1966 - November 1967 experience, which picks up more months of the declining growth rate. Group II caseload projections also take recognition of the fact that the earlier estimates assumed a greater awareness and utilization of certain outpatient benefits, which have not occurred to date. Increased certifications due to the availability of outpatient physicians' services, laboratory and radiology, and hospital outpatient services are being absorbed within predicted caseload growth.

The revised Medically Needy caseload estimate is 84,500 (or 27.4 percent) below the average monthly caseload projected for the December 14 budget estimates.

Two-fifths of the overall reduction relates to elimination of 33,800 persons formerly included for Group II benefit extension. The caseload reduction without Group II extension increment amounted to 18.5 percent of total Medically Needy, or 2.8 percent of the total Medi-Cal eligibles.

State mental hospitals

Mental Hygiene produced a revised estimate of Medi-Cal subventions for care of aged persons in State mental hospitals. This figure is approximately $4.0 million below the December 14 amount.

Nursing homes

Recent payment and utilization experience indicates that the method initially used to project nursing home days of care for fiscal 1968-69 produced an excessive number of days. The previous estimate of 18.5 million days was reduced to 15.7 million by projecting December 1966 through December 1967, experience by a least squares regression line.

The nursing home per diem rate used in the December 14 estimates was developed from cost statements reflecting rate adjustments retroactive to July 1, 1966. The average per diem rate applied to the current nursing home estimate was developed from new cost statements, reflecting rate adjustments retroactive to July 1, 1967. This rate, $12.05, was effective until February 1, 1968, at which time rates were adjusted for the State minimum wage increment.

On February 1, 1968, the maximum daily rate was increased from $12.74 to $14.00, effective to June 30, 1968. An overall average daily rate of $13.22 was used for this five month interval. A statewide average rate of $13.88 was derived for fiscal 1968-69, based on a normal annual rate increase of 5 percent ($13.22 X 1.05 = $13.88).

Gross expenditures were developed by multiplying projected days of care times $13.88. Patient liability was computed at the rate of $1.71 per day for Group I Medically Needy and $1.88 per day for Group II Medically Needy and subtracted from gross expenditures. Expenditures were further reduced by $8.6 million to reflect estimated cost reductions due to tighter utilization controls.

Group II maintenance need

The December 14 estimates included an adjustment for a revised maintenance need schedule assumed to be effective by July 1, 1968. The revised estimates do not contain this adjustment because PL 90-248 includes provision for some modification of the current maintenance schedule.

Short-Doyle program

The Short-Doyle program was included in the current 1968-69 subvention estimates by adding $4.0 million to the "all other services" category and distributing this amount among the aid groups.

CALIFORNIA MEDICAL ASS. PROGRAM

Report 400 #1.4

TABLE I ESTIMATED EXPENDITURES, by PROGRAM

Fiscal Year 1968-1969

Feb 26, 1968

Programs	Budget Estimates of Dec. 14, 1967	Revised Estimate	Difference
	$	$	$
Cash Grant	531 952 300	514 531 200	-17,421,100
AAS	132 323 000	121 789 300	-10,533,700
AB/ARB	9 377 000	8 572 800	-804,200
ATD	163 498 500	155 788 000	-7,710,500
APTD	226 753 800	228 381 100	+1,627,300
Medically Needy	315 797 900	312 245 800	-53,552,100
Group I	168 056 900	147 834 810	-20,222,100
Aged	135 824 700	119 925 700	-15,898,000
Blind	1 973 900	1 738 100	-235,800
Disabled	20 146 000	19 039 100	-1,106,900
Families	10 112 300	7 131 900	-2,980,400
Group II	147 741 000	114 411 000	-33,330,000
Aged	73 983 500	52 842 400	-20,141,100
Blind	893 500	725 700	-167,800
Disabled	33 975 800	30 399 100	-3,576,700
Families	38 888 200	29 443 800	-9,444,400
Nursing Home Adj.	27 000 000	27,000,000	-0-
Title XVIII(b) Exp.	16 258 800	16 258 800	-0-
Tot. Cost of Care	891 009 000	820 035 800	-70,973,200
Administration	28 657 807	28 657 807	-0-
Total Expenditures	$ 919, 666, 807	$ 848 693 607	$ -70 973 200

(a) Includes $12.0 million for hospital-based physicians and $4.0 million for Short-Doyle program.

(b) Excludes adjustment due to Group II revised maintenance need.

Calif. Med. Ass. Program

Table 2 Estimated Expend. by Maj. Types of Service
Fiscal Year 1968-1969

Service	Budget Estimate of Dec. 12, 1967	Revised Estimate	Difference
Physicians' Ser.	$ 191 643 800 (a)	$ 183 786 800 (a)	$ -7,857,000
Prescrip. Drugs	55 399 800	53 196 700	-2,203,100
Dental Care	47 201 700	46 564 300	-637,400
Co. Hospitals	107 205 900	104 037 700	-3,168,200
Other Hospitals	152 297 300	141 716 200	-10,581,100
State Mental Hosp.	21 959 800	18 008 100	-3,951,700
Nursing Homes	233 016 200	188 029 700	-44,986,500
All Other Services	39 025 700	41 437 500 (b)	+2,411,800
Nursing Home Adj	27,000,000	27,000,000	0
Title XVIII(B) Buy-in	16 258 800	16 258 800	0
Tot. Cost of Care	891 009 000	820 035 800	-70,973,200
Administration	28 657 807	28 657 807	0
Tot. Expenditures	$ 919,666,807.	$ 848 693 607.	$ -70 973 200

(a) Includes $12.0 million for hospital-based physicians.
(b) Includes $4.0 million for Short-Doyle program.

Table 3

Calif. Med. Ass. Proj.
Caseload Monthly No. of Certified Persons
By Program
Fiscal Year 1968-1969

Programs	Budget Estimates of Dec 14, 1967	Revised Estimate	Difference
Cash Grant	1,507,700	1,507,700	0
OAA	305,500	305,500	0
AB/APSB	12,800	12,800	0
AID	157,200	157,200	0
AFDC	1,032,200	1,032,200	0
Medically Needy	307,900	223,400 (a)	- 84,500
Group I	99,100	70,200	- 28,900
Aged	42,000	31,700	- 10,300
Blind	700	300	- 400
Disabled	9,300	7,800	- 1,500
Families	47,100	30,400	- 16,700
Group II	208,800	152,300	- 55,600
Aged	39,900	29,100	- 10,800
Blind	500	400	- 100
Disabled	9,800	8,500	- 1,300
Families	158,600	115,200	- 43,400
Tot. No. of Eligibles	1,815,600	1,731,100	- 84,500

(a) Medically Needy caseload projections were modified using more recent caseload experience; excludes caseload adjustment for Group II benefit extension

CALIFORNIA MEDICAL ASSISTANCE PROGRAM
Premises and Methodology of Revised Medi-Cal Expenditure Estimates
1967 - 1968

The attached tables present a comparison of the December 14, 1967, subvention budget estimates and current estimate revisions based on:

1. Modified Medically Needy caseload projections.
2. Elimination of Group II extension caseload increment and subsequent cost as a separate estimate component.
3. Reduction in estimated days of care for nursing homes, and revised per diem rates.
4. Revised State mental hospital estimate.
5. Elimination of Group II revised maintenance need adjustment.
6. Inclusion of the Short-Doyle program.

These changes are described in greater detail in the following sections.

Caseload

The Department of Social Welfare has not revised its Cash Grant caseload estimates; therefore, OHCS used these same caseload figures, as presented in the December 14 estimate package. The earlier Medically Needy caseload estimates were developed from a least squares regression line based on thirteen months' experience - August 1966 through August 1967. The growth rate of Medically Needy certified population declined significantly during May, June, and July, 1967. At the time caseload projections were developed for the December 14 budget estimates, caseload experience was available only through the month of September, thus the continuing effect of the reduced rate of growth was beyond prediction. The revised Medically Needy caseload projections were developed from November 1966 - November 1967 experience, which picks up more months of the declining growth rate. Group II caseload projections also take recognition of the fact that the earlier estimates assumed a greater awareness and utilization of certain outpatient benefits, which have not occurred to date. Increased certifications due to the availability of outpatient physicians' services, laboratory and radiology, and hospital outpatient services are being absorbed within predicted caseload growth.

The revised Medically Needy caseload estimate is 45,100 (or 20.9 percent) below the average monthly caseload projected for the December 14 budget estimates. Approximately one-half of the overall reduction relates to elimination of 25,400 persons formerly included for Group II benefit extension. The caseload reduction without Group II extension increment amounted to 10.4 percent of total Medically Needy, or 1.3 percent of the total Medi-Cal eligibles.

State mental hospitals

Mental Hygiene produced a revised estimate of Medi-Cal subventions for care of aged persons in State mental hospitals. This figure is $3.6 million below the December 14 amount.

Nursing homes

Recent payment and utilization experience indicates that the method initially used to project nursing home days of care for fiscal 1967-68 produced an excessive number of days. The previous estimate of 15.7 million days was reduced to 14.4 million by projecting December, 1966 through December, 1967, experience by a least squares regression line.

The nursing home per diem rate used in the December 14 estimates was developed from cost statements reflecting rate adjustments retroactive to July 1, 1966. The average per diem rate applied to the current nursing home estimate was developed from new cost statements, reflecting rate adjustments retroactive to July 1, 1967. This rate, $12.05, was effective until February 1, 1968, at which time rates were adjusted for the State minimum wage increment.

On February 1, 1968, the maximum daily rate was increased from $12.74 to $14.00, effective through June 30, 1968. An initial adjustment of $1.00 will be added to the schedule of each nursing home; thereafter, individual adjustments will be made to departmental costs, up to a maximum of $1.26, on the basis of revised cost statements. Adjustments will be retroactive to February 1. An average increment of $1.17 was selected for this period, raising the average daily rate to $13.22.

Days of care were separated into seven (July - January) and five (February - June) service month periods and were multiplied by the corresponding rate of each period to derive gross expenditure estimates. Patient liability, at the rate of $1.71 per day for Medically Needy Group I and $1.88 per day for Group II, was computed and subtracted from gross expenditures. Expenditures were further reduced by $7.0 million to reflect estimated cost reductions due to tighter utilization controls.

Group II maintenance need

Although a revised maintenance need schedule has been proposed it is doubtful it will become effective much earlier than July 1, 1968, when the revised Federal participation levels become operative. Thus, no adjustment was made for a revised schedule.

Short-Doyle program

The Short-Doyle program was included in the current 1967-68 subvention estimates by adding $4.0 million to the "all other services" category and distributing this amount among the aid groups.

Dental care and "other services"

Compared to year-to-date payments and apparent reduced utilization in some services

during the months subsequent to October, 1967, current expenditure estimates are too high for dental care and services and supplies of vendors in the "all other services" category. Present estimates are based on payment experience January through September 1967; thus not reflecting any effect of the September "cuts."

Dental care utilization subsequent to November, 1967 is not expected to increase sufficiently to absorb earlier reductions and to also achieve the current estimated expenditure level. Services of podiatrists, chiropractors, optometrists, and other vendors are more likely to close the gap between reduced payments and estimated fiscal year expenditures.

It is anticipated expenditure estimates in these categories for fiscal 1967-68 will be revised, possibly during March, with the availability of more payment and utilization experience reflecting the effects of temporary cuts in some services and the impact on utilization after the court ruling in November.

State of California
Office of Health Care Services

Program Cost Estimates Bureau
Report No. 400 #1
February 14, 1968

CALIFORNIA MEDICAL ASSISTANCE PROGRAM

Table 1. Estimated Expenditures, by Program

1967 - 1968

Program	Budget Estimates of Dec. 14, 1967	Revised Estimates of Feb. 14, 1968[a]	Difference
Cash Grant	$449,006,800	$441,348,000	$-7,658,800
Old Age Security	116,545,200	110,886,900	-5,658,300
Aid to the Blind	8,236,200	7,837,000	-399,200
Aid to the Disabled	129,658,600	125,727,600	-3,931,000
Aid to Families with Dependent Children	194,566,800	196,896,500	2,329,700[c]
Medically Needy	238,746,100	213,406,200	-25,339,900
Group I	125,558,500	121,120,200	-4,438,300
Aged	102,956,100	99,561,700	-3,394,400
Blind	1,479,700	1,445,600	-34,100
Disabled	14,396,400	14,509,500	113,100
Families	6,726,300	5,603,400	-1,122,900
Group II	113,187,600	92,286,000[b]	-20,901,600
Aged	58,653,000	45,702,600	-12,950,400
Blind	707,900	587,600	-120,300
Disabled	27,191,200	25,094,300	-2,096,900
Families	26,635,500	20,901,500	-5,734,000
Title XVIII (B) Buy-in	12,766,800	12,766,800	0
Total Cost of Care	700,519,700	667,521,000	-32,998,700
Administration	23,443,000	23,633,443	190,443
Total Expenditures	$723,962,700	$691,154,443	$-32,808,257

a/ Includes $6.0 million for hospital based physicians and $4.0 million for Short-Doyle.

b/ Excludes adjustment due to Group II revised maintenance need.

c/ Increase due to distribution of Short-Doyle program among aid categories.

State of California
Office of Health Care Services

Program Cost Estimates Bureau
Report No. 400 #1
February 14, 1968

CALIFORNIA MEDICAL ASSISTANCE PROGRAM

Table 2. Estimated Expenditures, by Major Types of Services

1967 - 1968

Service	Budget Estimates of Dec. 14, 1967	Revised Estimates of Feb. 14, 1968	Difference
Physicians' Services	$154,066,800 a/	$149,272,400 a/	$-4,794,400
Prescription Drugs	46,374,700	45,226,900	-1,147,800
Dental Care	39,697,200	39,429,900	-267,300
County Hospitals	99,838,400	98,324,800	-1,513,600
Other Hospitals	119,348,800	113,921,600	-5,427,200
State Mental Hospitals	21,959,800	18,382,000	-3,577,800
Nursing Homes	173,992,200	154,591,500	-19,400,700
All Other Services	32,475,000	35,605,100 b/	3,130,100
Title XVIII (B) Buy-in	12,766,800	12,766,800	0
Total Cost of Care	700,519,700	667,521,000	-32,998,700
Administration	23,443,000	23,633,443	190,443
Total Expenditures	$723,962,700	$691,154,443	$-32,808,257

a/ Includes $6.0 million for hospital-based physicians.

b/ Includes $4.0 million for Short-Doyle program.

CALIFORNIA MEDICAL ASSISTANCE PROGRAM

Table 3. Average Monthly Number of Certified Persons, by Program

1967 - 1968

Program	Budget Estimates of Dec. 14, 1967	Revised Estimates of Feb. 14, 1968	Difference
Cash Grant	1,357,400	1,357,400	0
Old Age Security	298,500	298,500	0
Aid to the Blind	12,800	12,800	0
Aid to the Disabled	127,000	127,000	0
Aid to Families with Dependent Children	919,100	919,100	0
Medically Needy	215,600	170,500[a]	-45,100
Group I	67,800	57,000	-10,800
Aged	30,800	27,500	-3,300
Blind	400	300	-100
Disabled	5,400	4,700	-700
Families	31,200	24,500	-6,700
Group II	147,800	113,500	-34,300
Aged	33,800	25,200	-8,600
Blind	400	300	-100
Disabled	7,500	6,900	-600
Families	106,100	81,100	-25,000
Total number of eligible persons	1,573,000	1,527,900	-45,100

a/ Medically Needy caseload projections were modified using more recent caseload experience; excludes caseload adjustment for Group II benefit extension.

Medi-Cal

HEALTH AND WELFARE AGENCY
Sacramento, California
Contact: Spencer Williams
February 20, 1968

FOR IMMEDIATE RELEASE

A five-member advisory committee to guide reorganization of Medi-Cal in the continuing effort to achieve improved operational and financial control was named today by Spencer Williams.

Appointment of the advisory committee was recommended by the Governor's Survey on Efficiency and Cost Control as the initial step in implementing far-ranging program revisions.

Named to the committee by Williams, Administrator of the Health and Welfare Agency, were:

Kenneth D. King, President, Fireman's Fund American Life Insurance Company, 3333 California Street, San Francisco;

Malcolm C. Todd, M.D., 1515 N. Vermont Avenue, Los Angeles, President-Elect of the California Medical Association;

Gordon Cumming, Administrator, Sacramento County Hospital, President of the California Hospital Association;

J. Scott King, Jr., Treasurer, The Rand Corporation, 1700 Main Street, Santa Monica; and

Roland E. Robbins, Vice President and General Manager, Bank of America, 350 Pine Street, Long Beach.

"I deeply appreciate the willingness of these outstanding citizens to assist us in reorganizing this complex and expensive program to keep it within fiscal bounds and assure that every dollar spent provides maximum health care benefits to the needy," Williams said.

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STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

Ronald Reagan, Governor
~~EDMUND G. BROWN, Governor~~

OFFICE OF HEALTH CARE SERVICES
1340 K STREET
SACRAMENTO, CALIFORNIA 95814

file

September 27, 1967

TO: MEMBERS OF THE HEALTH REVIEW AND PROGRAM COUNCIL

SUBJECT: CALIFORNIA HOSPITAL ASSOCIATION ACTUARIAL REVIEW OF 1967-68 ESTIMATES

Pursuant to your request of August 4, the actuaries engaged by the California Hospital Association have submitted their report on the various projections of Medi-Cal Program costs for fiscal year 1967-68. A copy of this report is attached, herewith, for your information.

As previously indicated during testimony before the Assembly Public Health Committee, this report shows areas of both agreement and disagreement. While the new figures verify the need for substantial program reductions, we are pleased to point out that, by virtue of more up-to-date figures derived from bills received, both the California Hospital Association actuaries and the Office of Health Care Services figures (also attached) indicate expenditures less than those reported on August 4.

Although these figures make us optimistic that we may commence restoration of services at an early date, no final decisions in this regard can be made until the issues presently before the Supreme Court are resolved. Furthermore, incomplete information as to the effects of the law suit on program costs between September 1 and the date the case is decided (probably mid-November) complicates the problem of determining the extent of restorations possible. This occurs because the longer the controls contained in the September 1 regulations remain in question, the longer program costs may continue at an accelerated rate and the fewer months remain in which to achieve necessary program economies.

The over-all estimates of expenditures contained in the staff analysis and the actuaries' reports are within 5 percent of each other. While the actuaries' study indicates expenditures of some $60 million less than the state's previous estimates, OHCS staff review based on updated data indicates a reduction of $26.5 million in estimated expenditures. The areas of difference are agreed by both staff and actuaries to be judgemental in nature and will require further review and analysis as still more recent data becomes available. These areas of difference are pointed out in some detail in the staff analysis attached.

In order that I may act in the future as promptly as possible and with the full advice of the Health Review and Program Council, I am requesting that you provide me with your order of priority listing for the restoration

of benefits removed from the program by the September 1 regulations. In this way, the restoration of benefits can be made promptly as soon as the fiscal situation becomes clear and available funds permit.

I want to express my appreciation to the California Hospital Association for the contribution of time and talent represented by this study.

SPENCER WILLIAMS
Administrator

Attachments

CALIFORNIA MEDICAL ASSISTANCE PROGRAM
Comments on Report of Consulting Actuaries to the California Hospital Association

In evaluating areas of difference and agreement between the estimates of the consulting actuaries and those of OHCS, it must be kept in mind that both sets of estimates are based on the assumption of a fully operating program unaffected by administrative actions subsequent to August 4, or by psychological inhibitions set up among beneficiaries and providers of service by the current controversy and its attendant publicity. In a sense this places the estimates in a "never-never land" of false reality, but it is important to keep them in context because they are the determinants of the amounts which must be reduced or might be restored, in terms of the total budget.

The following comments take up the points raised in the actuaries' report of September 15.

1. June 30, 1967 accruals and SB 1065 modified accrual saving

Staff is unable to agree with any reduction in the 1966-67 year end accruals at this time (staff is $16.8 million higher than actuaries). The 1967-68 ending accrual reduction due to the effects of SB 1065 (Chapter 1421 Statutes of 1967) of $56 million as computed by the actuaries is considered to be conservative and may be larger.

2. Population estimates

We agree that a reduction in the estimate for the Medically Needy group appears to be in order. The estimate of 229,300 contained in the August 4 package was based on experience through March 1967. Since then, data through July have become available, with July showing a reduction. Our straight-line projection based on 13 months' experience (July 1966 - July 1967) gives an average of 198,300 for 1967-68. This is 10,000 higher than the actuaries' estimate of 188,300. The difference results from their extrapolating the regression line from the low point of July rather than from the point of origin, which balances low against high points.

Revision of the OHCS caseload estimates for the Medically Needy resulted in reductions of estimates for all services except county hospitals, state hospitals and nursing homes, which were not derived from caseload projections. These reductions totaled $6.9 million.

3. Physicians' services

The OHCS estimate of physicians' services was based on experience through July 1967, with a 5 percent increment for "normal" upward movement in unit costs. The actuaries reduced the average cost per beneficiary for the aged on grounds that full effect of Title XVIII (B) has not yet been experienced, due to the necessity of a double build-up of the $50 deductible during fiscal 1966-67. Grounds for reducing averages for those under 65 are not clear. No increment for unit costs increases was used by the actuaries.

We believe it is safer to rely on January-June experience, and that unit cost increase must be included, since the estimates relate to the program before a roll-back was ordered. As the result of the differences in approach, combined with the Medically Needy caseload difference, the actuaries' estimate is $21.3 million lower than that of OHCS.

4. Extension of outpatient care to Medically Needy Group II

The actuaries' estimate was based on the composite Medically Needy Group I average cost per eligible for physicians' visits and other physicians' services. This has several disadvantages:

a. The Medically Needy Group I caseload is heavily weighted by Long-Term Non-Grant beneficiaries, who are not recipients of outpatient care. Many of them are in county hospitals, for whom there are no physician billings, even for inpatient care.

b. The Medically Needy Group I caseload contains a greater proportion of the aged than the current Group II and the anticipated new Group II eligibles. The Group I average cost therefore is more depressed by Title XVIII (B) participation.

The Medically Needy Group I composite average cost per eligible for physicians' services appears less appropriate as a base for estimating Group II outpatient cost than does the cash grant average for corresponding linkage groups, used by OHCS. The use of an upward adjustment factor for increased utilization would seem justified on the basis of the fact that the new group will be coming into the program specifically for outpatient care, and the current Group II beneficiaries, having come in because of inpatient care needs, may be expected to have increased need for and facility in use of the outpatient services.

The actuaries' estimate is $5.3 million lower.

5. County hospitals

An increased cost for county hospitals was developed by the actuaries through use of the average billing per eligible beneficiary during the period January-June 1967, plus an 8 percent increase in level of hospital cost.

We question the reliability of the county hospital billing pattern for the six months, and have instead relied on the counties' cost estimates supplemented by audits of the OHCS Special Audits Bureau.

The actuaries' estimate is $17.7 million higher.

6. Other hospitals

The OHCS estimate of $141.1 million is lower than its August 4 estimate by $3.0 million, as the result of reduction in the Medically Needy caseload estimate. It is higher than the actuaries' estimate by $7.9 million, due to use of a 12 percent increment over the full year for increased cost level, compared with the actuaries' use of 3/4 of an 8 percent annual rise.

7. Nursing homes

We are in agreement that the estimated nursing home cost needs reduction. However, the actuaries' base of March-June 1967 average cost per eligible appears to be a low point from which rising costs for the next fiscal year may be expected, due to the fact that the initial impact of Medicare's 100-day participation will have been exhausted for those remaining in the nursing homes. There also is question of whether an annual cost increment of 4½ percent is sufficient.

The OHCS revision is based on the estimated average number of licensed nursing home beds during 1967-68 (62,000) at a Medi-Cal occupancy rate of 63 percent. The resultant number of patient days approximates very closely the number derived from a projection of the caseloads at average number of patient days per eligible person during recent months. Total cost was obtained by multiplying total days by the estimated per diem rate under the revised reimbursement formula retroactive to July 1, 1967, adjusted for Title XVIII (A) participation and patient liability, and increased by a factor of 8 percent for increased cost level.

The new OHCS nursing home estimate of $168.3 million is lower than the August 4 estimate of $187.9 (Table 2) but higher than the actuaries' estimate of $153.4 by $14.9 million.

8. State mental hospitals

The actuaries noticed a decreasing monthly average cost per eligible for mental hospital care. They revised the 1967-68 estimate by multiplying the most recent month's average ($.99 rounded to $1.00) times the total caseload and distributing the cost among programs according to the percent distribution of the August 4 estimated mental hospital cost.

We have retained our original figure, $3.4 million higher than the actuarial estimate, because long-term cash grant patients in mental hospitals will revert to full Medi-Cal status after depleting their Medicare eligibility. It is anticipated the average cost per eligible trend line will turn upward in future months.

CALIFORNIA MEDICAL ASSISTANCE PROGRAM
Table A. Estimated Expenditures, by Type of Service
July 1, 1967 - June 30, 1968

Type of Service	OHCS		Consulting Actuaries	Difference Between OHCS Sept. 25 and Consulting Actuaries
	August 4	September 25		
Physicians' services	$155,359,200	$153,086,400 [a]	$131,823,480	- $21,262,920
Prescription drugs	48,356,900	47,683,300 [a]	47,648,880	- 34,420
Dental care	43,101,900	42,592,000 [a]	42,700,572	108,572
County hospital care	97,559,300	97,559,300	115,259,904	17,700,604
Other hospital care	144,142,500	141,122,700 [a]	133,256,688	- 7,866,012
State mental hospitals	21,959,800	21,959,800	18,558,000	- 3,401,800
Nursing homes	187,899,600	168,327,000	153,399,276	- 14,927,724
Other services	32,818,200	32,361,200 [a]	32,335,944	- 25,256
Optometrist	8,652,800	8,543,600	8,566,212	22,612
Chiropractor	1,392,200	1,382,800	1,384,740	1,940
Podiatrist	2,276,500	2,240,500	2,237,460	- 3,040
Home health agencies	1,825,800	1,815,900	1,814,160	- 1,740
Other services and supplies	18,670,900	18,378,400	18,333,372	- 45,028
Subtotal	731,197,400	704,691,700	674,982,744	- 29,708,956
Federal requirements				
Outpatient benefits extension (Group II)	11,342,400	11,342,400	6,000,000	- 5,342,400
Title XVIII (A) nursing home requirements	27,000,000	27,000,000	27,000,000	---
Other medical services				
Hospital-based physicians	6,000,000	6,000,000	6,000,000	---
Free-standing clinics	300,000	300,000	300,000	---
Title XVIII (B) buy-in	11,511,900	11,511,900	11,511,900	---
Total cost of care	787,351,700	760,846,000	725,794,644	- 35,051,356
Administration	23,358,286	23,358,286	23,358,286	---
Grand total	$810,709,986	$784,204,286	$749,152,930	- $35,051,356

[a] Revision due to decreased Medically Needy caseload estimate.

CALIFORNIA MEDICAL ASSISTANCE PROGRAM
Table B. Estimated Caseloads, by Eligibility Group
July 1, 1967 - June 30, 1968

Eligibility Groups	OHCS		Consulting Actuaries	Difference Between OHCS Sept. 25 and Consulting Actuaries
	August 4	September 25		
Cash Grant program	1,358,200	1,358,200	1,358,200	---
Old Age Security	297,800	297,800	297,800	---
Aid to the Blind	12,800	12,800	12,800	---
Aid to the Disabled	127,200	127,200	127,200	---
Aid to Families with Dependent Children	920,400	920,400	920,400	---
Medically Needy program	229,300	198,300	188,300	- 10,000
Group I scope of benefits	102,600	75,300	81,900	6,600
Aged	44,400	37,000	37,700	700
Blind	600	500	600	100
Disabled	5,200	5,900	5,200	- 700
Families and Foster Children	52,400	31,900	38,400	6,500
Group II scope of benefits	126,700	123,000	106,400	- 16,600
Aged	23,100	22,600	21,700	- 900
Blind	400	300	400	100
Disabled	8,100	7,300	8,100	800
Families	95,100	92,800	76,200	- 16,600
All programs	1,587,500	1,556,500	1,546,500	- 10,000
Outpatient benefits extension (Group II)	33,800	33,800	33,800	---
Total caseload	1,621,300	1,590,300	1,580,300	- 10,000

CALIFORNIA MEDICAL ASSISTANCE PROGRAM
Table C. Estimated Expenditures, by Program
July 1, 1967 - June 30, 1968

Eligibility Groups	OHCS		Consulting Actuaries	Difference Between OHCS Sept. 25 and Consulting Actuaries
	August 4	September 25		
Cash Grant program	$481,829,900	$476,657,000	$457,596,312	- $19,060,688
Old Age Security	123,267,200	120,632,700	105,111,788	- 15,520,912
Aid to the Blind	8,315,800	8,106,000	7,736,924	- 369,076
Aid to the Disabled	137,939,100	135,625,700	140,860,592	5,234,892
Aid to Families with Dependent Children	212,307,800	212,292,600	203,887,008	- 8,405,592
Medically Needy program	249,367,500	228,034,700	217,386,432	- 10,648,268
Group I scope of benefits	124,129,900	105,820,000	99,367,140	- 6,452,860
Aged	100,061,400	84,833,900	77,872,020	- 6,961,880
Blind	1,481,600	1,212,800	1,479,024	266,224
Disabled	11,904,400	13,035,600	11,532,768	- 1,502,832
Families and Foster Children	10,682,500	6,737,700	8,483,328	1,745,628
Group II scope of benefits	125,237,600	122,214,700	118,019,292	- 4,195,408
Aged	74,036,800	73,355,800	59,905,648	- 13,450,152
Blind	1,076,600	837,900	961,248	123,348
Disabled	28,820,000	27,128,500	35,461,428	8,332,928
Families	21,304,200	20,892,500	21,690,968	798,468
All programs	731,197,400	704,691,700	674,982,744	- 29,708,956
Federal requirements				
Outpatient benefits extension (Group II)	11,342,400	11,342,400	6,000,000	- 5,342,400
Title XVIII (A) nursing home requirements	27,000,000	27,000,000	27,000,000	---
Other medical services				
Hospital-based physicians	6,000,000	6,000,000	6,000,000	---
Free-standing clinics	300,000	300,000	300,000	---
Title XVIII (B) buy-in	11,511,900	11,511,900	11,511,900	---
Total cost of care	787,351,700	760,846,000	725,794,644	- 35,051,356
Administration	23,358,286	23,358,286	23,358,286	---
Grand total	$810,709,986	$784,204,286	$749,152,930	- $35,051,356