

LITTLE HOOVER COMMISSION



A PRESCRIPTION
for
MEDI-CAL

November 1990

LITTLE HOOVER COMMISSION

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The Honorable George Deukmejian
Governor of California

The Honorable David Roberti
President pro Tempore of the Senate
and Members of the Senate

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

The Honorable Kenneth L. Maddy
Senate Minority Floor Leader

The Honorable Ross Johnson
Assembly Minority Floor Leader

Dear Governor and Members of the Legislature:

The Little Hoover Commission has examined Medi-Cal and found that, while the program's intentions are good, it falls seriously short in its efforts to provide health care uniformly and equitably to California's poor. The program is riddled with procedural barriers that block access to medical care and discourage provider participation in the system. The result is that health care for the poor is rationed. It is not rationed systematically or logically, but instead is rationed according to the dictates of factors such as luck, circumstances, bureaucratic impulse, where the recipient lives and the availability of willing providers.

During its investigation, the Commission received testimony from hundreds of recipients and providers, including:

- * A woman who became pregnant in August and applied for Medi-Cal in September 1989. Her application was pending for more than seven months. During that time she suffered a fall and was hospitalized in her fifth month of pregnancy, was hospitalized for bleeding in her eighth month and gave birth prematurely in early April 1990. She and her three-week-old baby had still not received Medi-Cal cards when she testified to the Commission in late April 1990.
- * The director of a medical clinic in Southern California who had logged hundreds of phone calls that she had made to eligibility workers on behalf of patients trying to obtain Medi-Cal cards in a timely manner.
- * The director of another clinic who hired two case workers to assist pregnant women in completing Medi-Cal applications. Despite this extra commitment to make sure applications were complete and correct when turned in, patients at the clinic suffered delays of between two and five months in obtaining Medi-Cal cards even though the law requires applications to be processed within 45 days.

- * A Long Beach doctor who said prior approval for an operation on one of his lung cancer patients took more than a month. During that time, the patient's condition worsened and the cancer was deemed inoperable by the time permission was finally obtained.
- * Dozens of doctors who could document months of exchanging paperwork with the State in an effort to get reimbursements that they say routinely are less than 50 percent of their usual charges and less than their overhead costs.

These few examples were repeated, with variations, over and over during testimony and interviews until the Commission was convinced that Medi-Cal is a system that is under considerable stress. Faced with growing needs and limited resources, Medi-Cal strives to meet the health care needs of 3.7 million poor people on a budget of \$8.1 billion. But in many cases it fails to deliver on its promises.

The result is costly, in dollars and in human terms. Those who are eligible for Medi-Cal under the intent of state and federal laws may not be able to establish their eligibility in a timely manner, if at all. Once they become Medi-Cal recipients, they may not be able to find providers willing to accept them as patients. This may lead to their putting off preventive health measures or early treatment of diseases. The delay in obtaining health care, in turn, may make their eventual treatment expensive--especially if it takes place in a hospital emergency room--or futile if a disease has progressed past the point of cure.

In the real world, then, Medi-Cal does not meet its own goals of providing mainstream health care to the State's poor. Health care is instead effectively rationed for those who the program was designed to serve. The rationing is neither logically nor universally applied, but is rationing by chance. An applicant may live in a county where there are few eligibility processing problems or he may reside in a county where the system is clogged and convoluted. A recipient may be fortunate to find providers who accept Medi-Cal patients or he may be forced to rely on hospital emergency rooms. His health problems may require specialized treatment that is made difficult by the prior authorization process, or he may only require prescription drugs that are already included on Medi-Cal's list of permissible drugs. The recipient with multiple health problems may have the benefits of case management or managed care systems available to him, or he may be left floating free in the fee-for-service system. In short, the health care that a Medi-Cal beneficiary receives is influenced greatly by factors that have little to do with his health needs.

But if the Medi-Cal system can be diagnosed as ailing, the prognosis does not have to be grim. California can, and should, take aggressive steps to address the system's problems. The recommendations embodied in this report can be generalized in three main points:

1. Streamline present eligibility and reimbursement processes that affect recipients and providers.
2. Expand the use of the State's position as a mass purchasing agent to bargain for more efficient and effective ways of providing medical care.
3. Explore the potential of prioritizing health care so that any rationing that must occur takes place by logic rather than by chance.

The Little Hoover Commission believes the 28 recommendations outlined in this report and summarized in the above three goals are a prescription for a healthier Medi-Cal system that will operate more effectively and efficiently.

Sincerely,



NATHAN SHAPPELL, Chairman
/ Haig Mardikian, Vice Chairman
Senator Alfred Alquist
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**A PRESCRIPTION
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Executive Summary

Designed to meet the health care needs of the state's poor, Medi-Cal will spend \$8.1 billion on services to 3.7 million Californians in 1990-91. Yet this complex program will fall short of its promised goal of quality medical care for all who need it because of problems that directly affect recipients and the providers of medical service. The result will be costly, both in human and budgetary terms. Those who should be receiving medical care either will not receive it at all or will receive it after an illness has progressed to the point where it is more difficult, more expensive or even impossible to treat.

In this study, the Little Hoover Commission examines both the effectiveness and the efficiency of Medi-Cal. The Commission noted three persistent problems:

1. Recipients have difficulty accessing treatment.

The supply of medical providers is limited because many private doctors refuse to participate in Medi-Cal. Many patients live in geographical areas (either rural or inner city) with very few medical care providers.

2. The quality of medical care given recipients is often poor or inconsistent throughout the state. Few receive adequate preventive care that might head off later, more expensive medical problems. With the bulk of Medi-Cal dollars concentrated on long-term care and emergency hospital services, relatively few resources are dedicated to early detection and prevention of diseases.

3. Provider participation is low. Providers complain about two facets of Medi-Cal: They believe the reimbursement rate structure is too low, but more importantly they find the reimbursement and prior authorization process

too time-consuming, cumbersome and frustrating. As a result, many refuse to accept Medi-Cal patients.

Based on these problems, the Commission determined that its goal for the study was to improve access and the quality of medical care for recipients by streamlining the overall Medi-Cal process and by encouraging better provider participation. The Commission directed its energies toward finding long-range solutions to the system's endemic flaws. In addition, current operating problems were addressed by the study in four distinct areas of Medi-Cal: eligibility, managed care, reimbursement and prescription drugs.

After two public hearings, an extensive review of literature, numerous interviews and countless meetings with those involved in and affected by the Medi-Cal program, the Commission formulated 28 recommendations based on 12 findings.

Future Directions

FINDING 1: Medi-Cal cannot meet the needs of the future without altering its basic approach to providing health care for the poor.

The Medi-Cal system is under increasing pressures to meet the health care needs of a growing pool of people. At the same time, state and federal fiscal constraints make it very unlikely that the resources available to the system will grow at a commensurate pace. Combined with these two factors is the threat that the current system may face major cost adjustments if legal challenges are pursued and are successful. While a Bandaid here and a shift in policy there may allow Medi-Cal to absorb some problems, an overall new approach to providing medical care for the poor would better serve the system, its recipients and the State.

Recommendation 1: The Governor and the Legislature should broaden the powers of the California Medical Assistance Commission, vesting in it the authority to bargain on behalf of the State in all arenas of health care.

Recommendation 2: The Governor and the Legislature should allocate funds to the Department of Health Services to contract for a cost-benefit analysis of prioritizing health care procedures offered under Medi-Cal.

Eligibility

Establishing eligibility is the first step to participating in Medi-Cal as a recipient. Once eligibility is granted, recipients may face difficulties finding a provider, arranging transportation or child care so they can keep appointments or avoiding other stumbling blocks. But it is the initial step --getting a Medi-Cal card with the stickers entitling one to service--that can be the largest barrier to medical care access for the poor.

FINDING 2: Implementation of the eligibility process varies from county to county, resulting in unequal treatment of Medi-Cal applicants.

Although the Medi-Cal program has a specific set of guidelines for eligibility, these regulations can be applied diligently or laxly, completely or partially, depending on the capabilities and staffing of the county where the applicant resides. Faced with 11 separate forms for Aid to Families with Dependent Children (AFDC), food stamps and Medi-Cal, the eligibility worker--no matter how well-intentioned--may fail to hook an applicant into all the proper forms of aid that are available. The efficiency of the eligibility worker is further hampered by frequent changes in regulations that result from decisions by the federal government, the State and the courts.

Recommendation 3: The Governor and the Legislature should direct the Department of Social Services to evaluate the four pilot projects under SAWS, rank them according to feasibility for statewide use and develop a funding plan, taking into account available federal subsidies for uniform systems. Legislation also should be enacted to declare the State's intent to implement a single computerized system for eligibility processes.

FINDING 3: An overly complex application form is a barrier to eligibility for many otherwise qualified Medi-Cal recipients.

The main application form for the Medi-Cal program, known as the MC210, is 11 pages of tightly jammed questions about assets, income and personal history. It has been likened to the forms a taxpayer faces in April each year, but in reality it is far more exacting in detail. In addition, the applicant is required to produce back-up documentation to verify the information provided on the form. Although the application form varies from state to state, it

is a significant barrier to Medi-Cal enrollment in areas that use forms similar to California's.

Recommendation 4: The Governor and the Legislature should direct the Department of Health Services to give priority to ensuring that eligible recipients are approved in a timely manner.

Recommendation 5: The Governor and the Legislature should establish a disincentive system, similar to the federal 3 percent error rate allowance, to encourage counties to be diligent in efforts to qualify potential Medi-Cal recipients.

FINDING 4: Specialized categories of Medi-Cal applicants, including pregnant women, SSI recipients, nursing home residents and share-of-cost patients, face particular barriers to eligibility.

Although all Medi-Cal applicants face an arduous process for becoming eligible for services, some categories of applicants have problems that could be addressed with specific modifications of the State's current processes. These include pregnant women, SSI recipients, nursing home residents and share-of-cost recipients.

Recommendation 6: The Governor and the Legislature should implement the federal options for pregnant women known as presumptive eligibility and continuous eligibility.

Recommendation 7: The Governor and the Legislature should direct the Department of Health Services to require local verification of the eligibility status for SSI recipients if the federal government has failed to act within 60 days.

Recommendation 8: The Governor and the Legislature should establish a presumptive eligibility program for long-term care residents and should direct the Department of Health Services to seek any necessary federal waivers.

Recommendation 9: The Governor and the Legislature should direct the Department of Health Services to revamp the share-of-cost system.

Managed Care

Managed care is a term that in the health field usually conjures up images of HMOs (Health Maintenance Organizations), PPOs (Preferred Provider Organizations), IPAs (Independent Providers Association) and other acronym-laden entities that offer "package deals" on health care procedures. But in its broadest definition, the term managed care covers not only the coordination of health care actually delivered to a recipient but also the variety of management steps that are employed to ensure that such care is appropriate and economical.

FINDING 5: The State has failed to pursue vigorously capitated care systems that have the potential of improving medical care for recipients and lowering long-term costs.

Medi-Cal relies primarily on fee-for-service medical care providers; that is, when a patient receives services, Medi-Cal is billed by a provider and is supposed to pay for that specific service. Within the Medi-Cal system, however, there are other modes of providing health care, including capitated care and various forms of case management care. But while the health world outside of Medi-Cal has moved heavily in these directions, Medi-Cal's capitated care programs have remained static, covering less than 10 percent of those receiving Medi-Cal benefits.

Recommendation 10: The Governor and the Legislature should signal their support for and commitment to future capitated care negotiations by setting aside a specific pool of start-up funds.

Recommendation 11: The Governor and the Legislature should modify existing state statutes to encourage the creation and use of prepaid health plans.

Recommendation 12: The Governor and the Legislature should direct the Department of Health Services to develop incentives to encourage Medi-Cal recipients to opt for capitated care.

FINDING 6: The State has not maximized the use of case management systems in an effort to improve medical care and lower long-term costs.

One alternative model to prepaid health plans is primary care case management. Under this system, doctors sign up to provide case management of recipients for a capitated rate that does not include any hospital inpatient

treatment. Like prepaid health plans, the concept is to provide better managed care that benefits the recipient and cuts down on State expenses by eliminating over-utilization of services.

Recommendation 13: The Governor and the Legislature should direct the Department of Health Services to develop an incentive plan to encourage providers to become primary care case managers.

Recommendation 14: The Department of Health Services should expand its Targeted Case Management Project as rapidly as possible.

Recommendation 15: The Department of Health Services should design a system of incentives, both for recipients and providers, that would increase the likelihood that patients would receive preventive care.

FINDING 7: The State has failed to avail itself fully of the latest computer capabilities and statistical analysis methods to ensure efficient operation of Medi-Cal.

The State has set up an extensive system to grant prior authorization for medical care, known as Treatment Authorization Requests (TARs), to control costs and usage. In addition, the State makes some limited use of data from hospital discharge records throughout the state to determine if patterns of Medi-Cal care are different from care paid for through private sources. Both methods are in common use in the private health care industry. But neither of these steps have been taken in such a way as to maximize the benefits of the technology involved.

Recommendation 16: The Governor and the Legislature should direct the Department of Health Services to eliminate from the TAR process procedures that are routinely authorized.

Recommendation 17: The Governor and the Legislature should require the Department of Health Services to use TAR records to target problem providers, problem locations and problem diagnoses and procedures.

Recommendation 18: The Governor and the Legislature should require the Department of Health Services to analyze paid-claims history data and Small Area Analysis data, as well as any other information, to better discover patterns of use and

abuse and to formulate policies to alter those patterns when better efficiency or quality of care can be achieved.

Reimbursement

While providers have long complained that reimbursement rates are too low, anecdotal evidence and surveys point to the billing process itself as a major reason many providers refuse to participate in Medi-Cal. Since a lack of provider participation limits access to medical care for recipients, the reimbursement process plays a key role in the quality of care Medi-Cal is able to deliver.

FINDING 8: Claim forms, procedure designations and other processes for submitting bills to Medi-Cal constitute a complex burden for providers.

Modern medical care providers no longer automatically turn to the patient for payment. Providers today bill private patients, health insurance companies and government programs, such as Medicare and Medi-Cal, for their services on various forms. But the Medi-Cal claim forms are different in format, require meticulous attention to detail and use numbers and modifiers that are unique in the health care industry. This means that providers spend more time filling out the forms, are more prone to error and have difficulty keeping up with changes.

Recommendation 19: The Governor and the Legislature should enact legislation requiring the Department of Health Services to modify the Medi-Cal claim form to mirror other types of health care provider claim forms.

Recommendation 20: The Governor and the Legislature should enact legislation requiring the Department of Health Services to adopt Medicare procedure codes and to drop the use of special modifier codes.

Recommendation 21: The Governor and the Legislature should direct the Department of Health Services to publish reimbursement rate schedules and inform providers of limits and other criteria used in denying and suspending claims.

Recommendation 22: The Governor and the Legislature should create a claims-reimbursement pilot project fund.

FINDING 9: The process for addressing suspended claims and denials is complicated and frequently unresponsive to providers.

Once a claim has been kicked out of the editing and auditing process and placed in suspense, the provider who wants to pursue his reimbursement enters a no-man's land of acronyms and rigidly clocked timelines. Many providers have indicated to the Little Hoover Commission that the procedural hoops to be jumped through require so much time and effort by billing personnel that the cost of pursuing suspended claims frequently is greater than the bill involved.

Recommendation 23: The Governor and the Legislature should direct the Department of Health Services to implement a policy immediately of telling providers all reasons for denials of claims.

Recommendation 24: The Governor and the Legislature should enact legislation to require the Department of Health Services, in consultation with provider representatives and systems experts, to revamp the procedures involved in dealing with suspended and denied claims to create a simple, timely process.

FINDING 10: The system of incorporating a check in each Explanation of Benefit form is inefficient and costly both for the State and for the providers.

Providers are reimbursed in a weekly check-write process by the State Controller's Office. Large-scale providers, such as large hospitals, receive one check that has been hand-matched in the controller's office to the pertinent Explanation of Benefits. But rather than receiving one lump-sum check for each week's claims, other providers face as many checks as Explanation of Benefit forms since each form incorporates a check in the upper right hand corner that needs to be detached and deposited.

Recommendation 25: The Governor and the Legislature should direct the Department of Health Services and the State Controller's Office to work together to revamp the Medi-Cal check-writing procedures.

FINDING 11: The State has not taken full advantage of the fiscal intermediary's expertise in providing Medicaid services.

When EDS became the fiscal intermediary two years ago, it inherited a system already in place. While it has

made improvements and modifications required and/or allowed under its contract with the State, it has been hampered by a system that was poorly designed for today's Medi-Cal needs.

Recommendation 26: The Department of Health Services should seek a comprehensive review of the Medi-Cal system from EDS and solicit proposals for improvements across the broad range of Medi-Cal activities.

Prescription Drugs

When the Little Hoover Commission began its Medi-Cal study a year ago, one of the easiest areas to target for improvement was the State's procedures for purchasing drugs. Not only did the State pay top dollar in the nation for the drugs Medi-Cal patients used, but also the State had a rigid formulary that did not keep pace with developing drug therapies. During the course of the study, however, Medi-Cal officials fought for the second year in row for legislative authority to bargain for discounts on drug purchases. When the legislative session came to a close on August 31, 1990, Medi-Cal had won the right to trade access to the formulary for discount prices.

FINDING 12: The Department of Health Services has achieved key reforms of the drug purchasing system that should improve both the efficiency and the effectiveness of the pharmaceutical portion of Medi-Cal.

The Medi-Cal Drug Discount Program legislation, adopted in the closing hours of the 1990 legislative session, addressed pricing concerns, the rigidity of the formulary and the TAR process.

Recommendation 27: The Governor and the Legislature should make the Medi-Cal Drug Discount Program permanent.

Recommendation 28: The Governor and the Legislature should transfer the authority to negotiate drug contracts to the California Medical Assistance Commission.

Medi-Cal is a system under considerable stress. Faced with growing needs and limited resources, Medi-Cal strives to meet the health care needs of the State's poor but in many cases fails to deliver on its promises. But if the Medi-Cal system can be diagnosed as ailing, the prognosis does not have to be grim. California can, and should, take aggressive steps to address the system's

problems. The recommendations described above can be generalized in three main points:

1. Streamline present processes that affect recipients and providers.
2. Expand the use of the State's position as a mass purchasing agent to bargain for more efficient and effective ways of providing medical care.
3. Explore the potential of prioritizing health care so that any rationing that must occur takes place by logic rather than by chance.

The Little Hoover Commission believes the recommendations outlined in this report and summarized in the above three goals are a prescription for a healthier Medi-Cal system that will operate more effectively and efficiently.

Introduction

Medi-Cal is a complex program that is intended to meet the health needs of California's poor. Funded roughly 50 percent by the federal government and 50 percent by State government, the program's 1990-91 budget allocates \$8.1 billion to care for 3.7 million recipients, most of them either families on welfare or the aged, blind and disabled. Since Medi-Cal is one of the State's largest single expenditures, the effectiveness of the program and the efficiency with which it is run have a strong impact on the overall value that Californians receive for their state tax dollars.

In this study, the Little Hoover Commission investigates both the effectiveness and the efficiency of Medi-Cal. Although this massive program has a diversity of elements that could be examined, the Commission tightly focused its efforts to address the following problem areas:

1. Recipients have difficulty accessing treatment.

The supply of medical providers is limited because many private doctors refuse to participate in Medi-Cal. Many patients live in geographical areas (either rural or inner city) with very few medical care providers.

2. The quality of medical care given recipients is often poor or inconsistent throughout the State. Few receive adequate preventive care that might head off later, more expensive medical problems. With the bulk of Medi-Cal dollars concentrated on long-term care and emergency hospital services, relatively few resources are dedicated to early detection and prevention of diseases.

3. Provider participation is low. Providers complain about two facets of Medi-Cal: They believe the

reimbursement rate structure is too low, but more importantly they find the process for reimbursement and prior authorization too time-consuming, cumbersome and frustrating.

**Study goal is
to improve access**

The Commission believes that the three identified problems are inter-related, and any steps taken to address one area of concern will affect the other areas. Based on these issues, the Commission determined that its goal in the study is to improve access and the quality of medical care for recipients by streamlining the overall Medi-Cal process and encouraging better provider participation. Further, in recognition of the State's perennial budget constraints, the Commission restricted itself to seeking changes and improvements that could be made within the parameters of current state spending.

In pursuit of its goal, the Commission concentrated on four areas: eligibility, the reimbursement process, managed care and prescription drugs. The bulk of this report, therefore, addresses the Commission's findings in each of these areas, as well as recommendations for enhancing Medi-Cal's overall effectiveness and efficiency.

As it carried out its investigation, the Commission became increasingly aware that two issues made it difficult to remain within the original parameters of the study with regard to staying within current State budget allocations:

1. Current inefficiencies save the State money in the short term.

Although efficiency is usually thought to be synonymous with frugality, the fact is that Medi-Cal would cost the State a great deal more if it served all the individuals it was designed to serve by handling eligibility and reimbursement in an efficient manner.

It is estimated that two-thirds of those turned down for Medi-Cal are eliminated, not because they aren't eligible, but because they never complete the complicated forms and procedures. This means that simplifying eligibility forms and streamlining a process that is now time-consuming and cumbersome could increase greatly the number of Medi-Cal recipients and the immediate costs associated with their medical care.

A corollary effect of streamlining eligibility also may be an increase in the rate of fraud on the part of applicants. Almost everyone consulted in the course of this study agreed that applicants rarely attempt to gain Medi-Cal coverage through fraud because of the oppressive barrier presented by

both the eligibility process and the lack of provider participation. But if the program is made simple to enter and service is easy to obtain, Medi-Cal may experience rising costs associated with recipient fraud.

If streamlined, the reimbursement mechanisms also could substantially impact State costs. Providers have told the Commission they believe the State purposefully makes the reimbursement process difficult so that 10 percent of legitimate bills are never paid. While no proof was found to back up this assertion, it did become clear that many providers find it too expensive and time-consuming to pursue suspended and denied claims. Others refuse to bill Medi-Cal at all because of red tape, instead providing care on a charitable basis. This means that if the reimbursement process were streamlined and more providers were encouraged to participate in Medi-Cal, the number and amount of claims paid undoubtedly would increase.

2. Reimbursement rates are low. Under federal statutes and regulations, states have been required for the past decade to set reasonable rates to reimburse providers. A law known as the 1980 Boren Amendment requires state reimbursements to be "reasonable and adequate to meet costs of efficiently and economically operating facilities." In addition, the federal Omnibus Budget Reconciliation Act of 1989 elevated previous regulations to laws that require rates to be set high enough to ensure Medi-Cal patients have access to care to the same degree enjoyed by the general population.

Organizations and individuals as diverse as the California Medical Association, the National Health Law Program and a mid-level Medi-Cal official (who requested anonymity) indicated to the Commission during the course of its investigations that reimbursement rates have dropped so low in California that in many instances they are not covering the overhead of medical care providers. In this situation, not only is the State left open to lawsuits from providers, but it also could face federal sanctions, such as loss of funding.

If the State were found to be in the wrong by either the courts or the federal government, the Medi-Cal program could be faced with unplanned, immediate increases in provider rates. Such a court- or federal-ordered increase would preclude the State from achieving trade-offs or improvements that might otherwise be won if rates were instead increased as part of a comprehensive bargaining strategy to obtain more access and better services.

Both of these issues--inefficient procedures and low rates--contribute to the "hocus-pocus" that Medi-Cal has

become. California has a system that is the most generous in the nation if one examines optional services and optional eligible populations that the State has embraced on beyond the mandatory coverage the federal government requires. On the surface, we appear to have a comprehensive, mainstream-quality medical service for the State's poorest citizens. But the system does not work for:

- * people who fit the guidelines but cannot complete the paperwork for eligibility, and

- * people who are eligible but cannot find a provider who accepts Medi-Cal because of low rates or the red tape created by the reimbursement and prior authorization processes.

Both long-range plans and short-term solutions

The Little Hoover Commission, therefore, has looked beyond its original scope of solving short-term problems within current budget parameters. The Commission has directed its energies toward finding long-range solutions to the system's endemic flaws, in addition to the more immediate steps that can be taken to address current operating problems.

The following report begins with background material about Medi-Cal. The Commission's findings and recommendations are then presented in five sections: Future Directions, Eligibility, Managed Care, Reimbursement and Drugs. The report ends with a conclusion and appendices.

In the course of its investigation, which began in August 1989, the Commission conducted numerous interviews and reviewed extensive literature. A broad-based Medi-Cal Advisory Group, including representatives of recipients' interests, providers and the State, met frequently to discuss issues and potential solutions (please see **Appendix A** for a list of members). Two public hearings were conducted, one on April 26, 1990 in Los Angeles and the other on May 17, 1990 in Sacramento (please see **Appendix B** for a list of witnesses and participants). In addition, the Commission relied on a technical consultant, Paul O'Rourke, M.D., for research assistance.

Background

California's Medical Assistance Program, known as Medi-Cal, was created in 1966 as the State's version of Medicaid, a joint federal/state program authorized under Title 19 of the Social Security Act to meet the health needs of the nation's poor. In the ensuing quarter century, the program has grown and evolved by virtue of increasing needs, federal government dictates, State-imposed changes and court-ordered modifications.

In 1990-91, Medi-Cal will spend \$8.1 billion (a 12.4 percent increase over the previous year) to meet the needs of 3.7 million recipients. In general, persons eligible for Medi-Cal fall into three main groups:

* **Categorically Needy:** These are the people who receive Medi-Cal automatically because they qualify for one of the major public assistance programs--Aid to Families with Dependent Children (AFDC) or Supplemental Security Income/State Supplemental Program (SSI/SSP). In general, they are either single-parent families or people who are aged, blind or disabled. People in this category constituted 85.3 percent of Medi-Cal recipients in 1988.

* **Medically Needy:** These are families or people who are aged, blind or disabled and whose income is too high to qualify for AFDC or SSI/SSP. They are eligible for Medi-Cal if their medical needs would require them to spend so much of their income that they would fall below 133 percent of the AFDC income level for their household size. The medically needy made up 10.5 percent of Medi-Cal recipients in 1988.

* **Medically Indigent:** Persons not in families with dependent children and who are not aged, blind and

disabled, but who otherwise qualify for aid, are classified as medically indigent, about 3.7 percent of the 1988 Medi-Cal recipients. These include individuals under 21, pregnant women and persons in long-term facilities for non-age-related reasons.

Recent state and federal legislation has added new categories of recipients, including legalized and undocumented aliens, as well as extending benefits to a broader range of pregnant women and young children. The chart below details the types and numbers of people eligible for aid in 1988, as well as showing the cost of care and the average cost per person by category.

CHART 1

**MONTHLY MEDI-CAL RECIPIENTS IN 1988
BY PROGRAM AND CATEGORY**

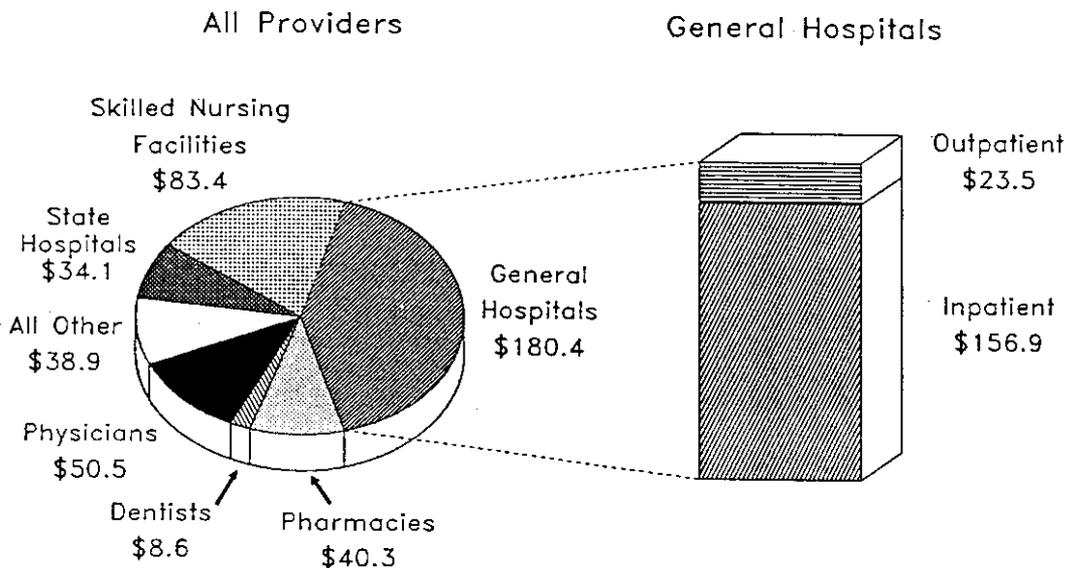
PROGRAM AND CATEGORY	NUMBER ELIGIBLE FOR AID	COST OF CARE PER MONTH	AVERAGE MONTHLY COST PER PERSON
TOTAL	3,129,173	\$5,235,227,814	\$ 150.98
Public Assistance	2,670,008	3,109,290,256	106.61
Aged	306,499	430,903,670	119.54
Blind	23,097	59,816,459	220.85
Disabled	456,978	1,394,173,056	260.67
Families	1,883,435	1,224,397,072	61.40
Medically Needy	329,760	1,816,027,920	458.93
Aged	87,039	832,795,691	797.34
Blind	415	4,805,513	964.96
Disabled	32,731	578,173,565	1,472.03
Families	209,575	400,253,151	159.15
Medically Indigent	115,975	297,254,462	213.59
Adults	9,030	81,741,893	754.35
Children	106,945	215,512,569	167.93
Special Dialysis	56	340,365	506.50
Total Parenteral Nutrition	8	198,008	2,062.63
IRCA Aliens	761	143,209	15.68
OBRA Aliens	3,093	705,371	19.00
Refugee/Entrant	9,512	11,268,223	98.72

Source of data: Department of Health Services
Annual Statistical Report, 1988

As Chart 1 on the previous page shows, 1,883,435 or 60.2 percent of all recipients are families on public assistance, by far the largest group. But the spending on this group--\$1,224,397,072--represents only 23.4 percent of the total budget, with an average per-person cost of \$61.40. On the other end of the scale, combining figures from the public assistance and medically needy categories, the disabled number 489,709 or 15.6 percent of the total recipients. The bill for the disabled runs \$1,972,346,621 or 37.7 percent of the total spending. Thus, Medi-Cal not only provides relatively inexpensive care for vast numbers of people, but it also underwrites intensive, expensive care for a smaller segment of society.

Medi-Cal meets the needs of its varied recipients by reimbursing about 70,000 providers for medical services. The chart below shows the distribution of monthly payments to provider groups during 1988.

CHART 2
AVERAGE MONTHLY MEDI-CAL PAYMENTS
BY TYPE OF PROVIDER IN 1988



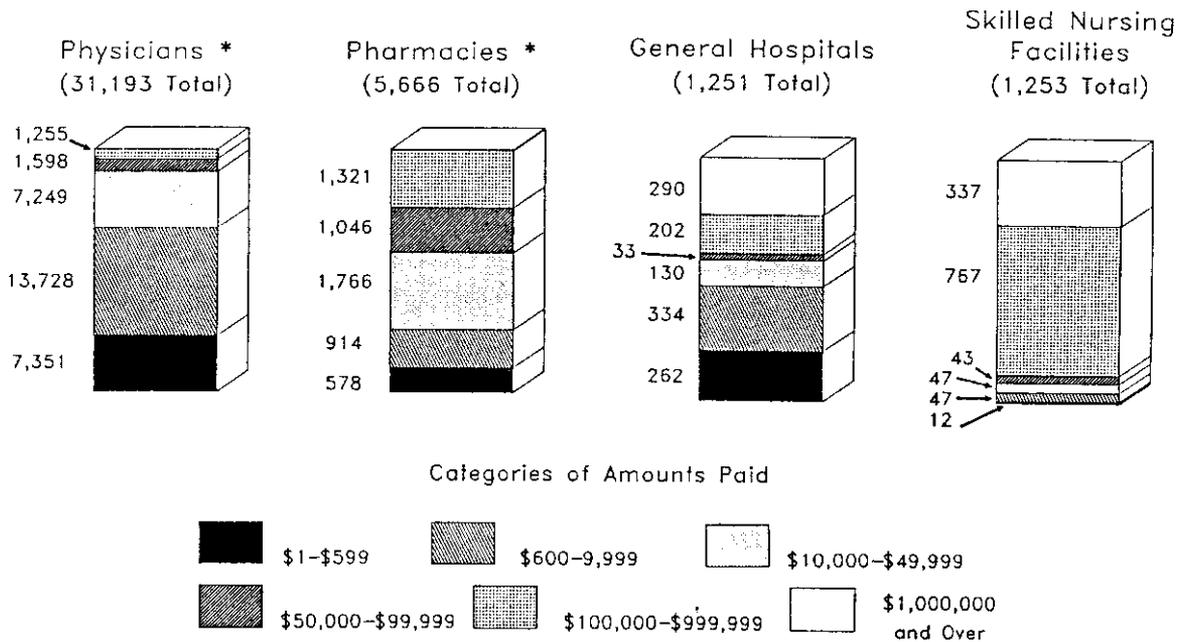
Note: All figures are in millions.

Source of data: Department of Health Services Annual Statistical Report, 1988

As the figures in Chart 2 on the previous page show, the bulk of Medi-Cal dollars--\$180.4 million a month or 41.4 percent--go to hospitals, with the largest amount, \$156.9 million, for inpatient care. Skilled nursing facilities receive \$83.4 million or 19.1 percent of monthly spending, while doctors receive \$50.5 million or 11.6 percent. Pharmacies, state hospitals, dentists and the general category of "all others" receive smaller amounts.

Another chart shows the extent of participation by individual providers in four selected groups: physicians, pharmacies, general hospitals and skilled nursing facilities.

CHART 3
PROVIDER PARTICIPATION IN MEDI-CAL
BASED ON AMOUNTS PAID IN 1988



* Not shown in chart are 12 physicians or physician groups and 31 pharmacies paid \$1 million and over

Source of data: Department of Health Services Annual Statistical Report, 1988

As Chart 3 above shows, the extent of participation varies widely depending on the type of provider. The bulk of the physicians who participated in 1988--21,079 or 67.6 percent--billed Medi-Cal less than \$10,000 for the entire year, with 7,351 or 23.6 percent billing under \$600. Thus, the overwhelming majority of doctors are seeing only a limited number of Medi-Cal patients.

On the other hand, the preponderance of skilled nursing facilities--1,104 or 88.1 percent--billed Medi-Cal in excess of \$100,000 in 1988, with 337 or 26.9 percent billing more than \$1 million.

The above statistics paint a picture of the magnitude of Medi-Cal, the people it affects as recipients and providers. But they are a still picture of a program that is on the move and undergoing substantial change across the country. A recent report assesses this change. In "Putting the Patient First,"¹ the author says Medicaid was meant to be a health insurance program for the poor, but increasingly it is becoming the payor of last resort for those who are **made poor** by illness, such as people in nursing homes or patients with AIDS. The author concludes that while the basic structure of Medicaid was designed to care for the acute needs of the non-elderly poor, long-term care is becoming an increasingly large portion of the program.

Medi-Cal dollars stretch to cover diverse needs

This shift is responsible for the tug-of-war that pulls Medi-Cal in disparate directions. California's citizenry is aging, with those 65 and older the fastest growing segment of population. But at the same time, the State's immigration and birth rates are high, and the number of AIDS-infected patients is growing. Constrained on the one hand by state budget parameters and pressed on the other by burgeoning needs, Medi-Cal must stretch its dollars to cover a broad range of care.

Under its mandate to examine state programs for effectiveness and efficiency, the Little Hoover Commission has been active in monitoring the Medi-Cal program for the past 15 years and thus has been a witness to the changing pressures on the system. Beginning with a comprehensive overview of all state health programs in 1975, the Commission has issued eight reports on Medi-Cal (please see **Appendix C** for a list of the Commission's Medi-Cal studies).

When the Commission's first report was issued in 1976, the Medi-Cal program budget was \$2.6 billion and recipients numbered about 2.5 million. Fifteen years later, the \$8.1 billion budget represents an increase of 311.5 percent, while the growth to 3.7 million recipients is an increase of roughly 140 percent.

While these figures appear out of balance, even if inflation is taken into account, the fact is that Medi-Cal costs have grown at a slower rate than overall health industry costs and at a slower rate than the State's cost of buying

1. "Putting the Patient First: A Kinder, Gentler Health System," Ronald F. Docksai, Policy Review, Winter 1989.

health insurance for its employees. In addition, the State pays a lower cost per Medi-Cal user than the 12 next largest states in the nation, and California's taxpayers pay a smaller share of their income to support the program when compared to the national average. And this is despite the fact that California has a higher percentage of its population receiving Medi-Cal than the next 12 largest states.²

Medi-Cal's good grades for economy have been hard won. A review of the Little Hoover Commission's earlier reports show that two major and potentially enormously expensive problems have been brought under control to some extent: administrative costs and claims processing methods.

The 1976 report criticized Medi-Cal's excessive administrative costs, which the report concluded were approaching 40 percent of the budget. In the 1990-91 budget, \$490.9 million is earmarked for claims processing, county administration and state administration, or about 6.1 percent of the total Medi-Cal budget. This compares favorably with the administrative costs of private companies. In 1986, health insurance companies spent 19.5 percent of premiums on administration, prepaid health plans spent 11.7 percent, and Blue Cross/Blue Shield spent 9.9 percent. Only self-insured plans spent less than Medi-Cal, with a lean 4.95 percent administrative cost.³

In the same 1976 report, the fiscal intermediary that handled Medi-Cal claims on behalf of the State came under severe criticism for lacking the capacity or inclination to adequately process and verify claims, while the State was criticized for fragmentation of auditing, investigations and quality control. Today, the fiscal intermediary is given, by comparison, glowing reports by both the State and providers in carrying out claims processing tasks, as will be discussed in more detail in the section on Reimbursement.

A pattern of problems in other areas has persisted and grown despite recommendations for improvements. Once again, from the findings in the 1976 Little Hoover Commission report:

- * The eligibility system for determining whether a person should receive Medi-Cal services is unduly complex and expensive to administer.

2. "The Medi-Cal Program in Perspective," Legislative Analyst's Office, March 1987.

3. "National Health Expenditures, 1986-2000," Health Care Financing Authority, Table 21.

- * Medi-Cal makes heavy use of hospitals and long-term care facilities, with relatively little emphasis on preventive health care and in-home alternatives to institutions.

**State slow to
use newest
technology**

The Commission quickly discovered that these items are still key problems today. Thus, many of the problems in the system are not new and, indeed, many of the answers to those problems are not new. What has changed is the technological environment. The State now has access to a broad range of tools for assessing what is going on in the Medi-Cal system and for making well-informed choices to manage the system. The Little Hoover Commission has concluded, however, that the State has been slow to embrace available technology, as will be shown in the following findings.

Future Directions

FINDING 1: Medi-Cal cannot meet the needs of the future without altering its basic approach to providing health care for the poor.

The Medi-Cal system is under increasing pressures to meet the health care needs of a growing pool of people. At the same time, state and federal fiscal constraints make it very unlikely that the resources available to the system will grow at a commensurate pace. Combined with these two factors is the threat that the current system may face major cost adjustments if legal challenges are pursued and are successful. While a Band-Aid here and a shift in policy there may allow Medi-Cal to absorb some problems, an overall new approach to providing medical care for the poor would better serve the system, its recipients and the State.

State generous with Medi-Cal options

California has consistently set its sights on providing the broadest number of people with the broadest range of services. A nationwide study⁴ said the State has set the most generous AFDC standards of any state in the nation. Standards for the designation of Medically Needy are set at the maximum allowed by the federal government. A category that allows health services for children is set for the maximum age allowed, intact families are given cash grants and Medi-Cal under the AFDC-Unemployed Parent program, and, as allowed under a federal option, California is one of nine states that covers pregnant women and children up to 185 percent of the poverty line. In fact, the State has gone further; using tobacco-tax dollars, California also provides Medi-Cal at 100 percent State expense (rather than the

4. ...And Access for All: Medicaid and Hispanics, National Coalition of Hispanic Health and Human Services Organizations, March 1990.

normal 50-50 split with the federal government) to pregnant women at 200 percent of the poverty line. In addition to embracing recipients beyond the minimum required by the federal government, California has also chosen to offer almost every optional service that is allowed. The budget impact of this generosity in terms of recipients and optional services can be seen in the chart below:

CHART 4

1990-91 MEDI-CAL COSTS TO COVER OPTIONAL SERVICES, RECIPIENTS

Service	General Fund Cost	Recipient	Cost
Drugs	\$284,845,000	Long-Term Care*	\$642,245,085
Adult Dental	39,433,000		
ICF-DD/DDN/DDH	234,875,000	Medically Needy	147,133,675
ICF-Regular	17,101,000		
Medical Transportation	16,100,000	Medically Indigent Children	58,779,150
Miscellaneous	32,425,000		
Other Medical			
Psychology	7,350,000	Medically Indigent Adults	<u>7,755,280</u>
Chiropractic	224,000		
Optometry/Optician	14,077,000		
Podiatry	2,572,000		
Prosthetic	1,742,000	Total	<u>\$855,913,190</u>
Orthotic	2,101,000		
Outpatient Clinic	15,398,000		
Surgicenters	1,861,000		
Heroin Detox Centers	776,000		
Indep. Rehab. Center	104,000		
Nurse Anesthetist	346,000		
Occupational Therapy	91,000		
Speech/Audiology	2,630,000		
Physical Therapy	121,000		
Hemodialysis Center	13,587,000		
Acupuncture	2,016,000		
Other Services			
Medical Equip.	20,362,000		
Hearing Aids	1,851,000		
Blood Bank	655,000		
Hospice Services	366,000		
All Other Providers	<u>88,384,000</u>		
Total	<u>\$801,393,000</u>		

Source: Department of Health Services

* Approximately 5 percent of long-term care recipients are considered Medically Needy and therefore would be eliminated if Medically Needy categories were eliminated.

As the chart on the previous page shows, optional services provided to Medi-Cal recipients will cost the State more than \$800 million in 1990-91. Similarly, the State will spend more than \$850 million providing services to categories of recipients it is not required to include in the Medi-Cal program. Thus as a matter of policy, California has chosen an expansive program rather than a pared-down version. And early indications are that it may be considering further expansions of the program. The California Legislature has been considering the plight of Californians who are neither covered by any form of health insurance nor by Medi-Cal, a number estimated to be between 4.8 million and 6 million. One plan discussed in the Legislature in 1990 would have met the needs of unemployed people without insurance--between 1 and 2 million people of the total--by making them eligible for Medi-Cal.

Many of those best acquainted with Medi-Cal, however, have shuddered to think of the impact of such a proposal on a system that is already struggling under the weight of 3.7 million recipients. As the following sections of this report will show, Medi-Cal promises quality medical care to the poor, but it frequently is unable to deliver it.

But the specter of additional recipients is not the only shadow in Medi-Cal's future. The system has squeezed its rates to such a low point, that many medical providers maintain they are operating at a loss:

* Nationwide, pediatricians say that the fee for a well-child visit averages 53 percent of normal charges, but that overhead runs 54 percent of the charges. In California, pediatricians say the reimbursement rate is closer to 40 percent of normal charges. A pediatrician in Los Altos told the Commission he treated a hemophiliac patient with AIDS 94 times in the course of four years. He billed Medi-Cal \$4,129, but was reimbursed only \$1,026. At less than 25 cents on the dollar, the reimbursement did not cover his overhead costs, which he pegged at 59 percent of his normal charges.

* Obstetricians say that even after Medi-Cal increased global pregnancy fees (the total fees paid for care during a pregnancy), they still received only \$1,007 rather than the \$1,590 average normal fee in California in 1988.

* A Yolo County doctor practicing in a multi-specialty group of 100 doctors said the group lost \$2 million on a caseload that was 10 or 12 percent Medi-Cal. After deciding to accept no new Medi-Cal patients, the losses dropped to \$1 million--still \$10,000 out of each doctor's pocket.

* A Tulare County doctor with a practice composed of 45 percent Medi-Cal patients said he determined that for every \$1 he took home, he had to write off \$1.71.

* Dentists have complained that the initial-visit fee of \$9 compares to \$18 from a typical Health Maintenance Organization reimbursement or \$50 from private-pay patients. Medi-Cal similarly gets a bargain rate for root canals, paying \$175 rather than the \$290 to \$500 range paid by other insurance and private patients.

* Psychiatrists say their rate of \$38 per session in the late 70s has only increased marginally to \$41 in 1990 while office costs have risen far more.

**Low rates leave
State open to
legal challenge**

Although providers have always complained that rates were too low, their arguments have gained stature in recent years. The 1980 Boren Amendment, which covers hospitals and long-term care facilities, requires state reimbursements to be "reasonable and adequate to meet costs of efficiently and economically operating facilities." A recent Supreme Court decision affirmed that states may be sued in federal court under the Boren Amendment by institutions that feel rates have been set inadequately.

Shortly following the Supreme Court decision, the California Association of Hospitals and Health Systems filed suit against California, maintaining that Medi-Cal only covers 55 percent of their costs for outpatient services and that hospitals lost \$211 million last year on Medi-Cal services. A National Health Law Program expert put the prospects for the suit in perspective, however; of 66 similar cases brought across the United States in the past, the overwhelming majority have ended with the courts finding that the states' methods for determining rates meet legal requirements.

In addition to the protection for facilities, other providers also are covered by statutory protections. The federal Omnibus Budget Reconciliation Act of 1989 directed states to ensure that their rates are high enough so that Medi-Cal patients have access to care to the same degree enjoyed by the general population. The statute further indicates that "the methods and procedures" of reimbursement--which includes claims processing requirements and time frames for payments--should not be a deterrent to provider participation.

The statute also specifically indicates that the results should be examined in geographic areas and not just on a statewide basis; in other words, if rural areas or inner cities are underserved, then rates are presumed to be inadequate.

The statute further singles out pediatricians and obstetricians, requiring states to report payment rates and the data that led them to the rates, broken out by provider type, procedure and geographic area.⁵

A key case that indicates how courts will treat suits filed under this statute was decided in early October 1990. Filed in 1987 when the statute was merely a federal regulation, *Clark vs. Kizer* argued that dental rates were too low. A U.S. District judge ruled on October 3 that Medi-Cal recipients had been denied access to dental treatment because dentists refuse to participate in a program that reimburses only approximately 40 percent of their normal rates. The judge found that 27 counties have no services and another 21 have only limited services for Medi-Cal recipients, and that the State, therefore, is out of compliance with its own provisions that dental services need to be available statewide. At the time of this writing, an order for injunctive relief in the form of higher dental reimbursement rates is expected to be issued before the end of 1990.⁶

Medi-Cal officials are not oblivious to the possibility of legal action in areas besides dental care being successful at some point. One mid-level official, who wished to remain anonymous, told the Commission that with "docs dropping out of the system, sooner or later the feds will enforce higher rates." The disadvantage of waiting for that to happen, the official said, is that the State will not be in control to bargain for the best package of services and accessibility in return for higher rates.

Thus, between increasing pressures for expanded service and mounting doubts about the ability of Medi-Cal to keep costs tamped down, the State faces an uncertain future that requires creative approaches. One answer is to put the State's massive purchasing power to work in areas besides pharmaceutical purchases and hospital inpatient treatment, where the State has already been successful at bargaining for services and costs.

The California Medical Assistance Commission (CMAC) has saved the State \$1.5 billion since 1982-83 by bargaining with hospitals and contracting for inpatient care. Between 1984 and 1989 overall hospital rates rose 44.9 percent, but Medi-Cal, with CMAC's bargaining clout, held hospital increases to 17.3 percent (although so-called "disproportionate share hospitals"--those with more than 20

5. "Medicaid Amendments," *Health Advocate*, Winter 1990.

6. "Medi-Cal recipients denied good dental care, judge says," *Sacramento Bee*, October 4, 1990, and interview with Jane Perkins, staff attorney for National Health Law Program, a participant in the suit, October 4, 1990.

percent Medi-Cal patient loads--were given increases of 29.7 percent during that period).

Similarly, as will be detailed in the section entitled Prescription Drugs, the State recently began using its purchasing power to bargain with pharmaceutical companies for discount prices on drugs.

CMAC already has the authority to bargain on behalf of the State with health maintenance organizations and has done so in the past, as will be discussed in Managed Care. But cost savings are not the only thing that CMAC could bargain for if its mandate were broadened. CMAC potentially could line up fee-for-service doctors--much as Preferred Provider Organizations do--who would accept Medi-Cal patients and provide case management services at set monthly rates. Although federal law precludes such capitated payments from exceeding fee-for-service rates, CMAC might entice participation with a combination of fees and income tax credits for unreimbursed charges.

Another option that CMAC could explore is to follow the lead of West Virginia where a feasibility study is now under way to combine state and local government workers along with Medicaid recipients in a pool. Providers would have to serve all members of the pool if they wanted to serve any. In West Virginia, approximately one-sixth of the state's population would be involved. CMAC officials have already indicated their interest in bargaining on behalf of the Public Employees Retirement System (PERS) for various medical services.

An expansion of CMAC's role as health care bargainer could give the State an avenue to creative options for dealing with growing Medi-Cal needs and ever-present budget constraints.

Recommendation 1: The Governor and the Legislature should broaden the powers of the California Medical Assistance Commission, vesting in it the authority to bargain on behalf of the State in all arenas of health care.

With a proven track record of purchasing medical services for the State, CMAC should be given the latitude to approach the State's health problems from a variety of directions.

Prioritizing care is an option to explore

Expanding bargaining opportunities is not the only way the State can meet the needs of the future. Another is to explore prioritizing services so that at least a minimal level of health care is available to all who need it.

An early goal of Medicaid was to ensure that all Americans had access to the same quality and level of health care. But in the quarter century since the program was created, health experts have begun to doubt the nation's ability to afford every advanced health care procedure for everyone who needs it or would benefit from it. In 1988, the United States spent \$540 billion, or more than 11 percent of the Gross National Product, on health care. Forty-two cents out of every health care dollar was spent by Medicaid and Medicare. In comparison, Canada has held its health care costs to 8.5 percent of its Gross National Product.⁷

Even with such tremendous expenditures by federal and state governments, the concept that health care is equally accessible to all that need it is an illusion. A study released by the Journal of the American Medical Association in September 1990 showed that how a person pays for his care--rather than the state of his health--dictates to some degree what type of care he receives. The study examined the care received by 38,000 patients with chest pains or circulatory disorders. Those with private insurance were 80 percent more likely to have angiography, an expensive procedure to examine blood vessels for blockages, 40 percent more likely to have bypass surgery and 28 percent more likely to have angioplasty (where balloons are inflated to press back the walls of clogged arteries). Those patients covered by Medicaid received roughly the same treatment as those who were uninsured, according to the study.⁸

Equally illusory is the concept that because a program like Medi-Cal approves certain services recipients will be able to get them. Barriers to access, which will be discussed in the following sections, stop many people from receiving even rudimentary services despite legislative intent to provide mainstream health care. Some have difficulty completing the eligibility process; others cannot find providers who are willing to treat Medi-Cal recipients.

**Rationing by
chance rather
than by logic**

In Oregon, where an experiment in the formal rationing of health care services is under way, experts have contended that health care is already effectively rationed because its availability is uneven, a situation that is mirrored in California. But instead of being rationed within a framework of logical choices, it is rationed by luck, circumstances, bureaucratic impulse, where the recipient lives and the availability of willing providers. In Pennsylvania, in fact, this concept of rationing by luck has been taken a step

7. "Why Canada's Health Care System is No Cure for America's Ills," Heritage Foundation, November 13, 1989.

8. "Study: Money calls health-care tune," Sacramento Bee, September 12, 1990.

further: When the state realized it had only enough funds to pay for a new expensive drug to treat 210 of its 800 schizophrenic patients, it decided to conduct a lottery, pulling names out of a hat to determine who would receive treatment and who would not.⁹

The Oregon experiment has received attention across the nation. Designed to widen eligibility, the state's Medicaid program allows more people to receive basic health care by limiting expensive and/or less effective treatments. The problem is to determine a hierarchy of medical procedures that everyone can agree places necessities at the top and luxuries at the bottom. Weighing prenatal care against heart transplants for 80-year-olds may be easy, but other choices are less clearly defined. The painful nature of these types of choices was made clear in 1987 when Oregon stopped funding organ transplants and expanded prenatal care instead. Shortly after that decision was made, a 7-year-old boy died before a local community could raise the remaining \$10,000 of the \$90,000 needed for a liver transplant.

In May 1990, Oregon officials released a preliminary list from a computer ranking of 1,600 procedures based on cost, duration of benefit and the quality that is added to the patient's well-being. But the list proved controversial. Fixing crooked teeth came out ahead of treating AIDS patients, a choice that met the criteria set up in the computer program but that left many doubting the ability of a computer to sort through medical care options. Oregon is now reworking the list and has applied for a federal waiver that would allow it to limit Medicaid services.¹⁰

While the underlying premise of Medi-Cal has been that recipients should receive a broad range of medical services, the reality has been that medical care is not delivered universally or uniformly to poor Californians, as the following sections of this report will show. Instead it is effectively rationed, with some recipients easily clearing eligibility hurdles, finding willing providers and receiving authorized treatments while others are left outside the system either through eligibility problems, an inability to find providers or difficulty in obtaining authorization for services. Rationing, if it is unavoidable because of the pressures on the Medi-Cal system, should be approached in the more systematic, logical way currently being explored by Oregon.

9. "Chance for a cure: Pennsylvania lottery will allocate expensive schizophrenia drug," Knight-Ridder News Service, July 28, 1990.

10. "Oregon reworking plan on health care rationing," Sacramento Bee, May 20, 1990.

Recommendation 2: The Governor and the Legislature should allocate funds to the Department of Health Services to contract for a cost-benefit analysis of prioritizing health care procedures offered under Medi-Cal.

While California's Medicaid program is much larger than Oregon's and serves a more diverse group of recipients, the Oregon approach could be a beneficial option for the State to pursue. Medi-Cal officials already speak of the need to pour any excess funds into preventive procedures, like prenatal care and children's immunizations. This informal emphasis on attending to necessities should be supported by an examination of what Medi-Cal offers and how the use of a priority list might free more resources to provide a better level of basic health care to all recipients.

Eligibility

Establishing eligibility is the first step to participating in Medi-Cal as a recipient. Once eligibility is granted, recipients may face difficulties finding a provider, arranging transportation or child care so they can keep appointments, or avoiding other stumbling blocks. But it is the initial step--getting a Medi-Cal card with the stickers entitling one to service--that can be the largest barrier to medical care for the poor.

The eligibility process for Medi-Cal piggybacks, in general, on the eligibility systems for various welfare programs--Aid to Families with Dependent Children, food stamps and others. Unlike Medi-Cal, which is under the jurisdiction of the Department of Health Services, these welfare programs are managed by the Department of Social Services. Both state departments allocate funds to counties to administer these programs. So from the recipients' perspective, their Medi-Cal application begins at their county's welfare office.

Although Medi-Cal is a statewide system, in that the regulations for eligibility are the same throughout the State, different counties implement the eligibility process differently. Thus, a recipient at one end of the state may be required to appear in person and wait through long lines to pick up an application and make an appointment to return with it completed at a later date. Another person elsewhere might be able to receive an application by mail and only make one trip to be interviewed by an eligibility worker. In one county, the eligibility worker may tell a pregnant teenager that a program is available to allow her to apply for Medi-Cal without her parents being notified, while in another county the teenager might only receive that kind of help if she knows enough to ask for it. In some areas, the application

process may be completed quickly and smoothly, while in other more-burdened areas the process may drag on for weeks.

From the State's perspective, such variations from county to county should be minor since the State issues training materials, alerts counties uniformly when changes in the programs are made and underwrites the cost of employing eligibility workers. The Department of Social Services pays 75 percent of the cost of administering its programs and expects the counties to pay 25 percent. Medi-Cal purports to pay 100 percent of the cost of processing eligibility. But counties have long maintained that the State's standards for how large a caseload an eligibility worker should be able to handle are unrealistic and that the State's payments, therefore, are woefully short of the real cost of processing eligibility.

**Counties with
more resources
cope better**

As a practical matter, this means that some counties with more resources can better cope with growing caseloads by hiring more eligibility workers while other counties simply process cases slower and slower. For instance, in San Bernardino County, an eligibility worker reported that while the State's standard caseload was 148, most workers carried between 210 and 230 cases. Intake workers would process 50 new cases a month, while the standard was 31.

(The Little Hoover Commission chose not to address caseload standards in this study, since that is the subject of a separate state study that may lead to adjustments in the coming year. However, the Commission noted that other hearings and studies have concluded that counties experience rapid turnover in eligibility workers because of low pay, high caseloads and stress from frequent program changes. This rapid turnover leads to a constant influx of new workers who must be trained to use complex, changing regulations before they can become efficient in processing paperwork and properly evaluating recipients.)

A nationwide study described in "...And Access for All"¹¹ found that California's Medi-Cal applications are processed in an average of 32 days, only slightly longer than the average 28.9 days found in seven large states. But advocates for recipients maintain that the wait more often is two to three months, with nursing home representatives claiming that they see delays of six to eight months with their clientele.

11. ...And Access for All: Medicaid and Hispanics, National Coalition of Hispanic Health and Human Services Organizations, March 1990.

The statistics for September 1989 in Los Angeles County, where roughly one-third of the recipients in the State are located, show that 90.15 percent of the family applications were processed before 45 days elapsed, as required by law for all but disabled applicants, with the remaining 9.85 percent being completed by 90 days. Under the category of aged, blind and disabled--where the process is slowed by waiting for federal approval for Social Security Income eligibility--67.44 percent were processed in under 60 days, as required by law for disabled applicants, while 32.56 percent were still pending.

While these figures may appear reasonable on the surface, recipient advocates argue that counties are able to "cook the books" by simply rejecting applications that have not been processed before the legal time limits have elapsed and telling applicants they must apply again with more detailed information. Although the Commission did not find proof for this allegation, it did gather anecdotal evidence in enough of a mass to indicate that problems with completing the eligibility process abound:

* The Commission was told at one of its hearings about a pregnant woman applying for Medi-Cal in San Francisco who went to the welfare office four separate times, but because the office would only take the first 15 people in line each day she was turned away. On her fifth try, when she was nine months pregnant, a friend camped out at the office beginning at 3 a.m. Although this final effort won her an application, she was notified several weeks after her child was born that her application was denied for lack of proof of pregnancy.

* A Long Beach woman told the Commission she became pregnant in August 1989 and applied for Medi-Cal on September 28, 1989. She was told she would receive her card and stickers within three months, but the card never came--not when she received emergency-room treatment after falling when she was five months pregnant; not when she started bleeding at eight months and was admitted to the hospital; and not when her baby was born prematurely at 35 weeks. She told the Commission: "I called so many times...and all they would say is that my papers are in a different file, or another person would tell me that my papers were missing or they would tell me they had not gotten my address. Oh, they would give me all kinds of excuses...they would tell me my worker was no longer in charge of my papers. So I didn't know what to do, I was really worried."

Despite her repeated phone calls, she still had not had her application processed by the end of April 1990 when she appeared before the Commission. Instead, various

hospitals and clinics were billing her and threatening to turn her over to a collection agency.

* The administrator of a community clinic in Long Beach said that of 311 pregnant patients registered for prenatal care between July 1989 and February 1990, 7 percent received Medi-Cal cards within 60 days. Fifty percent waited an average of 98 days and 43 percent were still waiting in April 1990. She estimated overall applications from pregnant women--which supposedly are being expedited under the State's direction--are taking between 60 days and 240 days.

* The prenatal director of a clinic in the San Fernando Valley said she obtained a grant to hire two employees specifically to screen and aid Medi-Cal eligible pregnant women in completing form work. From May 1989 through December 1989, they helped 644 women correctly and completely fill out applications. No one got a same-day card, although that option is supposed to be available to pregnant women. Only 18 got Medi-Cal cards within two months. In April 1990, when the director wrote to the Commission, 30 applications had yet to be acted on.

* The National Health Law Program reported that 59 percent of all applications for pregnant women in Los Angeles County were still pending after 45 days.

* The American College of Obstetricians and Gynecologists said that applications for pregnant women in Imperial County take between two and four months to process. The Imperial Valley Women's Clinic gave examples of 15 patients, all of whom took between three and five months for approval. When this amount of time is added on to the six weeks or two months minimum time to diagnose the pregnancies, many high-risk pregnancies are not on track for prenatal care until the fourth or fifth month, if then.

Pregnant women are not the only ones who face long delays. The health care coordinator for a non-profit clinic in South Central Los Angeles supplied statistics on three of the dozens of cases in which she has tried to help people complete their application process. One involved a woman and her three children who submitted an application in August 1989. None received cards before December and then each month different family members would receive cards, while others did not. The coordinator called the welfare office 22 times attempting to straighten the situation out. In two other cases, she has called 41 times and 57 times, never managing to resolve either of the situations.

The coordinator told the Commission one particularly compelling story about a 70-year-old man on dialysis who applied in June 1989. "I called his worker and said this is an emergency, the man is on dialysis, he has to buy medicine, he does not have money to buy food, much less to buy medicine....I kept calling his worker, I called the supervisor, I called the district director. He still didn't receive his cards even though he was clearly eligible. We would have to make two or three calls a month. Finally, about the 20th of the month he would get his card. Usually he couldn't hold out to buy medicine that long and had to spend \$30 or \$40 on medicine, which meant he had that much less money for food."

"Finally, in April, this month, his wife came in and said for the first time he had gotten his card. He had been in the hospital in February, very seriously ill in the hospital, and I called his worker and I said, 'well, you know, you're not going to have to worry about him too much longer because he's going to die and maybe by that time, you'll get his cards to him.'"

Emphasis on prenatal care causing problems

More than one person pointed out to the Commission that while California's recent emphasis on getting prenatal care to poor pregnant women is an excellent idea, it is causing other problems. First, it means that pregnant applicants are supposed to be pushed to the top of the heap of all other applications being considered, which slows down the process for other people who may need services just as desperately.

Second, expanding eligibility standards, as the State has done, to allow more women to receive Medi-Cal prenatal care is meaningless if the women who should be eligible now cannot complete the application process and find providers who will accept Medi-Cal.

And third, to fund some of the cost of expanding the service to more women, the State cut grants that were the financial underpinning of non-profit clinics serving poor pregnant women. The money that used to go to the clinics in the form of annual grants is now expected to filter through to them throughout the year in the form of Medi-Cal reimbursements for treating individual recipients. Unless eligibility is speeded up so that these clinics can rely on receiving Medi-Cal reimbursement for the care they give, many fear they may end up being forced out of business, leaving even fewer providers of prenatal care for poor women.

The actual processing of forms is not the only flaw in the eligibility process. The forms themselves have been

rated so complex that a 14th grade education is required to cope with them--a level of literacy that few Medi-Cal applicants may have attained. Since overloaded eligibility workers are not able to help the applicants work their way through the forms, the paperwork can be a frightening barrier.

As the first step in obtaining Medi-Cal services, the eligibility process should be designed to sort out quickly who will get help and who will not. The Commission has reached the conclusion that the process does not accomplish that goal. Instead, by all accounts, the system fosters confusion, delays needed treatment and serves as a deterrent to many who need services and would qualify for them but who either cannot or will not subject themselves to the application process.

FINDING 2: Implementation of the eligibility process varies from county to county, resulting in unequal treatment of Medi-Cal applicants.

Although the Medi-Cal program has a specific set of guidelines for eligibility, these regulations can be applied diligently or laxly, completely or partially, depending on the capabilities and staffing of the county where the applicant resides. Faced with 11 separate forms for Aid to Families with Dependent Children (AFDC), food stamps and Medi-Cal, the eligibility worker--no matter how well-intentioned--may fail to connect an applicant with all the proper forms of aid that are available. The efficiency of the eligibility worker is further hampered by frequent changes in regulations that result from decisions by the federal government, the State and the courts.

A 1989 study¹² of barriers to Medicaid access included this example of the complex requirements that eligibility workers must keep in mind:

"With regard to income, for AFDC recipients, \$30 plus one-third of their remaining earnings may be disregarded as income for the first four months of reciprocity in each 12-month period; for Food Stamps, 20 percent of all earned income may be disregarded for the duration of the reciprocity; for Medicaid, the first \$20 of earned or unearned income is disregarded, plus \$65 and

12. "An Examination of the Barriers to Accessing WIC, AFDC and Medicaid Services," Southern Regional Project on Infant Mortality, Southern Governors Association, September 1989.

one-half of the remainder of earned income if the individual has no unearned income."

Even that might not be so difficult to sort out if a worker could count on it not changing. But the past three years have seen a complex fragmentation of the Medi-Cal program, as various categories of eligibility have been added and various limitations on benefits for different categories have been created. For instance, there was a time when the complete range of services was available to a person who was eligible for Medi-Cal. Today, a pregnant woman might be eligible only for pregnancy services. In the same family, one child from a previous marriage might be eligible for complete Medi-Cal, while other children might be eligible for emergency services only.

According to Medi-Cal officials, from October 1988 until a little more than a year later in January 1990, eligibility workers were expected to adjust to the following changes:

October 1988: The federal government added illegal aliens to emergency and prenatal care.

December 1988: An injunction was issued by a judge that caused changes in the illegal alien program.

July 1989: The State picked up the federal option of covering pregnant women, and children up to the age of one, who were at 185 percent of the poverty level.

July 1989: A law was enacted to allow consideration of old medical bills when deciding if someone is financially qualified for Medi-Cal. The State expected to implement the law's provisions by **July 1990**.

August 1989: A judge ordered the provision of considering old medical bills to apply beginning in **September 1989**.

January 1990: The State decided to use new tobacco tax funds to expand Medi-Cal eligibility to include pregnant women and children who were at 200 percent of poverty line.

Training does not keep up with changes

In many cases, the State did not have time to provide training to county eligibility workers, regulations were not completed or paper forms were not ready on time. Since many recipient advocates keep abreast of the changes and press for recipients to receive newly created benefits, the inability of eligibility workers to keep up has caused tensions in many areas. One Long Beach advocate told the Commission in a letter that seven months after illegal aliens were supposed to be covered by Medi-Cal she was told her patient was not eligible by both an eligibility worker and the

worker's supervisor. After contacting higher county officials, the advocate said, "They made all kinds of excuses alluding to the fact that they get thousands of 'All County Bulletins' from the State, and no one has time to read them."

Recipients who do not know about programs, and therefore cannot ask to be evaluated for eligibility for them, may never learn about such alternatives as the "sensitive services" for minors (which allows pregnant minors to apply for Medi-Cal based on their own incomes and assets rather than on their parents'), "same day" issuance of a card for emergency prenatal care and retroactive benefits for three months prior prenatal care.

One eligibility worker whose testimony was reviewed by the Commission said that counties often are given bad information or late information. She said the charts distributed to eligibility workers to compute eligibility for the 185-percent-of-poverty program were several hundred dollars off. While the program went into effect on July 1, 1989, the handbook page was not printed until August 1989 and then was corrected in September 1989. "The public received stuffers (in the mail) explaining the new program before we were staffed and ready to implement it," she said. Workers are not given time to absorb changes but must continue with their caseloads, reviewing not only the changing circumstances of the applicants but also the changing ground rules of the programs.

**Burden could
be eased by
statewide system**

The burden shouldered by eligibility workers is well-suited to being eased by modern technology. A single, statewide computer system for determining eligibility is not only a logical outgrowth of a desire to implement programs fairly across the State, but is also a financially attractive concept. The federal government will underwrite an average 80 to 90 percent of the hardware costs if a state implements one system statewide.

Other states have moved ahead to integrate their various forms of aid. Texas began a series of pilot programs in 1986 to integrate Aid to Families with Dependent Children, Medicaid, Food Stamps, county health department health care, and county indigent care.

But it is Florida that has moved to the forefront with a state-of-the-art system now being designed and implemented, according to a report in *Government Technology*.¹³ With a centralized data center and 8,000 terminals in 300 agency facilities, the program will allow

13. "State and Local Government: Biggest Systems Integrators," *Government Technology*, January 1990.

eligibility workers to follow computer screen prompts as they interview applicants and determine the broadest range of programs that apply.

In addition, Florida's eligibility workers will be able to interface with the Social Security Administration, check work records, find out from the Department of Motor Vehicles about car ownership and run other cross-checks with 50 or 60 different agencies. As regulations for programs change, modifications will be made in the database uniformly and in a timely manner. In a concept paper put together by the state, entitled "The Florida System," the following benefits were outlined: improved services with timely and accurate benefits, ease of use for staff, increased productivity, the institution of uniform policy and reduction in error rates.

Such a system also would have the advantage of providing centralized and immediately updated eligibility files. A medical care provider could verify eligibility in much the same way that stores verify credit card purchases today: with a simple phone call and touch-tone entry of code numbers. This could allow the elimination of the card and sticker system that is subject to abuse and fraud when stickers are lost, traded, counterfeited or sold.

Single computer system is not being pursued

But California's attempts to embrace a centralized, computerized system in the past have been unsuccessful. While logic might dictate that a state-controlled, uniform system would allow for easy modifications, efficient training and uniform application of state standards, politics--in the form of counties wanting their own type of computer systems and computer companies trying to elbow each other aside to win the State's business--have intervened. Instead, the State is now pursuing four different model programs in a project known as the Statewide Automated Welfare System (SAWS). The models are being piloted in Napa County, Merced County, Los Angeles County and in a consortium of 19 counties. Thus, Medi-Cal eligibility will continue to be fragmented even after an investment in modern technology.

Recommendation 3: The Governor and the Legislature should direct the Department of Social Services to evaluate the four pilot projects under SAWS, rank them according to feasibility for statewide use and develop a funding plan, taking into account available federal subsidies for uniform systems. Legislation also should be enacted to declare the State's intent to implement a single computerized system for eligibility processes.

An official with Electronic Data Systems Corporation (EDS), the firm that now processes Medi-Cal claims and that

is also developing the Florida system, told the Commission that a similar system in California could be put in place for \$200 million to \$300 million in a shorter period of time than the projected four-prong SAWS project. But regardless of what computer model is used, a single system statewide would have the advantages of uniformity and centralized control. Such a system could well put an end to a process that has become unwieldy both for recipients and eligibility workers.

FINDING 3: An overly complex application form is a barrier to eligibility for many otherwise qualified Medi-Cal recipients.

The main application form for the Medi-Cal program, known as the MC210, is 11 pages of tightly jammed questions about assets, income and personal history (please see **Appendix D** for a copy of the form). It has been likened to the forms a taxpayer faces in April each year, but in reality it is far more exacting in detail. In addition, the applicant is required to produce back-up documentation to verify the information provided on the form. Although the application form varies from state to state, it has been determined to be a significant barrier to enrollment in areas that use forms similar to California's.

In a 1988 study for the Southern Governors' Association,¹⁴ Sarah Shuptrine and Associates found that 62.7 percent of all Medicaid denials in 17 southern states were because the applicant failed to complete the procedural requirements, while only 26.2 percent of applications were not approved because of excess assets or income. On a nationwide basis, procedural denials averaged 59.7 percent, while denials for excess assets or income averaged 21.4 percent. In some cases, applicants may have dropped out of the process when they realized they did not meet income or assets criteria; but in many other cases, the form may have proved too complicated to understand.

Medi-Cal officials point out that no tracking is done in California to determine why applications are withdrawn or why they "die" in the system without ever being completed. The chart below shows the caseload activity for selected large counties in 1989, including the number of applications counted as "withdrawals." This category shows applications that have been withdrawn by the applicant or that have not been completed because the applicant failed to keep

14. "Study of the AFDC/Medicaid Eligibility Process in the Southern States," Sarah Shuptrine and Associates, Southern Governors' Association, April 1988.

appointments during the application process. At least some of these withdrawals can be attributed to people giving up because of the complexity of the forms.

CHART 5

AVERAGE MONTHLY 1989 MEDI-CAL ELIGIBILITY CASELOAD ACTIVITY

County	Intake	Continuing	Denials	Withdrawals	Percent of Withdrawals
Alameda	2,801	12,742	620	547	19.5%
Fresno	2,089	13,202	561	72	3.4%
Los Angeles	17,164	110,717	4,116	5,399	31.5%
Orange	5,335	23,495	1,245	238	4.5%
Riverside	3,053	11,452	1,127	143	4.7%
Sacramento	2,404	10,828	878	369	15.3%
San Bernardino	2,667	16,417	692	126	4.7%
San Diego	6,249	26,441	2,209	378	6.0%
Santa Clara	4,234	14,530	1,509	286	6.8%
Statewide	70,049	359,283	20,513	8,535	12.2%

Source of data: Department of Health Services

As Chart 5 above shows, withdrawals on a statewide basis represent about 12.2 percent of the number of applications submitted each month. But in the state's largest county, Los Angeles, withdrawals represent a much higher 31.5 percent of applications submitted. Two other counties also have withdrawal rates that are significantly higher than the other counties reviewed: Alameda County with 19.5 percent and Sacramento County with 15.3 percent.

The difference in withdrawal rates could be attributed to some counties doing a better job of helping with the completion of applications. Or some counties may screen out potential applicants more thoroughly in the beginning, discouraging those who clearly are not eligible from even filling a form. Recipient advocates believe the overall withdrawal rate is actually much higher than the State's statistics reflect and that, in addition, two-thirds of the applications that are denied are due to failure to complete the paperwork.

The advocates are not alone in their contention that the forms are too complicated. As part of its Prenatal Care

Access Initiative, The Sierra Foundation funded a study¹⁵ of the main Medi-Cal application form in March 1989. Readability experts found that the form required a 14th-grade-level education to understand it and that its completion took between 30 minutes and two hours. Although the study's authors could find few questions to trim because of federal requirements, they did revise the form, turning it into a 16-page document that required only a ninth-grade reading level. Testing of the document showed that fewer errors were made by applicants and that it could be completed in 30 to 45 minutes.

**Process of
simplifying forms
is underway**

According to state officials, the Sierra Foundation revisions were studied by a working group of state and county representatives and some aspects were incorporated into a final version. That version, which also reads at the ninth-grade level, is expected to be used by counties by the beginning of 1991 (please see **Appendix E** for the revised form). In addition, the State is now working with county representatives to devise a shorter form to screen pregnant women who may be eligible for assistance under the 185-percent- and 200-percent-poverty thresholds.

But simplifying the paperwork may not be the only or even the most meaningful step that could be taken. In "An Examination of the Barriers to Accessing WIC, AFDC and Medicaid Services,"¹⁶ the authors point out that the federal system has built-in incentives to keep states from wrongly granting eligibility. But there are no incentives to make sure that those who are turned away are not denied incorrectly. Thus, a state faces a penalty if its error rate of granting Medicaid incorrectly exceeds 3 percent. But no one except the would-be Medicaid patient suffers when an application is denied incorrectly.

Such is not the case in North Carolina, according to the same study, where a 1974 federal court order is in effect that requires the state to not only process applications within 45 days but to also assist applicants in meeting eligibility requirements. If applications are either pending after 45 days or if they are incorrectly denied, the county responsible is fined. In order to meet the dictates of the court order, North Carolina has the lowest caseload per eligibility worker in the country, enabling workers to share the responsibility with the applicants for filling out the forms and digging up verifying documentation. The state has an error rate of less than 1 percent and denies only 19.1 percent of applications

15. "Redesign Project for the Medi-Cal Application Form," The Sierra Foundation Prenatal Care Access Initiative, Fall 1988.

16. "An Examination of the Barriers to Accessing WIC, AFDC and Medicaid Services," Southern Regional Project on Infant Mortality, Southern Governors Association, September 1989.

for failure to comply with procedural requirements, compared to the 59.7 percent procedural denial rate nationally.

California's counties have a similar low error rate--0.8 and 1.8 percent during parts of 1989--but no similar commitment to maximize approvals for applicants. In some ways that is difficult to understand: Indigent people who are not added to the Medi-Cal rolls, where the medical care is paid for by the federal and state governments, often end up in county health facilities as unreimbursed-care cases. In 1987-88, the California Association of Public Hospitals said county hospitals lost \$669.1 million due to bad debts and charity cases. With 11 percent of the hospital beds statewide, these institutions were stuck with 59 percent of the charity and bad debt cases.

**Counties have
stake in making
people eligible**

Counties that understand this dynamic--that the health care for poor people will either end up as a cost to the county or can be shifted to cost the federal/state program instead--should be eager to qualify as many people as possible for Medi-Cal. But instead county attention appears to be riveted on the concept that the State needs to provide more funds to hire more eligibility workers.

The implementation of a uniform, computerized intake system, as recommended above, would bring a greater human dimension to the eligibility process by allowing workers to help applicants through each step of completing requirements. But the slow process of moving to computerization should not leave these problems in limbo in the meantime. The State should pursue short-term goals that will simplify the eligibility process and underscore the need for counties to give a high priority to establishing eligibility for qualified applicants.

Recommendation 4: The Governor and the Legislature should direct the Department of Health Services to give priority to ensuring that eligible recipients are approved in a timely manner.

The State should pursue a goal of keeping paperwork to a minimum until a computer-based system is in place. The State is understandably eager to keep its error rate below 3 percent, since each percent above that rate costs the State \$16 million, according to Medi-Cal officials. But by squeezing the rate to below 1 percent, as the State has been able to do, counties may well be acting so rigorously that qualified applicants are also turned away. The tradeoff for a simple, smoother, more streamlined system may be an error rate that comes much closer to the 3 percent standard.

The State also should move quickly to adopt simplifications that the federal government does allow. For instance, the Omnibus Budget Reconciliation Act of 1989¹⁷ says that for pregnant women and children (the "newly eligibles") the methodologies to determine income and resource eligibility may be less restrictive than methodologies for cash assistance programs. Thus, the State's intention to modify forms for pregnant women should be pursued vigorously and in a timely manner.

Recommendation 5: The Governor and the Legislature should establish a disincentive system, similar to the federal 3 percent error rate allowance, to encourage counties to be diligent in efforts to qualify potential Medi-Cal recipients.

Counties should be subject to random auditing by the State to ensure that applicants are not incorrectly denied benefits. Error rates exceeding a certain percentage should result in a levy of fines against the county. The creation of this disincentive system could be coupled with efforts to educate counties about the costly link between unreimbursed care cases and their failure to establish qualified applicants as eligible for Medi-Cal.

FINDING 4: Specialized categories of Medi-Cal applicants, including pregnant women, SSI recipients, nursing home residents and share-of-cost patients, face particular barriers to eligibility.

Although all Medi-Cal applicants face an arduous process for becoming eligible for services, some categories of applicants have problems that could be addressed with specific modifications of the State's current processes. These include pregnant women, SSI recipients, nursing home residents and share-of-cost recipients.

**Pregnant women
need timely care**

Pregnant women, unlike other poor people seeking coverage for health care, have a problem that cannot be put on hold while the system sluggishly moves through applications. A baby will emerge in approximately nine months, regardless of where its mother's paperwork is. The goal, therefore, should be to expedite eligibility for women who in the normal course of events would be approved for services anyway. A side benefit of expediting eligibility would be to attract more obstetricians into the program.

The system, as it operates now, does not do a good job of meeting the needs of pregnant women. A 1987

17. "Medicaid Amendments," Health Advocate, Winter 1990.

General Accounting Office study showed only 36 percent of pregnant women on Medicaid receive prenatal care, while 81 percent of those privately insured do. A Houston Law Review article¹⁸ notes that in half of California's 58 counties, there are so few obstetricians willing to take Medi-Cal that 175,000 pregnant women have no doctor. In Los Angeles County, there is one doctor for every 707 pregnant women. The American College of Obstetricians and Gynecologists report that 20 percent of the obstetricians in the State provide care to more than 70 percent of pregnant Medi-Cal recipients.

While obstetricians join other types of providers in complaining about low rates and the red tape of the billing process, their No. 1 complaint is denial of reimbursement, according to an April 1990 survey of Orange County obstetricians conducted under the direction of the March of Dimes. Doctors may proceed with prenatal care while the woman tries to complete the eligibility process, only to have the qualifying card and stickers never come. Or they may provide service under the Medi-Cal system's global fee basis --in which a single fee is paid to cover health care during the length of the pregnancy--only to lose the entire amount when the patient loses her eligibility. The Commission was told about one National City doctor who had four patients lose their Medi-Cal eligibility close to their delivery dates. He could not bill Medi-Cal for the global fee and, under the law at the time, he could only bill on a fee-for-service basis retroactively for two months.

But the federal government allows states to adopt three options that California has yet to embrace: presumptive eligibility, continuous eligibility and a waiver of the assets test. Twenty-seven states have adopted presumptive eligibility, 43 have continuous eligibility and 41 have waived the assets test.

Under presumptive eligibility, a provider who is certified to make such determinations, following streamlined guidelines, can proceed to treat a pregnant woman and bill Medi-Cal during the time her application is being processed. While this federal option presumes that an application will be processed within 45 days, as required by law, other states have ensured that even if the deadline passes the woman will still be treated under Medicaid with the state picking up the full cost of her care until such time as her application is finally completed. This provision serves as a powerful inducement for the application to be finalized within 45 days.

18. "Increasing Provider Participation in the Medicaid Program: Is There a Doctor in the House?" by Jane Perkins, staff attorney for National Health Law Program, Houston Law Review, 1989.

The adoption of continuous eligibility allows women, once certified for Medi-Cal, to remain on the program throughout their pregnancy and delivery regardless of any change in their income status.

The waiver of the assets test allows a woman to be qualified as eligible for Medi-Cal without having to produce documentation of the value of any assets she owns, such as a car or jewelry. A study in Alameda County showed that less than 2 percent of Medi-Cal applications are denied because the applicant has too many assets (as opposed to having too much income).

Recommendation 6: The Governor and the Legislature should implement the federal options for pregnant women known as presumptive eligibility and continuous eligibility.

Presumptive eligibility and continuous eligibility would add an unknown cost to the State's Medi-Cal expenses. But multiple studies have found that for each dollar spent on prenatal care among high-risk populations, between \$3 and \$4 is saved on the care that would otherwise be needed for low-birth-weight babies and intensive care treatment. Without options that ensure pregnant women achieve and keep Medi-Cal status, many may not receive prenatal care throughout the course of their pregnancy. The catch for the Medi-Cal budget is that the savings at birth are likely to be accruing to counties and others who normally foot the expense of treating pregnant women and their newborns not covered by Medi-Cal as unreimbursed care or charitable cases.

**People on
SSI/SSP face
delays**

Another population that faces procedural barriers when applying for Medi-Cal are those who qualify through their being approved by the Social Security Administration for the Supplemental Security Income/State Supplemental Program (SSI/SSP)--usually the aged, blind and disabled. Under law, Medi-Cal applications for the disabled must be processed within 60 days. But the Social Security Administration routinely takes more than 60 days to verify eligibility for SSI/SSP. As noted earlier in this section, Los Angeles County in September 1989 showed that only 67.44 percent of the applications from the aged, blind and disabled had been processed within 60 days, with the remaining pending an unknown amount of time longer.

Recommendation 7: The Governor and the Legislature should direct the Department of Health Services to require local verification of the eligibility status for SSI recipients if the federal government has failed to act within 60 days.

Rather than waiting for the federal government to approve the application, the State should process the Medi-Cal portion of the application. This would ensure that this population is not left without health care because of procedural barriers.

Long-term care residents face stumbling blocks

A third category of applicants facing barriers are long-term care residents. Long-term care residents who are not in a guardianship arrangement but who may not have full use of their faculties create a special problem when their own funds run out and it is time to apply for Medi-Cal. They may be unable to gather the required documentation for eligibility and the nursing home is left with neither private pay nor government reimbursement until the process is complete.

The director of a Morro Bay long-term care facility wrote to the Commission about this problem, saying the facility usually has nowhere to discharge a non-paying patient because no one else will accept someone who cannot pay and there usually is not a caregiver in the person's home.

"That leaves the facility with the wait-and-pray option. For those facilities that are not a religious franchise, their prayers go unanswered. I have experienced Medi-Cal applications taking over 10 months. Why? Usually because the application was filed incomplete. This can mean one or two cancelled checks cannot be found by the confused spouse at home. Or the family member or friend doesn't have the time or interest to go through the humiliating ordeal....The loss of cash by the facility during this process affects the ability to provide service....Expenses are reduced to offset anticipated shortfalls. Expenses being reduced equates to services being reduced to the frail elderly."

The California Association of Health Facilities provided example cases to illustrate the problem further:

* One patient admitted herself to a long-term care facility in Redding. By the time her Medi-Cal application was submitted, she was confused and unable to handle her financial affairs. A son in Los Angeles, ill himself and with no financial resources, was unable to provide the information about his mother that was required by Medi-Cal. The woman eventually died, and the facility wrote off her bill as uncompensated care.

* A facility in Burbank had to write off \$37,000 when a patient's conservator failed to complete the Medi-Cal process and refused to pay privately. The matter grew more complicated when the conservator died.

Recommendation 8: The Governor and the Legislature should establish a presumptive eligibility program for long-term care residents and should direct the Department of Health Services to seek any necessary federal waivers.

At a time when California is pressing nursing homes to improve the quality of care they deliver, it seems short-sighted to require them to absorb losses that are not of their own doing. The State, instead, should create a system of presumptive eligibility that ensures nursing homes will be able to bill Medi-Cal for the care they are delivering whenever a patient appears to fall within asset and income guidelines. If patients subsequently are found ineligible because of assets or income, the State can pursue reimbursement from responsible parties or estates.

Share-of-cost program is burdensome

The fourth category of applicants who face particular barriers is share-of-cost recipients. Medi-Cal recipients who qualify for the program, but who have enough excess income that they are required to pay for a portion of their medical care each month, are called share-of-cost recipients. The current system for handling these recipients is designed in such a way that it is a burden for both the State and the recipient.

Since the amount that a share-of-cost patient owes each month is based on his income, the State requires the income to be checked on a quarterly basis. Any change requires the recomputation of the person's share of cost and the reprocessing of all paperwork, even if it is only to require the recipient to pay a few dollars more each month. Medi-Cal officials have said they are examining the cost-benefit aspect of the system, with the intention of exempting a certain level of change in income. For instance, if it costs \$25 to handle the reprocessing of the application, the State would say that income would have to change more than \$25 before the share-of-cost would be altered.

From the recipient's end, the present system requires him to have each medical provider sign a special form indicating bills that the recipient has incurred and paid that month. Other states, however, allow recipients to submit receipts and/or bills to the State as proof that the share-of-cost has been met.

Recommendation 9: The Governor and the Legislature should direct the Department of Health Services to revamp the share-of-cost system.

State officials already have recognized that the share-of-cost system is unwieldy and complicated. Immediate

steps should be taken to set limits on income changes that would require share-of-cost adjustments, and regulations should be changed to allow the submission of receipts and bills as proof that the share-of-cost criteria have been met.

Managed Care

"Managed care" is a term that in the health field usually conjures up images of HMOs (Health Maintenance Organizations), PPOs (Preferred Provider Organizations), IPAs (Independent Providers Associations) and other acronym-laden entities that offer "package deals" on health care procedures. But in its broadest definition, the term "managed care" covers not only the coordination of health care actually delivered to a recipient but also the variety of management steps that are employed to ensure that such care is appropriate and economical.

Managing health care in such a way as to maximize medical value received for the dollars expended benefits patients, providers and the government. In the best of worlds, patients receive a higher quality of care through earlier intervention and through the implementation of medical standards that are scientific and uniform. Providers can concentrate on medicine rather than bureaucracy, and see patients at earlier and more treatable stages of diseases. And the government is able to target its finite dollars to those who need the most help and to procedures that will produce the greatest benefit for patients.

Medi-Cal, however, does not provide such a managed-care utopia in its present form. This section of the Little Hoover Commission's study examines both aspects of managed care as employed by Medi-Cal, beginning with the management of the health care delivered and then moving on to cost-management techniques.

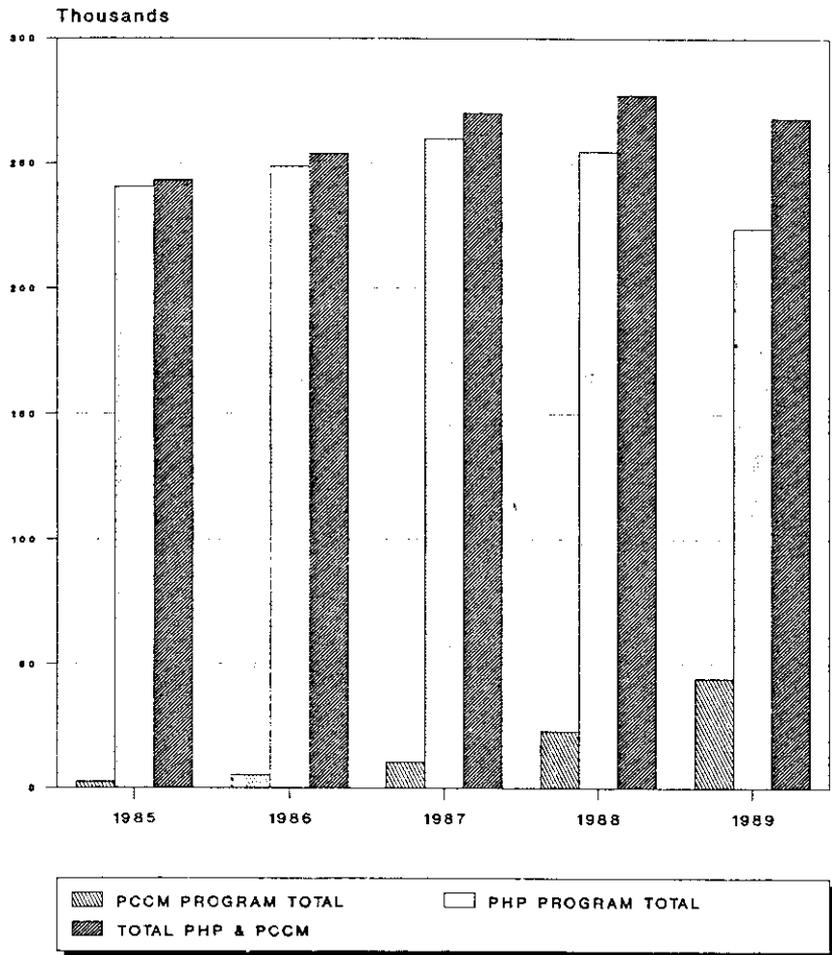
FINDING 5: The State has failed to pursue vigorously capitated care systems that have the potential of improving medical care for recipients and lowering long-term costs.

Medi-Cal relies primarily on fee-for-service medical care providers; that is, when a patient receives services, Medi-Cal is billed by a provider and is supposed to pay for that specific service. Within Medi-Cal, however, there are other modes of providing health care, including capitated care. Capitated care refers to a system of paying an organization a set amount, in advance, to provide health care for an individual. While the health world outside of Medi-Cal has moved heavily in this direction, Medi-Cal's capitated care programs have remained static, covering less than 10 percent of those receiving Medi-Cal benefits.

The chart below shows the enrollment in capitated systems--prepaid health plans (PHPs)--and in primary care case management programs (PCCMs), which will be discussed in the next finding:

CHART 6

1985-89 ENROLLMENT IN PREPAID HEALTH PLANS AND PRIMARY CARE CASE MANAGEMENT PROGRAMS



Source: Department of Health Services

As Chart 6 on the previous page indicates, the five-year span from 1985 through 1989 has seen a gradual, but now accelerating, growth in primary care case management recipients, but the number of those enrolled in prepaid health plans has actually declined. By January 1990, 223,841 recipients were enrolled in prepaid health plans that had capacity for 581,995 recipients, and 44,055 were enrolled in primary care case management systems. Each year, the combined numbers covered under these types of plans have been less than 300,000, a relatively small portion of the 3.7 million current Medi-Cal recipients.

**Capitated care
is the norm
in working world**

How does the coverage of these recipients differ from those in the fee-for-service system? As defined earlier, capitated care refers to a system of paying an organization a set amount in advance to provide health care for an individual. Californians who receive their medical care from Kaiser Permanente, Foundation, Health Net and other similar plans are enrolled in capitated care plans. In fact, by some estimates, 70 percent of employed Californians now have this type of health coverage rather than the fee-for-service insurance plans that were much more prevalent two decades ago.

The traditional advantage of capitated systems is a lower cost. The payor, whether it is government or an employer, pays a lower total amount for the care of a large pool of people than it would if each person's care were paid for a service at a time. The organization receiving the lower rate is supposed to be able to generate its profit margin by eliminating over-utilization of services and by providing primary and preventive care that may sidestep the need for more expensive treatments at later dates.

Unfortunately, capitated systems have not always lived up to expectations, neither from the State's perspective nor from the recipient's. On the State's part, such systems have not served well as cost-cutting mechanisms because few capitated systems can get by with the funds the State is able to commit to this type of care. Federal law requires that Medi-Cal pay less under capitated systems than it would for the same services in a fee-for-service system. But with the State's fee-for-service rates already cut to bare minimums, it is difficult for a prepaid health plan to take the even-lower rate, add an administrative cost and avoid operating at a loss. In fact, capitated plans in Monterey County, Fresno/Madera Counties and Sonoma County (the Redwood Foundation) all either failed or were terminated when the State determined they were costing more than fee-for-service, according to Department of Health Services' officials.

From the recipients' side, critics say that capitated care in general acts to create under-utilization of service and usually places more emphasis on short-term profitability than on long-term health needs. The problems are worsened, the critics believe, for the type of people who are on government-funded health programs like Medi-Cal because they are generally a less healthy population and they have few resources to force organizations to deliver needed services.

In testimony before both the Little Hoover Commission and the U.S. House of Representatives Subcommittee on Health and the Environment, the National Health Law Program said that the barriers capitated care systems place between recipients and service are particularly burdensome for Medi-Cal recipients. These include long waits on telephones to make appointments (many Medi-Cal recipients may only have access to pay telephones), delays in getting care and lengthy internal review procedures for denial of treatment. In addition, because Medi-Cal recipients drop in and out of the health plans as their eligibility status changes, prepaid health plans have little incentive to emphasize short-term treatments to ward off long-term expensive illnesses. Chances are, the recipient will no longer belong to the plan in the future.

These problems with capitated care for the poor were recognized early on by the federal government, particularly when patterns of "skimming"--taking only the healthiest patients and refusing the sicker ones--and taking the capitated payments and providing the least amount of care possible were found in early Medicaid capitated plans across the nation. These abuses led to federal protections written into the Medicaid program. The major one is that Medicaid recipients are guaranteed freedom of choice so that they can disenroll from capitated plans that fail to meet their needs.

**Inadequate care
exists in
both systems**

Unfortunately, the freedom-of-choice protection guarantees the Medi-Cal recipient nothing beyond his ability to leave a specific capitated plan. Quality of care is not ensured, whether the recipient is in a capitated plan or is making free choices in the fee-for-service sector. Recipient advocates are able to cite case after case of the failure of capitated plans to meet the needs of enrollees: a two-year-long wait for gynecological examinations in one program; delayed referrals for specialty care; and little coordination of services for disabled recipients. In fact, a 1989 study of Medicaid capitated demonstration projects across the nation found that none of the sites provided adequate and timely prenatal care and that none of the sites provided adequate

immunizations for children.¹⁹ But these specifics about the lack of quality care in capitated systems can be matched, example for example, with stories about the inadequacy of care found in the fee-for-service system. Prenatal service is scarce or impossible to obtain in many areas. Preventive services such as immunizations are frequently not provided. Recipients face almost impossible access barriers if they live in rural or inner city areas where providers who will accept Medi-Cal are few. In other words, recipients are just as likely to find barriers to adequate medical care when they are free to pick and choose their providers as when they are limited to a capitated system's providers.

While capitated care has proved disappointing to both the State and the recipients, there have been some success stories with prepaid health plans in California. Where these systems have carefully constructed safeguards, problems have been fewer and the benefit has been clear: Recipients are tied into a system that is responsible for their care and they are not left on their own with a medical problem and the telephone book trying to find a provider.

The Santa Barbara Health Plan is one example. A Health Insuring Organization (HIO), the plan is run by a public entity created by Santa Barbara County. The plan, which began operation in 1983, serves 26,000 recipients each month by paying providers in the community to provide medical care. While there have been some complaints about access, complaint and grievance procedures are available to recipients. The plan's director notes the following advantages offered by the system:

- * The provision of medical care is organized into a true "system" that can promote availability, continuity and quality of care, while at the same time reducing "doctor-shopping" and duplicative, unnecessary or inappropriate services.

- * Emphasis is placed on prevention and early detection of illness, especially through health education efforts, rather than incurring higher costs resulting from delayed care.

- * A greater flexibility of benefits can be offered compared to the fee-for-service sector, with the use of home health rehabilitation services, home uterine monitoring and other more cost-effective options.

19. "Evaluation of the Medicaid Competition Demonstrations," Health Care Financing Review, Winter 1989.

* The decentralization of Medi-Cal administrative procedures by having the local organization handle most administrative functions offers the advantages of local responsiveness to providers and recipients.

A similarly modeled plan in San Mateo County has been tracked since it began operation in 1988 by the California Medical Assistance Commission (CMAC). With 712 doctors (including 247 primary care physicians) caring for 29,950 recipients, the plan has had a total of 64 complaints and 6 grievances filed. In its evaluation, CMAC rated the San Mateo system a success.

Contra Costa County's plan presents a different model. A publicly run system that actually provides health service with its own employees (as opposed to Santa Barbara's status as an insurance system that contracts with private providers), Contra Costa markets its plan aggressively in the private and public sectors. Recipients, therefore, include Medi-Cal, Medicare, public employees and private citizens. In 1980, the plan served 1,000 Medi-Cal recipients, a number that grew to 6,900 out of the 15,000 people enrolled in 1989. The plan's director believes they have been successful in holding health care expenses in line while improving accessibility and broadening benefits.

**Duplication of
good capitated
plans blocked**

In at least some portions of the State, then, capitated plans have worked well in providing health care for Medi-Cal recipients. Despite the success of California's model prepaid health plans, Medi-Cal has been unable to expand capitated care. Federal restrictions that enforce freedom of choice for recipients are one barrier; waivers for more projects like Santa Barbara's and San Mateo's, which were grandfathered into Medi-Cal before the restrictions were invoked, have been impossible to obtain.

The federal government has not been the only stumbling block. In 1986, after CMAC had successfully negotiated 10 contracts in San Diego County to set up a system of Health Maintenance Organizations for 160,000 Medi-Cal recipients to choose from, the Legislature refused to authorize \$34 million to begin the project. Doctors objected to the plan because some would lose patients; recipient advocates were against it, believing there were inadequate protections built in to ensure quality care.

The importance of capitated care as a method of managing the health of all individuals, including the poor, makes it imperative that the State move more aggressively in this direction. While money may not be saved in the short term because of startup and administrative costs, there is the potential for dramatic savings in long-term and emergency

care. Recipients are guaranteed access and the benefits of case management in well-run capitated systems.

Recommendation 10: The Governor and the Legislature should signal their support for and commitment to future capitated care negotiations by setting aside a specific pool of funds for prepaid health plan development.

Legislative backing for capitated care could include strong provisions for adequate safeguards, including systems to guarantee timely access to providers, standards of preventive care to be provided, and complaint and grievance procedures. The National Health Law Program's proposed mechanisms for safeguards in the San Diego system (please see **Appendix F** for details) is one model that could be followed.

Recommendation 11: The Governor and the Legislature should modify existing state statutes to encourage the creation and use of prepaid health plans.

Under present law, when a Medi-Cal recipient declines to choose between fee-for-service and a prepaid health plan (where such a choice is available), the "default" mechanism is fee-for-service. Reversing this policy, so that the default is prepaid health plans, would increase enrollment without depriving recipients of freedom of choice.

In addition, current law says that guaranteeing extended Medi-Cal eligibility to recipients in capitated plans can only be offered if it does not increase costs. This restriction should either be lifted or at least modified to allow pilot projects to test the effect of extended eligibility.

Extending eligibility would be an inducement to both providers and recipients. Prepaid health plans usually are not designed to function well when members frequently dis-enroll, so guaranteeing a recipient's eligibility for six months would encourage the plans to seek Medi-Cal business. Recipients would benefit from the extended eligibility, and thus might be enticed to join prepaid health plans.

Recommendation 12: The Governor and the Legislature should direct the Department of Health Services to develop incentives to encourage Medi-Cal recipients to opt for capitated care.

In areas where Medi-Cal recipients have a choice, they frequently only learn about capitated care plans from a harried eligibility worker who may not take time to explain

options fully. The State should make a greater effort to encourage recipients to try capitated plans and should ensure that recipients are given balanced, complete information about their choices.

In addition to capitated care, the State has at its disposal other methods of directly managing the care of Medi-Cal recipients, including primary care case management and targeted case management.

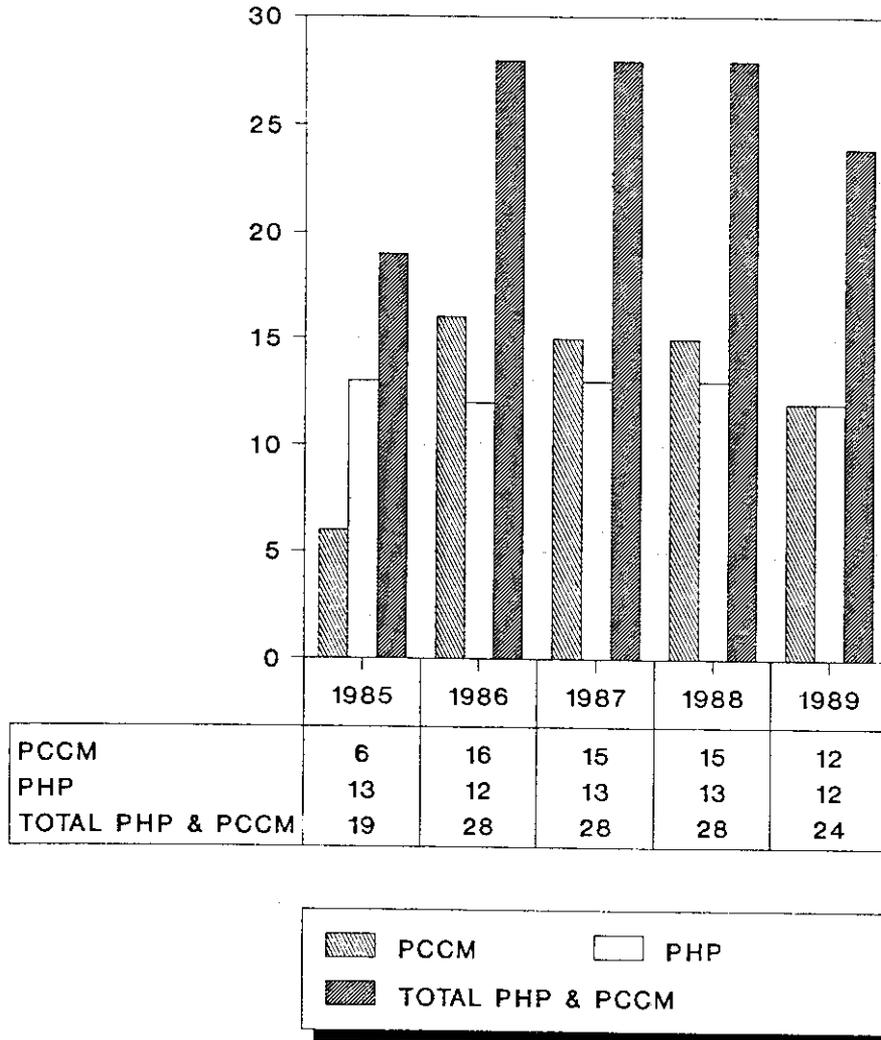
FINDING 6: The State has not maximized the use of case management systems in an effort to improve medical care and lower long-term costs.

One alternative model to prepaid health plans is primary care case management. Under case management, one "gatekeeper" health care provider is in charge of all aspects of a person's medical care, including determining when specialists and hospitalization are needed. Under this system, doctors sign up to provide case management of recipients for a capitated rate that does not include any hospital inpatient treatment. Like prepaid health plans, the concept is to provide better managed care that benefits the recipient and cuts down on state expenses by eliminating over-utilization of services.

Unfortunately, also like prepaid health plans, the number of providers operating under this program is not growing. The chart on the next page shows the number of contractors providing both prepaid health services and primary care case management:

CHART 7

MEDI-CAL PREPAID HEALTH PLAN AND
PRIMARY CARE CASE MANAGEMENT CONTRACTORS 1985-89



Source: Department of Health Services

As Chart 7 indicates, the number of providers of primary care case management declined in 1989 to 12. While some providers left the program, those who remained in it greatly increased the enrollment of Medi-Cal recipients. By the end of 1989, 41,518 recipients were being served by primary care case management programs, compared to 21,927 at the end of 1988.

As an incentive to providers, the State operates a Savings Sharing Program as part of primary care case management. Doctors receive approximately half of the money the State has saved through the program. In 1988, the State reported saving \$3,515,360, or about 24.4 percent

of the expected fee-for-service cost of providing medical care to the same recipients.

**Cases targeted
for savings and
quality care**

In another type of case management, the Department of Health Services is operating a pilot project called Targeted Case Management. The project is designed to lower costs by intensively managing the care for people with acute, complex health problems--such as troubled pregnancies, ill newborns, accident victims and stroke patients--and patients with chronic health problems that require repeated hospitalization. Nationally, 2 percent of the country's population consumes half of all the hospital resources, and high-cost medical care users generally account for 30 to 40 percent of all health care dollars spent. When Medi-Cal statistics were examined, State officials determined that 1 percent of all Medi-Cal recipients use 30 percent of the system's funds, 5 percent use 60 percent of Medi-Cal dollars and 24 percent are responsible for 90 percent of the spending. Targeting these people in a special program is meant to yield substantial savings. In addition, the coordination of medical services for the recipient holds out the promise of improved quality of care in many cases.

Four different capitated plans are participating in the three-year pilot project, which involves about 200 patients whose care is directed by nurse case managers. As the first year of the project is ending, Medi-Cal has been able to gather early examples of substantial savings:

* One man with uncontrolled diabetes, problems from a past stroke, lung disease, lupus and hypertension consistently made use of emergency rooms and clinics on a weekly basis. Once he became part of the targeted program, the care of his health problems was better coordinated. In addition, the nurse in charge of his case enrolled him at a senior citizens' center for daily activities and socialization. His weekly visits for health care dropped off. Annual savings, once the cost of case management was subtracted: \$1,360.

* A woman suffering from major depression, hypothyroidism, arthritis, and a broken hip, as well as recovering from gall bladder surgery, refused to follow medication orders and "inappropriately used" the health care system. In the targeted program, her health problems were better controlled. Annual savings, after case management costs: \$7,470.

* Another woman who was suffering from severe stress, obesity and depression frequently went to emergency rooms and was an abuser of prescription drugs. The

targeted care reduced her medical problems and saved \$2,957 in one year.

* A pregnant woman who had a previous history of delivering a premature baby that required intensive care was taught how to use a home uterine monitor and was followed closely through several early-labor episodes. The baby was carried to term, a direct result of the home uterine monitoring, according to the case manager. The savings, compared to having a premature baby in intensive care, was estimated to be \$74,653.

While the Targeted Case Management program is limited to those with acute, complex illnesses or chronic diseases, case management can also be employed beneficially for routine recipients when it encourages preventive health care. Typically, Medi-Cal recipients are far less likely to seek early treatment, have prenatal care and obtain childhood immunizations than patients in the private sector. The result of this is that Medi-Cal recipients frequently are sicker by the time they seek medical attention and may require higher-cost treatment.

In a letter to the Commission, the American Academy of Pediatrics said that 16 years of "well-child" visits--the routine medical checkups recommended for children at certain ages--and immunizations cost about \$609 for exams, \$157 for immunizations, \$66 for tuberculosis tests, \$63 for urinalysis and \$32 for blood tests. The total, \$927, is far less than what one day in the hospital would cost, not counting X-rays, drugs, laboratory work and any therapy that might be needed. Other health care experts say that \$1 spent on prenatal care can save \$3.38 in emergency and long-term services for ill newborns.

Thus, practical experience as well as common-sense theorizing are proving the value of various forms of case management for improving care and lowering costs.

Recommendation 13: The Governor and the Legislature should direct the Department of Health Services to develop further incentives to encourage providers to become primary care case managers.

More and more doctors today join in independent provider associations (IPAs), preferred provider organizations (PPOs) and other mechanisms for tying providers into pools of patients. Although Medi-Cal fees for primary care case management may not be enticing enough on their own to encourage doctor participation, the Department of Health Services already provides one incentive by giving the providers half of the money saved through the use of case

management. In addition, the Department could explore the feasibility of the State granting providers tax credits to cover some or all of the difference between the fees they normally would receive and their capitated Medi-Cal payments.

Recommendation 14: The Department of Health Services should expand its Targeted Case Management Project as rapidly as possible.

With the early data cited above showing such promising results, Medi-Cal should move ahead and encourage all capitated care plans to set up Targeted Case Management units for patients who need complex, acute care or who are "revolving-door" users of hospitals. In addition, a method for bringing the benefits of targeted case management to the fee-for-service arena should be developed. This might involve a special unit of nurse case managers reviewing Treatment Authorization Request files (the documentation of requests for prior approval of medical services) or paid-claims history records to pinpoint patients who could best benefit from management and then managing the cases by directing fee-for-service activities.

Recommendation 15: The Department of Health Services should design a system of incentives, both for recipients and providers, that would increase the likelihood that patients would receive preventive care.

The State should review its reimbursement policies with the goal of encouraging the providers to deliver preventive care. At the same time, it should design incentives to encourage recipients to seek out prenatal care and immunizations. Although the Commission heard many tales of people not being able to obtain Medi-Cal services, it was also noted in the course of the study that a major complaint of providers is that many Medi-Cal recipients fail to keep appointments and do not come in for health care when they are advised to. One Sierra Foundation-sponsored program in the Sacramento area has encouraged Medi-Cal women to keep appointments for prenatal and postpartum care by giving cash grants at each appointment, or free baby gifts.

**Managing care
also means
controlling costs**

The above concepts address managed care from the perspective of delivering health care to recipients. Turning to the second way of managing care--controlling costs--the Commission has reviewed Medi-Cal's prior authorization procedures, and also the system's use of modern computerized techniques to spot abuses and misuses of the program.

FINDING 7: The State has failed to avail itself fully of the latest computer capabilities and statistical analysis methods to ensure efficient operation of Medi-Cal.

The State has set up an extensive system to grant prior authorization for medical care, known as Treatment Authorization Requests (TARs), to control costs and usage. In addition, the State makes some limited use of data from hospital discharge records throughout the State to determine if patterns of Medi-Cal care are different from care paid for through private sources. Both methods are in common use in the private health care industry. But neither of these steps have been taken in such a way as to maximize the benefits of the technology involved.

Between 30 and 50 percent of all Medi-Cal care requires a provider to obtain a TAR. TARs are required for all surgery, all long-term care admittance, all hospital inpatient stays, some office procedures, durable medical equipment, non-emergency medical transportation and medication not on the State's list of allowed drugs. In addition, optional medical services offered by Medi-Cal require TARs: services by psychiatrists, podiatrists, acupuncturists and chiropractors. Also, once a recipient has used his two monthly stickers for medical services, any additional service requires a TAR.

The process begins when a provider mails a TAR document to one of 12 field offices. (Hospital and long-term care TARs are usually processed on-site by permanent or traveling Medi-Cal staff, depending on the size of the facility. Pharmaceutical TARs can be obtained by phone, except for refills of prescriptions, which must be submitted by mail.) The document identifies the recipient and the provider, describes the medical problem and lists the procedure for which approval is being sought. In field offices that have been automated--the last ones were to be on line by the end of 1990--the information is entered into computers and edited for errors. A medical consultant then reviews the file, using his access to the recipient's profile and previous medical history to help him assess the request.

The consultant is supposed to determine if the requested procedure is a benefit covered by Medi-Cal, if it is medically appropriate, if it is supported by adequate medical information and if it represents the most reasonable and lowest cost alternative. His decision is then entered into the computer and a notice is mailed to the provider. After the procedure is completed, the provider enters the TAR authorization number on the claim for reimbursement. When the claim is processed (a procedure discussed in the next

section of this report), it will be denied for payment unless an authorizing TAR is on file in the computer system.

TARs that are denied can be appealed, at an informal level by phone with the medical consultant or formally in writing to the Department of Health Services.

TARs drive providers away from Medi-Cal

TARs and the way they are used by Medi-Cal are a particular bone of contention between providers and the State. In fact, TARs battle with low rates and complex reimbursement procedures for the honor of being the worst aggravation that is driving providers out of the Medi-Cal system. Providers see the use of TARs as a pure cost-containment effort by the State, with no benefit in terms of the quality or appropriateness of care provided. They say that the TAR process is time-consuming and frequently serves as nothing more than a hindrance meant to discourage providers from performing medical procedures, regardless of the need.

Medi-Cal is not the only system that has been accused of placing procedural stumbling blocks in the way of medical care. In an article entitled "Health Care Rationing Through Inconvenience," the author writes:²⁰

"Many strategies for the containment of medical costs have emerged from systems of managed care--gatekeeping by a primary care physician, prior authorization and utilization review, assumption of financial risk through capitation payments to the provider with financial disincentives for hospitalization or referral to specialists, and so forth. But another feature has crept into the managed care formula and has been largely overlooked: that of slowing and controlling the use of services and payment for services by impeding, inconveniencing and confusing providers and consumers alike."

"In managed care's arsenal of cost-control weaponry, probably none is more potent--except for restricting hospital admission--than superseding the physician's autonomy by a managerial-review process in which armies of claims clerks, administrators, auditors, form processors, peer reviewers, functionaries and technocrats of every

20. "Health Care Rationing Through Inconvenience: The Third Party's Secret Weapon," Gerald W. Grumet, M.D., *The New England Journal of Medicine*, August 31, 1989.

description insinuate themselves into a complex system that authorizes, delivers and pays for medical service."

"Paradoxically, the savings that ordinarily accrue to an efficiently managed business are reversed in the case of insurance carriers, whose bungling, confusion and delay impede the outflow of funds. For carriers, inefficiency is profitable."

The author goes on to note that government programs such as Medicaid and Medicare are particularly prone to such methods, including reams of paperwork and the use of obscure codes, acronyms and terminology. The exchange of information to gain authorization can take weeks rather than the minutes that could be involved if systems were streamlined. And when the authorization arrives it usually carries disclaimers saying that payment is not guaranteed; authorization only means that the procedure is medically indicated, but the recipient may not be eligible at that time or be covered for that benefit.

The State, however, defends its use of TARs, likening them to a second medical opinion that assures procedures are warranted. In 1989, Medi-Cal received 1,325,747 TARs, approved 895,253 or 67.95 percent, modified 155,135 or 11.77 percent and denied 67,087 or 5.09 percent. Another 200,089 or 15.19 percent were returned to the provider, bringing the effective denial rate to 20.28 percent. These TARs were processed by a staff of 488 people, 323 of them professional or technical employees, 149 clerical or support staff and 16 administrators. Medi-Cal has determined that the system, which costs \$22 million to operate, saved \$110 million in denied services, a figure that probably would grow substantially if there were a way of calculating services that were not provided because of the deterrent effect of the TAR system.

The deterrent effect is very real. One Medi-Cal recipient told the Little Hoover Commission that she encountered doctors who were unwilling to submit treatment plans to the TAR procedure even though they felt treatment was medically necessary. She said this unwillingness places the recipient in a bind: With no denial on record, the recipient has nothing to appeal to Medi-Cal. She also said she has found that when physicians do submit a TAR and it is denied, they often are unwilling to go through the extensive, time-consuming process of appealing the denial. The recipient has no way of fighting the system except through a provider.

**Providers have
litany of TAR
horror stories**

There are providers who work within the TAR system but feel stymied by what they believe are its inadequacies. The Commission received the following examples of TAR problems from a variety of sources:

* A Penn Valley respiratory care practitioner told the Commission that when he has been asked to perform pneumography (sleep study trend analysis) on newborns afflicted with apnea (problems with breathing), his requests to perform the service in the child's home have been refused authorization even though it would cost about one-third less than the same test performed in a hospital. "Subsequently, the child has had to go to the hospital for the same test. I have then been called by the hospital and requested to perform the test in the hospital. Needless to say, the overnight or two-day hospital stay and test is quite a bit more expensive..."

* A Vallejo allergist complained that medicines that are required by current medical practices for the treatment of asthma are not on Medi-Cal's list of approved drugs. But seeking TAR approval for each prescription has proven unsatisfactory. "It is virtually impossible to get through on the 800 number, and when you do you get some incredible clerk, who barely speaks English, for whom everything must be spelled out. This takes at least 15 minutes for one patient. I simply do not have the time."

* A dermatologist wrote that almost all care other than a simple office visit requires a TAR. "The payment rates on Medi-Cal are so low as to make it completely uneconomic to ever attempt to obtain a TAR for any care of skin diseases. Even the treatment of pre-cancerous and malignant lesions requires special permission. ... Our office simply provides the appropriate care and simply bills Medi-Cal for an office visit. My personal time, my staff's time and the delays inherent in attempting to obtain TARs make it too costly for us to attempt to take that route as opposed to just giving away the care."

* A Carmichael obstetrician said Medi-Cal patients who are RH negative and, thus, who are in danger of delivering seriously ill babies, are blocked from taking antenatal Rhogam between 28 and 30 weeks of gestation, the standard medical practice for RH negative pregnancy. Pharmacies will not fill the prescription because they refuse to go through the TAR process and the drug is not on the main Medi-Cal list of approved drugs.

* The American College of Obstetricians and Gynecologists say the rigid TAR process is not accommodating of the vagaries of the birthing process.

TARs have to be obtained for any time beyond two days in the hospital. Since the clock starts running when the patient enters the hospital, a patient with a long and arduous labor in excess of 24 hours may not have any time to recuperate under medical supervision before being sent home.

* Pediatricians have pointed out that Medi-Cal refuses to pay for home phototherapy for babies with jaundice, even though this treatment is a standard practice today and is cheaper than keeping a baby in the hospital for treatment.

* A doctor felt he could treat a patient's broken leg with an ankle splint that would have cost \$25 or \$30. But he was refused a TAR since ankle splints are not covered by Medi-Cal. A walking cast, office visits and a walker were covered, however, so the case ended up costing Medi-Cal three office visits at \$17 each, \$60 for the application of a cast and \$20 for materials, more than three times as costly as the treatment recommended by the doctor.

* A Clovis obstetrician complained that he could not get reimbursement for the full \$132 cost of ParaGard IUDs even though the four-year protection afforded is "a great bargain when compared to the cost of oral contraceptives and when compared to the cost of a pregnancy and more people on the Medi-Cal program due to these pregnancies." He said that when he appealed the low reimbursement of \$84, that amount was taken back by Medi-Cal, but no larger amount was ever issued.

* TARs are denied for home uterine monitoring for women with histories of premature labor because it is not a covered benefit. But studies have shown that the monitoring is effective in helping women carry babies to term because they are able to recognize early labor symptoms much earlier, enter a hospital and be treated to halt the labor. These studies have indicated that thousands of dollars can be saved in avoided neonatal intensive care.

* A Santa Rosa pediatrician said the TAR process discourages doctors from using more effective and appropriate drugs. For instance, when amoxicillin first came out it was more expensive than ampicillin as an antibiotic for treating ear infections, so even though it had fewer side effects and better compliance requirements (it only had to be taken three times a day instead of four), it was not placed on the list of approved drugs. But after the price of amoxicillin dropped below that of ampicillin, it still took another 10 years for Medi-Cal to add it to the list of drugs. An ophthalmologist echoed the same problem, saying that glaucoma drugs have to be prescribed separately to avoid

TARs because cheaper, combination drops have not been placed on the approved list.

* A nursing home whose billing personnel failed to file for a TAR renewal on the anniversary date of a recipient was denied payment for the entire month, losing \$1,675.

* A Long Beach doctor said that delays in securing permission to perform surgery for lung cancer threatened the health of two of his patients. In one case, the delay--from August 21, 1989 when the TAR was requested until September 15, 1989 when it was approved--could not be shown to have caused added problems, although the potential for harm existed. But a TAR was requested on December 13, 1989 for the second case and approval was not received until January 15, 1990. "Repeat X-ray then showed pleural effusion. Thoracentesis showed malignant cells, so she was deemed inoperable. The one-month delay is felt to have jeopardized any possible chance of cure by surgical resection."

* A family practitioner in Ukiah maintains that TAR approvals are not handled uniformly around the State. He cited an example of a patient who was able to receive TAR-required drugs through a university medical center but when he prescribed the same drugs, approval was denied. He said the denial led to two hospitalizations for the patient, which cost about \$20,000 compared to the \$120 cost of the drugs.

* A 1989 survey by the California Association of Medical Product Suppliers of its members found that TARs were processed in 11 to 41 days, with an average time of 27 days (the State's figures show an average of just over five days). Common problems cited were inconsistencies between various field offices on whether approvals were given for the same types of requests; busy phone lines; and requests for additional information three and four times rather than all at once.

Providers also complain that the consultants reviewing the requests are not usually trained in specialties that the services involve and do not keep up with medical standards of practice. A dermatologist's request, for instance, may be handled by someone who has a general practitioner background. State officials, however, say monthly meetings are held to keep consultants current on standards and to try to ensure uniformity of TAR handling. They add that now that the TAR process is computerized, Medi-Cal will be able to break down, by consultant, procedures that are approved and denied. This information

can be used to reduce error rates and encourage more uniform performances on the part of all consultants.

**TARs could
be put to
better use**

Computer analysis of the TAR records, as well as paid-claims history records, also could be an effective tool to spot patterns of abuse and misuse of the Medi-Cal system. The largest fraud discovered in recent times, however, was not uncovered with the help of the TAR system. Instead, it was anonymous tipsters that led to the discovery early in 1990 that over the past several years more than \$200 million had been paid for fraudulent claims for diapers, rubber bedsheets and other supplies that were never delivered or used. Computer analysis of trends might have spotted this fraud sooner.

Other computer and statistical analysis methods are available for reviewing patterns within health care systems. Medi-Cal has purchased information gleaned from hospital discharge records in the State, known as Small Area Analysis data. But officials say they have not had adequate resources, in staff and time, to make the best use of these records and other methods of identifying disturbing trends.

When they have been able to use the data, even on a limited basis, it has shown its potential for saving money and improving care. In one instance, a review of data showed that Medi-Cal pays 50 percent of the pediatric hospital bills in the State, but covers less than 50 percent of the children. One situation that was occurring was that Medi-Cal was paying to admit children to hospitals for pneumonia much more frequently than private payors were. Closer examination of the problem showed that doctors were reluctant to send these children home where they felt the parents would not follow directions or where living conditions were poor. The State set up a pilot program that sent public health nurses into the homes daily. The result was a substantial cost savings because hospital admissions for this diagnosis dropped, and also better, less frightening care for the children.

The importance of statistical review has been recognized at the federal level. The Inspector General for the federal Health and Human Services Agency recently offered states a computer program to help identify suspicious patterns of prescribing and purchasing of commonly abused drugs.²¹ The program was developed after Medicaid officials realized that \$525 million in Medicaid funds were spent on drugs that are favorites of street pushers--demerol, valium and others. They ran a test of the program in the

21. "Better Medicaid controls on prescription drugs urged," Sacramento Union, June 23, 1990.

Washington, D.C. area and found 682 recipients, 50 doctors and 39 pharmacists who were using more than the usual amount of abusable drugs. One patient identified by the program received 18 percent of all the demerol prescribed to Medicaid patients in that area in 1988. Another patient had 111 prescriptions in one year, all of them abusable drugs. Providing such a computer tool to all the states could put a halt to misuses of these drugs, the federal government believes.

Similarly, the use of computerized and statistical studies to determine what is actually going on within Medi-Cal would be an invaluable management tool. The State, however, has not poured enough resources into making use of the data it has in hand, such as paid-claims history records. In addition, the State has used its prior authorization system--the TARs--in a heavy-handed, cumbersome way that has not provided meaningful oversight but instead has become an irritating barrier that discourages provider participation in Medi-Cal.

Recommendation 16: The Governor and the Legislature should direct the Department of Health Services to eliminate from the TAR process procedures that are routinely authorized.

In private industry, prior authorization and utilization review mechanisms are selective, focusing on procedures most likely to be abused, or expensive or unusual procedures. Such selective review makes economic sense. There appears to be little value in requiring a TAR for a procedure that is routinely approved; if hernia operations, for instance, are always approved there is little sense in requiring prior approval. The Department of Health Service should study the TAR records from several years and remove procedures from the TAR process that have a high rate of approval, perhaps 85 percent and above. This would allow routine medical care to be provided without imposing extra delays on the recipients and extra paperwork on providers.

Recommendation 17: The Governor and the Legislature should require the Department of Health Services to refine its TAR system to target only problem providers, problem locations and problem diagnoses and procedures.

Medi-Cal has a duty to keep taxpayers from footing the bill for fraud and abuse, and a prior authorization procedure is one mechanism that can be used to ensure that. But a system that requires 100 percent review of more than one-third of all Medi-Cal procedures appears to work

more as deterrent to providers, increasing the costs and the bureaucratic "hassle" they face.

Medi-Cal officials have said that new automation in the TAR offices will allow statistical analysis that has not been possible in the past. These records should be used to target unusual amounts of activity by providers, unusual levels of specific procedures or diagnoses and areas of the State where practices appear to be outside the norm. Medi-Cal could then focus its efforts on improving these "hot spots" and allowing most providers to proceed with routine business.

Recommendation 18: The Governor and the Legislature should require the Department of Health Services to analyze paid-claims history data and Small Area Analysis data, as well as any other information, to better discover patterns of use and abuse and to formulate policies to alter those patterns when better efficiency or quality of care can be achieved.

The TAR process is not the only means available to Medi-Cal to study patterns of use and abuse. The State has access to data from outside the system and can also review its paid-claim history files. This kind of information can be used to control the length of stays in hospitals, to pinpoint the necessity for emphasizing alternative treatments and to spot patterns of inappropriate treatment.

To properly manage Medi-Cal, the State needs to know what is going on within the program over the course of time. Investments in statistical studies and computerized techniques may not produce counterbalancing savings in reduced or less expensive treatments in the same year, but it is an important way for Medi-Cal to maximize its efficiency and effectiveness in the long run.

Reimbursement

While providers have long complained that reimbursement rates are too low, anecdotal evidence and surveys point to the billing process itself as a major reason many providers refuse to participate in Medi-Cal. Since a lack of provider participation limits access to medical care for recipients, the reimbursement process plays a key role in the quality of care Medi-Cal is able to deliver.

In general, the reimbursement process is paper-intensive, requiring multi-digit numbers to be meticulously entered on unique, complex forms. Any mistake that causes the bill to be pulled out of the payment process results in a complicated exchange of further information and various levels of appeal pursued under an array of 60- and 90-day deadlines.

Providers maintain the system is needlessly complex and, in fact, is a bureaucratic stumbling block erected by the State to save money by denying and delaying payment of legitimate claims. The State, however, maintains that the bulk of claims are paid promptly and that any problems begin with providers who refuse to treat billing in a businesslike manner.

Over the life of the program, the State has tried different modes of handling reimbursement, including internally, by exclusive contract and by competitively bid contract. The current claims processing contractor (known as the fiscal intermediary) is Electronic Data Systems Corporation (EDS), a worldwide corporation that handles Medicaid programs in 15 other states and other social program data processing needs in 19 California counties. In a competitive bid process, EDS won the contract to handle Medi-Cal claims two years ago, taking over from Computer

Sciences Corporation. The company had been criticized heavily for failing to process claims in a timely manner and perform adequate checks and balances.

Under an enhanced contract that has devoted more state dollars to the claims process, EDS has greatly improved the fiscal intermediary operation. When EDS took over in April 1988, there were 22 days worth of claims that had been submitted but were not yet in the computer system, and there were 1.8 million claim lines that were in suspense (individual items on a claim that had been kicked out of the payment process and were awaiting further action).

Today, EDS typically has fewer than nine days' worth of claims that have yet to be entered in the system and 800,000 claims in suspense. While its contract with the State requires it to handle 90 percent of claims within 25 days of receipt and 99 percent within 85 days, EDS is handling 90 percent in 12 days and 99 percent within 31 days. Under its contract, EDS has made other improvements, including extensive outreach to train providers on billing procedures and a system for phone-in verification of eligibility.

Of the hundreds of complaints the Commission received about the reimbursement process, a significant portion dealt with problems that were built into the system before EDS took over. In some cases, the State and the fiscal intermediary already have moved to improve particularly irksome features of the system, but perceptions on the part of providers have not yet caught up with reality.

For instance, the Commission was told frequently that EDS could not correct obvious, simple errors on claim forms, such as changing a gender code from male to female when the procedure was a hysterectomy and the patient's name was feminine. But EDS now does have that ability, according to state officials. Also, providers protested about denials being impossible to understand without looking up codes in a poorly organized manual the size of a New York City phone book. But for the past two years denials have been explained in English, as well as in code numbers, and the providers' manuals have been updated and streamlined. Another sore point that has since been resolved: Recipients can now be identified by Social Security number, which Medicare and many other health systems use, rather than by a 14-digit number uninterrupted by dashes or spaces that is unique to Medi-Cal.

In fact, of particular note throughout this study was the repeated praise given to EDS by providers even as they complained vehemently about the system that EDS operates.

A letter from a Sacramento dermatologist was typical. While complaining that low reimbursement rates and Medi-Cal's time-consuming procedures are close to convincing him to quit treating Medi-Cal patients, he wrote: "I feel that EDS has been doing an outstanding job compared with any of the intermediaries that I have worked with in the last 13 years while I have been in Sacramento. They are tremendously more efficient, thorough and accurate than any of their predecessors. Their task must be an unmanageable burden."

2.1 million claim lines filed in average week

Indeed, the task that the Medi-Cal fiscal intermediary faces is mammoth. In an average week, about \$112.8 million is paid on more than 2.1 million claim lines to 28,000 providers. The size of the numbers involved is so huge that EDS can maintain sincerely that the majority of claims sail through the system with no complications--and providers can argue just as persuasively that hundreds of thousands of claim lines are snagged in the system every month. Both are correct, as shown by an example of four weeks' billing statistics from January 22 through February 16, 1990 provided by the Department of Health Services. Of the 11,613,822 claim lines that received action:

Approved	8,601,464	74.1%
Denied	1,264,871	10.9%
Suspended	1,747,467	15.0%

During that same four weeks, EDS received 8,636,081 claim lines, 557,575 claims inquiry forms, 389,295 resubmission turnaround documents and 13,003 first-level appeals.

A bare-bones description of EDS' role begins with the arrival of claims, usually containing multiple claim lines. Claims are either submitted on forms that are optically scanned and stored in computer files or they arrive electronically to be fed directly into computers. They are put through an "edit" process to find errors, inconsistencies and missing information. Clean claims are then put through an "audit" process to cross-check history files; this catches discrepancies like a claim for an appendectomy on someone who has already had an appendix removed. Claims that survive both editing and auditing are sent to the State Controller's Office for payment.

But it is the claims that do not make it through this process on the first run through that have resulted in providers' frequently voiced frustration. Medi-Cal officials question the seriousness of access problems related to provider participation since the number of procedures per recipient continues to increase each year. But surveys of

various groups of providers indicate that they are either leaving the Medi-Cal program or limiting the number of Medi-Cal patients they treat in large part because of paperwork problems.

FINDING 8: Claim forms, procedure designations and other processes for submitting bills to Medi-Cal constitute a complex burden for providers.

Modern medical care providers no longer automatically turn to the patient for payment. In addition to billing private patients, providers today bill health insurance companies and government programs, such as Medicare and Medi-Cal, for their services on various forms. But the Medi-Cal claim forms have their own format, require meticulous attention to detail and use numbers and modifiers that are unique in the health care industry. This means that providers spend more time filling out the forms, are more prone to error and have difficulty keeping up with changes.

One of the most frequent suggestions made by providers during the course of this study was that Medi-Cal use a universal claim form or the same form used by Medicare. State officials, however, said Medicare is moving in the direction of adopting the Medi-Cal format. In the meantime, providers are faced with a complicated form that is difficult to read and that requires different information in a format different than other health payors' forms. This requires providers to take extra efforts to train their billing personnel.

Medi-Cal's claims forms are designed to be optically scanned. This means that data must be entered in precise locations because the scanners only look in certain spots for information. The problem this can cause was illustrated by one nursing home whose new computer program entered the code designation for the home just outside of the location-of-service box. An entire month's worth of claims were placed in suspension for lack of a location. The information was on the form, but not where the machinery expected it to be.

Although the forms are processed by scanners, they do include a section where providers may write additional information. But because the claims are read by scanners, rather than humans, no one reads the explanatory notes before a claim is edited and audited. A claim can be placed in suspense even though the information that justifies the validity of the claim is submitted on the form. Although these handwritten notes are supposed to be examined before a suspended claim is either denied or returned for further

information, providers maintain that they frequently must repeat information that has already been provided.

Another opportunity for frequent errors lies in the coding required. Many of the numbers are 14 or 16 digits long, with no spaces or hyphens to aid a human in transcribing them properly. Until recently, Medi-Cal used a special 14-digit number for recipients rather than the 10-digit, hyphenated Social Security number used by Medicare and many other institutions. The switch to allow Social Security numbers has not gone smoothly, according to system users, because some records are still referenced by the 14-digit codes.

In addition, Medi-Cal has 42,000 outpatient procedure codes, including many modifiers (usually two-digit numbers that are added to normal procedure codes) that are used by no other health organizations. Billing personnel, who routinely may use a few dozen codes to describe their procedures when they bill most organizations, find they must remember special additional numbers or look up in manuals special codings when dealing with Medi-Cal. A Mountain View ophthalmologist told the Commission on May 9, 1990 of his problems in this regard when billing for cataract surgery for a woman:

"A Treatment Authorization Request (TAR) was requested on December 6, 1989 and approved on December 11, 1989 for procedure code 66984 (cataract extraction with intraocular lens implant). Medi-Cal was billed on January 22, 1989 for procedure code 66984. On January 29, 1990 we received a Resubmission Turnaround Document requesting a procedure modifier. This was returned to Medi-Cal the same day with a modifier -70 as requested. No one else in the world requires this modifier!"

"On February 16, 1990 the procedure was denied by Medi-Cal because 'code does not match TAR procedure code. A new claim or TAR required.' On March 22, 1990 a claims inquiry form was sent to Medi-Cal explaining the reason for the difference in codes, modifier -70 which was added at their request."

"On April 19, 1990 the same denial was received as on February 16, 1990. That is, denial of procedure because 'code does not match TAR procedure code.'"

"The problem, of course, is that we are caught up in a maze of codes and procedure numbers that must match exactly the programmed status of the Medi-Cal computer. There is no one to talk to and there is no one to give accurate information."

Thus, although the cataract surgery had been approved in advance, the doctor still had not been able to obtain payment when he wrote to the Commission five months after the procedure had taken place.

Providers also have complained about the lack of published reimbursement rate schedules and other information that is not shared with them but affects their ability to be paid. Providers bill their "customary and usual" fees and then receive whatever reduced rate Medi-Cal has allocated for the service described. This provides a bookkeeping headache in that the amount billed is never really expected to be paid and amounts must be written off the providers' books as the Medi-Cal payments come in.

In addition, Medi-Cal has a set of limits that cause claims to be suspended or denied. The American College of Pediatrics says these frequency-of-visits limits (the fourth visit in any one month is not reimbursed and no more than six office visits can be billed in a 90-day period) particularly do not work for their practices since children frequently are ill for several different reasons in the course of a month. They complained that a child might be seen twice in one day: in the morning for asthma and in the afternoon for a broken arm. Or if an asthma patient is monitored closely by daily appointments, it would still be cheaper for the State than if the child were placed in a hospital. The myopic nature of the system is particularly evident when twins are born: Claims for the babies' care are automatically suspended because the system is only set up for single births.

**Red tape on
bills frustrates
providers**

The effect of the problems outlined above can be gauged with surveys that have indicated that providers are pulling out of Medi-Cal or are limiting their participation:

* A 1986 San Francisco Medical Society survey concluded that doctors were reimbursed for only 64 percent of the claims submitted, leading to an average \$51,000 write-off of uncompensated care per doctor annually. While 90 percent of the doctors protested that fees were too low, 71 percent said the paperwork was too burdensome and 66 percent said reimbursement was too slow.

* The American College of Obstetricians and Gynecologists charges that in California four out of 10

obstetrical claims are suspended and 50 percent of the suspended claims are never paid. Because of consent-form requirements, all sterilizations are suspended--and thus slowed in the processing--even when the claim is legitimate. A 1988 nationwide survey by this group shows that 11 percent of those who do not now serve Medicaid patients would do so if the reimbursement process were simplified.

* The Sacramento-El Dorado Medical Society surveyed its membership in the Spring of 1989. Of the 562 physicians who answered the survey, almost 83 percent had Medi-Cal patients, although most limited the number in their practices. The primary complaint, after low reimbursement rate (35.6 percent), was red tape and hassle related to billing (19.7 percent). Of those who did not accept Medi-Cal patients, the most often cited reason after low rates (25.8 percent) was not wanting to go through red tape and hassle related to billing (16.1 percent).

* The California portion of a 13-state survey entitled "Pediatrician Participation in Medicaid: 1978 to 1989"²² showed that 85 percent of the pediatricians surveyed took Medi-Cal patients in 1978, but that the figure dropped to 77 percent in 1989, and 39.4 percent restricted the numbers of Medi-Cal patients in their practice. For the same 11-year period, the survey showed pediatricians reporting a 90 percent increase in claims returned, a 10 percent increase in the time needed to fill out forms and an 8.3 percent increase in claims processing time.

* An April 1990 Orange County survey showed only 35 percent of the county's obstetricians serving Medi-Cal patients. The worst problems in the order cited: denial of reimbursement for services already rendered, low rates, excessive paperwork, delays of payment, liability and program regulations.

* A Fresno-Madera Medical Society survey from March 1990 showed that claims processing was a major issue for 51 percent of those answering, with a special emphasis on suspense problems. "The hassle factor" was named as the number one deterrent to Medi-Cal participation, followed by low fees and the cost of billing.

More informal methods of measuring dissatisfaction with Medi-Cal's reimbursement process yielded the same results. At a forum sponsored by the California Medical Association in San Francisco in March 1990, one doctor complained that if the State makes a mistake--whether in the processing of the claim, in the prior approval process or in

22. "Pediatrician Participation in Medicaid: 1978 to 1989," *Pediatrics* Volume 85, No. 4, April 1990.

eligibility procedures--it is the doctor who has to resubmit forms and complete appeals paperwork. The State saves money through delays, and the incompetence of bureaucrats is thus rewarded, he said. He described a case in which a 48-year-old needed a measles immunization. The computer, programmed to believe that such immunizations are only for children, kicked it out and labeled it as a bill that should be submitted to the Child Health and Disability Prevention program. Two phone calls, three letters and documentation one-eighth of an inch thick still yielded the same result: Bill the Child Health and Disability Prevention program. The doctor maintained that the process was not worth the \$30 bill involved, either for him or for Medi-Cal. Other doctors at the same forum described the Medi-Cal program as punitive, designed to treat everyone like cheaters, abusive, adversarial and demeaning.

In a December 1989 letter forwarded to the Little Hoover Commission, a Cerritos pediatrician said he would no longer be accepting Medi-Cal newborns. "We are receiving many more denials of payment for our Medi-Cal services, with the only recourse being a lengthy burdensome appeals process that is not worth the reimbursement that might be obtained."

A July 1989 letter from a Tarzana ophthalmologist also recounts a decision to leave the Medi-Cal program:

"When Medi-Cal now takes one year or longer to pay, it is no longer acceptable. When Medi-Cal constantly sends me notices of suspends on my claims and then eventually denies the claim for payment, it is no longer acceptable. When Medi-Cal denies payment for lack of a proper number in some blank on a form or denies on subsequent enquiries when all numbers and blanks are properly filled out and all paperwork is properly documented, it is no longer acceptable. When Medi-Cal wastes money by sending sheets of pending claims on suspends and a check for 28 cents, it is no longer acceptable. When Medi-Cal changes my billing codes to something lower and now pays me \$14.75 for an office visit when my private patients are paying \$55 and when Medicare pays me \$35 for the same service, it is no longer acceptable. It costs me money to see somebody for \$14.75 even without doing all the paperwork and waiting six to 12 months for the payment."

Similar complaints and comments were relayed to the Commission in enough bulk to warrant the conclusion that the reimbursement process discourages provider participation.

The State, while maintaining that careful compliance with the claims procedures is the best answer for providers who want bills paid quickly, has acknowledged the burden imposed by the picky system. Medi-Cal officials have discussed setting up pilot projects to handle billing on behalf of small providers, either in rural and inner-city settings where participation in Medi-Cal needs to be encouraged or in targeted specialties for which there are too few providers. The intent would be to entice providers into the system by having the State, rather than the fiscal intermediary, handle their billing in the short term, with special training programs so that the billing could revert to normal in the long run.

**Electronic
billing smooths
the process**

Another solution is the eventual phasing out of paper forms. The optical scanning system, which has been given up by many industries outside health care because of its error-prone nature, was in place when EDS became the fiscal intermediary. While there are no plans to scrap the system, the State and EDS are working to encourage providers to bill electronically instead. During a six-month period ending in mid-1990, electronic claim filing rose from 46 percent to 50 percent of all claims submitted. The State, EDS and providers agree that electronic billings sail more smoothly through the system and are less subject to human error, either on the part of the providers or EDS. Under legislation enacted in 1989, the State and EDS are to develop software by January 1991 to market to providers to encourage the use of electronic billing and to ensure the availability of programming tailored to meet Medi-Cal's requirements.

Until electronic billing is universal, providers will be faced with the demanding system already in place when they take the first steps of submitting a claim. The system is more than just an irritating headache: The American College of Obstetricians and Gynecologists reports that it costs providers \$8 to file most insurance claims, but almost double that--\$15--to file a claim with Medi-Cal. While some of this extra cost may always exist because of Medi-Cal's exacting auditing standards, there are short-term steps that would improve the front-end of the reimbursement process.

Recommendation 19: The Governor and the Legislature should enact legislation requiring the Department of Health Services to modify the Medi-Cal claim form to mirror other types of health care provider claim forms.

While a universal claim form may not be achievable because of Medi-Cal's present need to have claims optically scanned, the format of information requested can be modified to more closely match other commonly used forms. This would reduce human error and decrease the clerical time needed to complete the forms.

Recommendation 20: The Governor and the Legislature should enact legislation requiring the Department of Health Services to adopt Medicare procedure codes and to drop the use of special modifier codes.

The Department of Health Services should determine alternative methods for gathering the information now gleaned through the use of special modifier codes if such information is needed for quality or utilization control. In cases in which these special codes have been instituted over the years to respond to legislative mandates to compile studies or document trends, the Department should review the current need for such information and seek legislative relief from any mandates that are no longer useful.

Recommendation 21: The Governor and the Legislature should direct the Department of Health Services to publish reimbursement rate schedules and inform providers of limits and other criteria used in denying and suspending claims.

Providers have a right to know what reimbursement rates the State is using. They also would have a better chance of conforming to the State's ideals of service if they were apprised in advance about limits on office visits and other automatic criteria for placing bills in suspense or denying them.

Recommendation 22: The Governor and the Legislature should create a claims-reimbursement pilot project fund.

The Department of Health Services would use the pilot project funds to set up experimental billing services for small providers in under-served geographical locations or in specialties for which there is low provider participation. The Department also would use the funds to begin a low-interest loan program to help small and/or non-profit providers purchase the hardware and software necessary for electronic billing. In addition, the funds could be used for any other creative attempt to ease the claims reimbursement process.

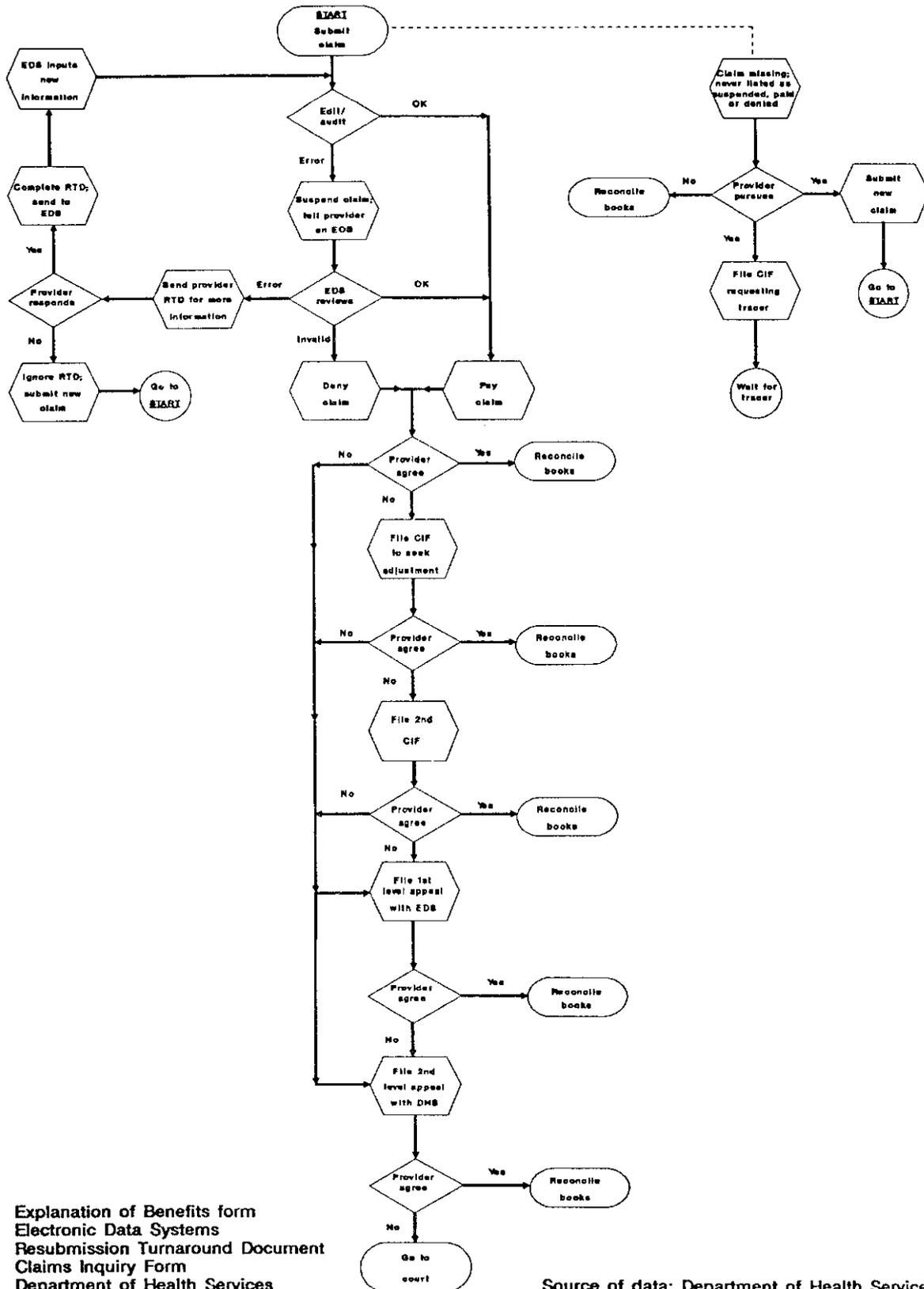
FINDING 9: The process for addressing suspended claims and denials is complicated and frequently unresponsive to providers.

Once a claim has been kicked out of the editing and auditing process and placed in suspense, the provider who wants to pursue reimbursement enters a no-man's land of acronyms and rigidly clocked timelines. Many providers have indicated to the Little Hoover Commission that the procedural hoops to be jumped through require so much time and effort by billing personnel that the cost of pursuing suspended claims frequently is greater than the bill involved. The State has modified some troublesome procedures since EDS became the fiscal intermediary two years ago, but overall Medi-Cal officials maintain the system is responsive.

The chart on the next page tracks the path of a submitted claim:

CHART 8

MEDI-CAL PROCEDURES TO OBTAIN REIMBURSEMENT



- EOB - Explanation of Benefits form
- EDS - Electronic Data Systems
- RTD - Resubmission Turnaround Document
- CIF - Claims Inquiry Form
- DHS - Department of Health Services

Source of data: Department of Health Services

As Chart 8 on the previous page shows, when a claim is received by EDS it is put through an editing and auditing process. If the claim clears this process, it is paid. If an error is found by the computer, the claim is placed in suspense for evaluation by EDS and the provider is notified on his Explanation of Benefits (EOB) form (the form that serves to explain the status of all claims and that is accompanied by a reimbursement check) that the claim is in suspense. Despite the fact that the EOB may not tell the provider what has caused the claim to be suspended, he should not submit a Claims Inquiry Form (CIF) to find out what the problem is. Instead, he should wait until the claim has been adjudicated within the EDS system and he has been notified on some future EOB that it has been paid or denied.

EDS reviews the suspended claim. If the problem can be cleared up by EDS or if the claim was rejected for incorrect reasons, EDS can order it to be paid. If the claim is found to be invalid based on the computer rejection and EDS' review, then the claim is denied.

If EDS needs more information, the provider is sent a Resubmission Turnaround Document (RTD) to respond to questions about a claim that has been placed in suspense. The RTD will list all the errors the computer has found on the claim. The provider may ignore the RTD and submit a new claim. But if he chooses to respond to the RTD, he has 60 days to complete the form. When the newly submitted information is placed in the claim and it is edited again, other errors may be generated. For instance, the original claim may have a medical procedure number that does not require a Treatment Authorization Request (TAR) clearance, but is an incorrect procedure number. Once that is fixed, the editing process the second time around may then determine that a TAR number is required. This may generate another RTD to the provider. If a second, and final, RTD is sent to the provider on the same claim, he has 30 days to respond.

As the middle of the chart indicates, if a claim is either denied or paid and the provider disagrees with the action taken, he can begin an appeals process. If the payment is either under or over what he believes he is due or if he feels it has been denied incorrectly, he requests an adjustment by filing a Claims Inquiry Form (CIF) within 60 days of receiving his EOB. If that does not produce the desired response, he has 60 days from the date of the original CIF to file another CIF. If EDS's response still leaves him unsatisfied, a first-level of appeal must be filed with EDS within 90 days of whatever action has prompted the appeal (denial of the claim or a negative response to a

CIF). If EDS still denies the claim, a second-level appeal may be filed with the Department of Health Services within 90 days. If the second-level appeal is denied, the provider has one year within which to file a claim in court. At any time, the provider may skip the CIF process and directly file a first-level or second-level appeal.

The right side of the chart addresses the lost claim. Claims that never show up on EOBs can be traced with a CIF or new claims may be submitted. This part of the process was particularly thorny until July 1, 1990. Prior to that date, providers had only 60 days from the date of service to bill Medi-Cal. Without being aware that a claim was lost, a provider might still be waiting for a claim to show up on his EOB as suspended, denied or paid when the 60 days expired. He then would be unable to submit a new claim.

To get around this problem, some providers routinely began sending tracer CIFs on all claims that had not shown up on EOBs by the end of 45 days. Others routinely submitted new claims at the end of 45 days without waiting to learn what had happened to the originals. Both of these actions, taken as defensive measures by providers, served to clog up a system that already handles massive numbers of submissions. In fact, state officials said that some providers were warned to desist when it was discovered that their computers were programmed to automatically crank out repeated claims regardless of the status of the original claim.

Since July 1, 1990, however, providers have had six months from the last day of the month of service to bill Medi-Cal. State officials say they are encouraging providers to wait a full 60 days to see if a claim is noted on an EOB. If it is not, they then should file a new claim rather than bothering with a CIF.

All of the provider's 60-day and 90-day deadlines for filings are mirrored by 60-day deadlines for EDS or the State to respond. A particularly contentious claim, if fought through every level and delayed the longest amount at each level, would take 14 months from the time it is denied until a provider might turn to the courts.

**Even "winning"
may not mean
fee will be paid**

But that is not the worst possible scenario: Presume that a claim has been fought all the way to the second level of appeal and the State determines an error has been made. The denial is lifted, but that does not mean the claim will necessarily be paid. A claim may have been denied for several reasons, but the provider is only informed of one, based on a hierarchy of reasons set up by the State. Medi-Cal officials say it would be very expensive to list all reasons

for claim denials because of the limited room on the EOB. But the practical effect is that a claim may be protested up to the highest level, the provider may be vindicated--and then the claim may be denied for an unrelated, lower-level reason that has been lurking there from the beginning, unbeknownst to the provider. A particularly determined provider may, at that point, begin the CIF and appeals process again to address the new reason for denial. In theory, this process could continue as many times as there are different reasons for denial.

The State estimates that about 50 percent of denials are reversed and they point out that there are relatively few appeals filed. The following figures, supplied by EDS, show first-level appeal activities for January 1990:

12,608 on hand at beginning of month
13,454 new appeals received
12,788 processed
13,274 on hand at end of month

During January 1990, the State received 1,105 second-level appeals to add to the 3,404 it had on hand at the end of December 1989. Compared to the millions of claim lines filed each month, this small number of claims fought to the bitter end is small. But providers maintain that the level of activity does not indicate overall satisfaction with billing outcomes; the reason the appeals process is not used more frequently is that it is too time-consuming and costly. Providers say they are particularly irritated when an office visit is downgraded automatically from an intensive level to an intermediate or brief visit; the difference in fee is enough to make them feel nit-picked, but not enough to justify the expense of fighting for an adjustment.

Even the early steps of trying to pry a claim off the suspense file are burdensome. When a provider tries to correct a claim, all original documentation must be resubmitted, including a copy of the Explanation of Benefits form showing the claim has been suspended. Because this oversize document does not fit many copying machines, one Medi-Cal critic has contended that providers need to be experts at the Japanese art of origami to submit new documentation by folding and manipulating the originals to allow for copying. This is a particularly irksome requirement for providers since they have been told repeatedly that EDS keeps all original documentation on file and on microfiche where it supposedly can be accessed by computer.

To get around these requirements, many providers ignore Resubmission Turnaround Documents (only about 40 percent are ever returned to EDS) and Claims Inquiry Forms

and merely submit a new claim. Meanwhile, the old claim remains withering in the suspense file for 60 days, until it dies automatically.

**"Chess game"
tests providers
endurance**

The system, even when successfully negotiated, leaves providers disheartened. Writing about the lack of desire to participate in Medi-Cal, the president of the Northern California Psychiatric Society, recently said:²³

"One gets the feeling that one is involved in an elaborate chess game, where the goal is one of out-maneuvering a highly skillful opponent. All of the rules of this game are on the table but are voluminous in content. There are three separate and distinct appeals that you must file for a denied claim. The odds are against your managing to remember and to appropriately apply each and every one of them to each and every unpaid claim. Sooner or later, something slips through the cracks."

The Little Hoover Commission received dozens of examples of billing frustrations from providers. Reciting at least some of them serves not only to illustrate the various types of pitfalls but also to demonstrate that the complaints are not just a few isolated incidents.

* One San Francisco psychiatrist described his experience in attempting to collect payment for four one-half hour hospital visits:

"I submitted my bill at the end of May 1989. I received a denial code 347, indicating that the place of service was not indicated. I had, in fact, indicated the place of service with the appropriate numbers. Nevertheless, I sent out inquiries and corrections on July 10 and July 21, 1989. On July 23, 1989 I received a note that action was being taken and the claim was in suspense. On September 8, 1989 I received a note that my claim was again in suspense. I re-inquired on October 3, 1989. At that time, I was asked to submit all the original materials, including the claim, the Medi-Cal Explanation of Benefits and prior inquiries."

23. "A Medi-Cal Practice, Part One: The Economic Realities," The Northern California Psychiatric Physician, April 1990.

"On October 18, 1989 I received another note that my claim was again in process. On December 18, 1989 I received a request to resubmit the claim. And finally, on May 17 of 1990, I received a denial coded 382, 'This claim was received after the six-month billing limitation.' This claim, by the way, which covered four visits at about \$24 per visit, would have earned me less than the amount of time that I spent attempting to receive reimbursement."

* An El Camino ophthalmologist wrote in April 1990 that he hoped in the near future there would be a resolution of claims for service (cataract surgery on both eyes of a patient) from January 1987. He detailed dates of communications with and inquiries to Medi-Cal in a two-and-a-half-page letter, along with 24 pieces of documentation. Midway through his tribulations, EDS took over the claims reimbursement function and the ophthalmologist began seeking advice from a series of EDS employees. At one point, the claims became entangled with that of another recipient who was unknown to the doctor. Finally, he submitted a second-level appeal after failing in his 14 separate attempts, in writing and by phone, to have the matter resolved.

* From a Santa Rosa OB-Gyn practice: "Numbers are changed from what we send in on our original billings and when we send CIFs to correct their information, it is a total waste of time because they ignore what we tell them. They never acknowledge their mistakes....The time I spend copying and rebilling and typing CIFs is ridiculous. Some of the files I have are a quarter of an inch thick and each time you get a denial, all of that paper garbage has to be recopied."

The same practice complained that a Cesarean section delivery was billed for \$480.64 but that EDS added an "80" modifier, which converted a primary surgeon fee to an assistant surgeon fee. The reimbursement was for \$96.13, which the doctors planned to appeal. "We have now had to handle this claim on four separate occasions, paying for all of the time and expense of my office people, plus the cost of photocopying plus the cost of postage in order to obtain a fraction of what the patient's care is worth."

* A Salinas pediatrician who said he is taking no new Medi-Cal patients wrote that out of every 100 bills he sends Medi-Cal, only 55 are paid within a month. "The other 45 are put into suspense and we have to trace these. It may take us up to a year to collect our suspended claims."

* A doctor's letter to the editor in the Sacramento Bee told about his inability to get payment for treating a serious fractured arm for three months. He billed Medi-Cal \$672.50, but the bill was denied because "another doctor has already been paid"--in this case, the emergency room physician at the hospital who had the arm X-rayed and applied a temporary splint before referring the child to the doctor for treatment. "I hope the Medi-Cal system powers-that-be take another look at situations like this and apply a bit of common sense. I probably have saved the State in the neighborhood of \$2,000 to \$3,000 simply by treating the patient in my office. I find it very difficult to accept this type and level of behavior from Medi-Cal."

* A La Mesa pediatrician spent more than a year trying to collect \$300 for caring for a baby born nine weeks prematurely. Despite winning a second-level appeal, his claim continued to be denied because computers showed it had already been paid. The "payment" was the original \$41 he had received, which had been taken back by EDS when he filed a complaint that the amount was too low.

Providers report that the normally complex system becomes almost byzantine when other outside systems are involved. Cross-over claims are those in which the patients are eligible for both Medicare and Medi-Cal. Medicare must be billed first and then Medi-Cal may or may not pay any shortfall. And the computer automatically kicks out claims for those over 65 to be checked with Medicare even when the patients involved are resident aliens or others not eligible for Medicare. Providers also noted that bills sometimes are "ping-ponged" between Medi-Cal and California Children's Service when ill children are treated for something other than the main disease that makes them eligible for the special children's program.

**Complex system
is a stumbling
block to access**

The State maintains the claims suspense and appeal system is structured to protect due-process rights and to keep a tight rein on errors and fraud at the same time. But the complexity of the system is a disincentive for providers to participate in Medi-Cal and, therefore, serves as a barrier to access for recipients.

Recommendation 23: The Governor and the Legislature should direct the Department of Health Services to implement a policy immediately of telling providers all reasons for denials of claims.

The denial of a claim may be based on several reasons, all of which are noted by EDS' computerized process. But providers are told only about the top reason, based on a hierarchy of reasons defined by the State. This

top reason for denial is listed on the provider's Explanation of Benefits form. Because of the format of the EOB (which will be discussed in the next finding), the State says there is little room for listing more than one reason and that such a change would cost millions of dollars. Nonetheless, a sense of fair play, not to mention efficiency, suggests that the providers should have the same information available that the State does when making the decision to appeal a claim denial. And regardless of the actual affect on the eventual outcome of denials, changing this policy would help change the pervasive provider perception that the system is stacked against them.

Recommendation 24: The Governor and the Legislature should enact legislation to require the Department of Health Services, in consultation with provider representatives and systems experts, to revamp the procedures involved in dealing with suspended and denied claims to create a simple, timely process.

While the Medi-Cal system has grown and become increasingly computerized, the original paper-oriented processes for dealing with disputed claims have remained much the same. RTDs are routinely ignored by those who find it speedier to file a new claim; CIFs are regularly skipped over when providers proceed straight to first- and second-level appeals. And there seems scant justification for requiring submittal of extensive copies of original records that the fiscal intermediary already has on file. A more streamlined process, with well-defined steps and making full use of today's technology, would be less frustrating for all concerned.

FINDING 10: The system of incorporating a check in each Explanation of Benefit form is inefficient and costly both for the State and for the providers.

Providers are reimbursed in a weekly check-write process by the State Controller's Office. Large-scale providers, such as large hospitals, receive one check that has been hand-matched in the controller's office to the pertinent Explanation of Benefits. But rather than receiving one lump-sum check for each week's claims, other providers face as many checks as Explanation of Benefit forms since each form incorporates a check in the upper right hand corner that needs to be detached and deposited.

Each EOB has room to account for 39 claim lines, so providers with hundreds of claims lines each week may be faced with dozens of checks. And since an EOB may contain many suspended or denied items, checks have been

issued for under \$1. The system creates bookkeeping and bank-deposit headaches for providers, besides subtly reinforcing their feeling that Medi-Cal pays them inadequately.

The chief of Medi-Cal's Procurement Project blamed the system on outdated machinery used by the State Controller's Office. Not only does it cost the State eight cents for each check issued, he pointed out, but the system also causes the Medi-Cal program other problems by limiting the space available to explain actions on various claim lines. But the manager of disbursement operations for the State Controller's Office says the problem lies in the computer program for reimbursement. The information that is transmitted to the Controller's comes in the format that produces the Explanation of Benefits with the check incorporated. Changing the program would allow the Controller's Office to produce the checks differently.

Recommendation 25: The Governor and the Legislature should direct the Department of Health Services and the State Controller's Office to work together to revamp the Medi-Cal check-writing procedures.

Like other aspects of Medi-Cal's reimbursement process, the check format needs to be revamped to meet the needs of the current system.

FINDING 11: The State has not taken full advantage of the fiscal intermediary's expertise in providing Medicaid services.

When EDS became the fiscal intermediary two years ago, it inherited a system already in place. While it has made improvements and modifications required and/or allowed under its contract with the State, it has been hampered by a system that was poorly designed for today's Medi-Cal needs.

In California, the role of EDS is mostly limited to processing claims by computer, educating doctors about how to submit claims and processing first-level appeals of rejected bills. But in many of the 15 other states where EDS has a current Medicaid contract, the company's duties are broader, as can be seen on the chart on the next page:

CHART 9

MEDICAID ACTIVITIES PERFORMED BY EDS IN OTHER STATES AND CALIFORNIA IN 1990

STATE	Current Contract	New Software	Systems Operation	Claims Processing	Provider Relations	Correspondence/Appeals	Utilization Review	Third Party Liability	Prior Authorizations	Fiscal Responsibility	Accounts Receivable	Fraud and Abuse	Hospital Audit	Case Management	Managed Care
Alabama	✓		✓	✓	✓	✓	✓ ¹	✓		✓	✓				
Arkansas	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓				
California	✓		✓	✓	✓				✓						
Colorado	✓	✓	✓												
Connecticut	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	
Delaware	✓	✓	✓	✓	✓	✓	✓	✓		✓					
Florida			✓	✓	✓	✓			✓	✓	✓				
Georgia	✓	✓	✓	✓	✓		✓		✓	✓			✓		
Idaho	✓	✓	✓	✓	✓				✓						
Indiana		✓	✓	✓	✓	✓	✓	✓	✓		✓ ²				
Kansas	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	✓	
Kentucky		✓	✓	✓	✓		✓	✓	✓				✓		
Louisiana		✓	✓	✓	✓				✓	✓	✓	✓			
Mississippi			✓	✓	✓				✓	✓					
Missouri		✓	✓	✓	✓				✓						
New Hampshire	✓	✓	✓	✓	✓					✓					
New Mexico	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓				
North Carolina	✓	✓	✓	✓	✓			✓	✓	✓					
North Dakota		✓													
Oregon		✓													
Tennessee		✓	✓	✓	✓	✓	✓		✓	✓					
Texas	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vermont	✓	✓	✓	✓	✓		✓		✓	✓	✓		✓		
Washington		✓	✓												
Wisconsin	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Wyoming	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓					

¹ Provider

² Long-term care

Source: Electronic Data Systems Corporation

As Chart 9 indicates, EDS has a large pool of experience in many different Medicaid functions. For instance in Texas, EDS is involved in all aspects of the program: developing new software, operating the computer

system, processing claims, keeping up provider relations, handling correspondence and appeals, pursuing third-party liability and handling accounts receivable. In addition, EDS conducts the utilization review program that detects abuse and fraud and the prior authorization system to ensure services are warranted, as well as handling case management for recipients who are past abusers of the system and promoting managed care programs.

Besides being a source of expertise in these added areas, EDS might achieve greater efficiency in the claims processing arena if the prior authorization system and the utilization review mechanisms were better integrated rather than operated separately by the State.

Recommendation 26: The Department of Health Services should seek a comprehensive review of the Medi-Cal system from EDS and solicit proposals for improvements across the broad range of Medi-Cal activities.

Although a top-to-bottom overhaul of the computerized functions of Medi-Cal may not be financially feasible, the State should explore all options for improving the system of dispensing and paying for medical services. A top EDS official has said that if the company were philanthropic in nature, they could do much to improve Medi-Cal's procedures. While underlying his remark is the concept that changes would be accompanied by a large price tag, it also indicates that EDS has untapped expertise that the State should evaluate and attempt to make use of.

While few Medi-Cal recipients are aware of the intricacies of the reimbursement system, they feel the impact when providers decide to drop out of Medi-Cal rather than cope with procedural barriers. Thus, to encourage broad-based provider participation and greater access to care for recipients, the State should concentrate on streamlining reimbursement mechanisms.

Prescription Drugs

When the Little Hoover Commission began its Medi-Cal study a year ago, one of the easiest areas to target for improvement was the State's procedures for purchasing drugs. Not only did the State pay top dollar in the nation for the drugs Medi-Cal patients used, but also the State had a rigid formulary that did not keep pace with developing drug therapies. During the course of the study, however, Medi-Cal officials fought for the second year in row for legislative authority to bargain for discounts on drug purchases. When the legislative session came to a close on August 31, 1990, Medi-Cal had won the right to trade access to the formulary for discount prices.

California was not alone in paying high prices for drugs. A publication put out by a special interest group called The Pharmacy Freedom Fund²⁴ reported that between 1978 and 1988 the prices for the top 50 drugs in existence over the span of the full decade rose an average of 311 percent compared to an increase in the cost of living of 186 percent. Some selected drugs and corresponding prices for the same quantity 10 years later:

Drug	1978	1988	Higher
Dilantin	\$4.26	\$12.38	290.6%
Ortho Novum	3.40	13.63	400.8%
Motrin	8.30	17.31	208.6%
Lopressor	9.25	32.79	364.4%
Lomotil	11.66	27.69	237.4%
Valium	10.00	36.98	369.8%

24. "Equal Access," Pharmacy Freedom Fund, 1990.

The same publication noted that the United States paid a far higher price for drugs than other countries, as is shown below:

Drug	Canada	U.S.	Higher
Dilantin	\$42.77	\$73.82	172.6%
Ceclor	70.88	105.13	148.3%
Ortho Novum	7.03	12.23	174.0%
Lopressor	16.56	28.10	169.7%
Seldane	31.96	45.14	141.2%
Valium	5.91	27.78	470.1%

Drug	Mexico	U.S.	Higher
Ceclor	\$6.72	\$22.36	332.7%
Faldene	3.36	37.27	1109.2%
Retin-A	5.43	18.42	339.2%
Lomotil	2.04	6.62	324.5%

Although California was not alone in paying high prices for drugs, other government agencies, including the County of Los Angeles, the Veterans Administration and even the State Department of General Services (in buying drugs for prisons and State hospitals) were able to achieve discounts, as the chart below shows:

CHART 10

EXAMPLES OF DRUG PRICES BY PURCHASING AGENCY

Drug	List Price	Medi-Cal	General Services	Los Angeles County	Veterans Admin.	Percent difference*
Ceclor	149.08	149.08		116.10	55.67	168%
Dilantin	9.48	9.48	6.93	8.29		37%
Halcion	36.49	36.49	34.10	35.76	9.98	266%
Lo/Ovral	16.37	16.37	1.75	1.75		835%
Lopressor	39.31	37.34	24.13	30.32	11.94	213%
Tagamet	57.65	54.77	38.59	38.59	27.65	98%

* "Percent difference" column is based on the differential between what Medi-Cal pays and the lowest price offered to other agencies. For example, the price paid by Medi-Cal for Ceclor is 168 percent greater than the price paid by the Veterans Administration.

Source of data:
Department of Health Services

As Chart 10 indicates, in many cases Medi-Cal was paying the highest price set for a particular drug while other agencies were obtaining deep discounts. Medi-Cal officials estimated similar discounts would save the program \$50 million a year.

Price disparities were not the only problems facing Medi-Cal. Because of slow regulatory processes, the addition of new drugs to the formulary could take 18 months or longer. As a result, advances in medicine that might save other kinds of health care costs or that might prove more effective for patients were left off the formulary for years. Among those medications missing from the formulary were any cholesterol-lowering drugs, advanced asthma medicine, new AIDS drugs, important ulcer medication and some mental health drugs.

In addition to drug prices and a slow-adapting formulary, the Medi-Cal system for approving the purchase of drugs not listed on the formulary--Treatment Authorization Requests (TARs)--was viewed as unwieldy and a deterrent to both pharmacists and doctors.

FINDING 12: The Department of Health Services has achieved key reforms of the drug purchasing system that should improve both the efficiency and the effectiveness of the pharmaceutical portion of Medi-Cal.

The Medi-Cal Drug Discount Program legislation, adopted in the closing hours of the 1990 legislative session, addressed pricing concerns, the rigidity of the formulary and the TAR process. The key elements:

- * The Department of Health Services retains control of a formulary, now referred to as a "list of contract drugs."
- * The Department continues to use five criteria for evaluating drugs for placement on the contract list: safety, efficacy, essential need, misuse potential and cost.
- * Drugs are placed on the list either through a bid or non-bid process at the discretion of the Department, and contract terms are confidential.
- * Drugs on the old formulary are grandfathered on to the contract list, subject to a negotiated contract being achieved.
- * Short cuts in administrative hearing procedures are created to allow the Department to place drugs on the list quickly.
- * A requirement is imposed on the Department to enhance the processing of Treatment Authorization Requests for drugs not on the contract list.
- * A two-year sunset of the program's provisions is established.

By mid-September 1990, shortly after the legislation was signed into law, the State had already negotiated contracts with four drug manufacturers and another five contracts were being discussed. The four finalized contracts added 15 drugs to the list of contract drugs, two of which are classified by the federal government as important therapeutic gains and four of which fill in gaps in various therapeutic categories for which the old drug formulary had no pre-approved drugs listed. These added drugs previously would have required a TAR if prescribed for Medi-Cal patients. Placing them on the pre-approved list is expected to increase their usage and, therefore, the cost to the State. Medi-Cal officials said the cost of adding all but one of the drugs to the list is \$25.3 million, compared to a savings from discounts of \$26.7 million. The other drug, however, is expected to add about \$20.3 million to Medi-Cal's drug costs--but it is the first cholesterol-lowering drug authorized by Medi-Cal and it is expected to save long-term health care costs.

The new drug bargaining program is criticized by some who believe there is a conflict in having the Department of Health Services act as bargainer when it also retains the role of choosing drugs for the approved list based on medical need rather than on economy. There are fears that the Department will exclude necessary drugs from the list if the manufacturers refuse to come to the table and offer discounts.

The Department has argued, however, that there is a broad enough range of drugs in most therapeutic categories to give the Department latitude in selecting drugs that are discounted over drugs that are not. The Department also maintains that the list of pre-approved drugs will actually be more inclusive than the old formulary, since new drugs were not added to it in a timely manner under old procedures.

With the new program already moving ahead, the State has made significant strides toward achieving economies in drug purchasing and improving the process for authorizing drug use.

Recommendation 27: The Governor and the Legislature should make the Medi-Cal Drug Discount Program permanent.

The drug discount program should not be automatically phased out in two years, a time span that will barely allow the Medi-Cal program to begin sorting out the benefits of contracting for drugs. The two-year sunset provision allows pharmaceutical lobbyists a chance to derail

the program in the future. Instead, the program should be made permanent and then altered in the future if necessary.

Recommendation 28: The Governor and the Legislature should transfer the authority to negotiate drug contracts to the California Medical Assistance Commission.

The Medi-Cal Drug Discount negotiators now housed in the Department of Health Services should be transferred to the California Medical Assistance Commission (CMAC) to keep the State's health-care bargaining responsibilities in one unit. Under this arrangement, CMAC would work closely with the Department, which would retain the authority to determine what drugs should be included on the list of contract drugs. This separation of duties may also deflect any criticism that the Department of Health Services is making choices about which drugs should be available to Medi-Cal recipients based solely on price and successful bargaining for discounts.

The strides the State has made in bringing its purchasing power to bear on the prices it pays for prescription drugs should lead to better health care for Medi-Cal recipients. Not only are a wider selection of drugs becoming more readily available under the new drug discount program, but also the savings on drug purchases can be used to provide more care for recipients.

Conclusion

Medi-Cal is a system under considerable stress. Faced with growing needs and limited resources, Medi-Cal strives to meet the health care needs of the State's poor but in many cases fails to deliver on its promises. As has been documented in this report, the program presents barriers not only to those it is designed to serve but also to those who provide the services.

The results of these barriers are costly, in dollars and in human terms. Those who are eligible for Medi-Cal under the intent of state and federal laws may not be able to establish their eligibility in a timely manner, if at all. Once they become Medi-Cal recipients, they may not be able to find providers willing to accept them as patients. This may lead to their putting off preventive health measures or early treatment of diseases. The delay in obtaining health care, in turn, may make their eventual treatment expensive--especially if it takes place in a hospital emergency room--or futile if a disease has progressed past the point of cure.

Recipients are not the only ones short-changed by the system. Providers find Medi-Cal frustrating to the point that many refuse to participate. While providers complain about low fees and procedural red tape, the question of dignity is a strong undercurrent of provider attitudes about the program. Providers say they feel the system treats them universally as presumed cheaters and as charlatans whose diagnoses and treatment plans need to be double-checked at every step. These feelings translate into an unwillingness to provide services under the program in some cases, and in other cases may lead providers to alter the way they treat Medi-Cal patients.

In the real world, then, Medi-Cal does not meet its own goals of providing mainstream health care to the State's poor. Health care is instead effectively rationed for those who the program was designed to serve. The rationing is neither logically nor universally applied, but is rationing by chance. An applicant may live in a county where there are few eligibility processing problems or he may reside in a county where the system is clogged and convoluted. A recipient may be fortunate to find providers who accept Medi-Cal patients or he may be forced to rely on hospital emergency rooms. His health problems may require specialized treatment that is made difficult by the prior authorization process, or he may only require prescription drugs that are already included on Medi-Cal's list of permissible drugs. The recipient with multiple health problems may have the benefits of case management or managed care systems available to him, or he may be left floating free in the fee-for-service system. In short, the health care that a Medi-Cal beneficiary receives is influenced greatly by factors that have little to do with his health needs.

But if the Medi-Cal system can be diagnosed as ailing, the prognosis does not have to be grim. California can, and should, take aggressive steps to address the system's problems. The recommendations embodied in this report can be generalized in three main points:

1. Streamline present processes that affect recipients and providers.
2. Expand the use of the State's position as a mass purchasing agent to bargain for more efficient and effective ways of providing medical care.
3. Explore the potential of prioritizing health care so that any rationing that must occur takes place by logic rather than by chance.

The Little Hoover Commission believes the recommendations outlined in this report and summarized in the above three goals are a prescription for a healthier Medi-Cal system that will operate more effectively and efficiently.

APPENDICES

Appendix A - Membership of Little Hoover Commission Medi-Cal Advisory Committee

Appendix B - Witnesses at Little Hoover Commission Medi-Cal Hearings

Appendix C - List of Little Hoover Commission Studies Relating to Medi-Cal

Appendix D - Medi-Cal Application (1990)

Appendix E - Revised Medi-Cal Application (To Be Used Beginning January 1, 1991)

Appendix F - Proposed Recipient Protections for Capitated Care Programs

APPENDIX A

MEDI-CAL ADVISORY COMMITTEE MEMBERS

Tom Baughman, Director of Special Programs
California Association of Health Facilities

Victor Boisseree, Vice President
of Professional Affairs
California Pharmacists Association

Steve Clark, Vice President
California Association of Hospitals

Stan Dorn, Staff Attorney
National Health Law Program

Merv Forney, Vice President
Electronic Data System

Thelma Frazier
for Senator Diane Watson, Chairwoman
Senate Health & Human Services

Norman Gould, Representative
California Association of Health Facilities

Byron J. Gross, Directing Attorney
of the Government Benefits Unit
Legal Aid Foundation of Los Angeles

Peter Hansel, Health Care Consultant
Senate Office of Research

Dido Hasper, Executive Director
Chico Women's Health Center

Julie Higgs, Program Analyst
Legislative Analyst's Office

Michael Holland, Director
CAPH Clinicians for Health Care Equality
California Association of Public Hospitals

John Kindler, Revenue Management Chief
Los Angeles County Health Services

Jack Light, Vice President
California Medical Association

Eugene Lokey, Legislative Advocate
California Health Federation

Michelle Melden, Staff Attorney
National Health Law Program

Vince McElroen, President
Quality Medical Adjudication

Jane Perkins, Staff Attorney
National Health Law Program

John Rodriguez, Deputy Director
of Medical Services
Department of Health Services

Peter Schilla, Staff Attorney
Western Center on Law and Poverty

Steve Thompson, Director
Assembly Office of Research

Sam Tobin, Director of Research
California Medical Assistance Commission

Carol Wallisch
for Assemblyman Tom Bates, Chairman
Assembly Human Services

Lucien Wulsin
for Assemblyman Burt Margolin, Chairman
Assembly Special Committee on
Medi-Cal Oversight

Tom Yanger, Chief of Prosecutions
Bureau of Medi-Cal Fraud and Patient Abuse
Attorney General's Office

APPENDIX B

WITNESSES AT COMMISSION HEARINGS ON MEDI-CAL

April 26, 1990 - Medi-Cal Public Hearing

Department of Health Services

John Rodriguez, Deputy Director
of Medical Services

California Medical Association

Jack Light, Vice President

California Pharmacists Association

Vic Boisseree, Vice President

Electronic Data Systems

Merv Forney, Vice President

National Health Law Program

Stan Dorn, Staff Attorney
Brenda Vargas, Medi-Cal Recipient

Pharmaceutical Manufacturers Association

Deborah J. Kapsa, Director
Western Regional Office

Public Participation

Christie Addis
Medi-Cal Recipient

Maria Anaya
Westside Medical Center

Lynn S. Carman
Bay Area Legal Foundation

Norm Gould
Calif. Assoc. of Health Facilities

Daniel Higgins, Md.
American College of Emergency
Physicians

Lynne Kersey
Los Angeles Homeless
Health Care Project

Mary Lopez
South Central Family Health Center

Fred Mayer
Pharmacist Planning Service, Inc.

Doreen Prieto
Medi-Cal Recipient

Vicky Reyes
La Cuna Pregnancy Services

Rena Spiegel
Northeast Valley Health Center

Melanie Stephens
Interfaith Hunger Coalition

WITNESSES AT COMMISSION HEARINGS ON MEDI-CAL

May 17, 1990 - Medi-Cal Public Hearing

Department of Health Services

Frank DeBernardi, Chief
Field Services Branch
John Rodriguez, Deputy Director of
Medical Services

American Academy of Pediatrics

Charlotte Maxwell Newhart, Chief
Administrative Officer

California Medical Assistance Commission

Eric Gold, Vice Chairman
Michael W. Murray, Executive Director

Contra Costa Health Plan

Milton S. Camhi, Executive Director

William M. Mercer, Inc.

Dr. Arnold Milstein

Merrithew Memorial Hospital and Clinics

Frank J. Puglisi, Jr., Executive Director

National Health Law Program

Michele Melden, Staff Attorney

Pharmacists Planning Service, Inc.

Fred Mayer

Santa Barbara County Health Authority

Steven Krivit, Director of Regulatory &
Legislative Affairs

Relative of Recipient

Katherine E. Griggs

Public Participation

Laura Brown, Chico Feminist Women's
Health Clinic

Dido Hasper, Chico Feminist Women's
Health Clinic

Brenda Tickler, Sunnyvale (Representing self
& disabled individuals)

Katharine R. Humphreys, Public Coordinator
Tri-Counties Regional Center

Michael Holland, California Association of
Public Hospitals, San Mateo

APPENDIX C

LITTLE HOOVER COMMISSION Previous Medi-Cal Studies

The Little Hoover Commission has been active in monitoring the state's Medi-Cal system for the past 14 years, beginning with a comprehensive overview of all state health programs in 1975.

Previous reports and their date of issuance are:

A Study of the Administration of State Health Programs	January 1976
Supplemental Report on Medi-Cal Program, Department of Health	September 1977
An Analysis of Community Hospital Medi-Cal Audits	July 1978
Administration of the Medi-Cal Program--Second Supplementary Report	February 1979
Medi-Cal Reform Letter	September 1979
Health Care Delivery System Reform Letter	May 1980
Office of Special Health Care	March 1983
Review of the State's Medi-Cal Program and the Effects of the Reforms Letter Report	May 1987

APPENDIX D

INSTRUCTIONS:

Whether or not you receive Medi-Cal will be decided on the information you give on this form. Be sure to read and answer every item. If you need extra space for any item, see page 9.

If you are completing this form on someone else's behalf, the terms "applicant" and "you" apply to the person you are applying for.

"Family member" means applicant, spouse, applicant's or spouse's children under 21.

STATEMENT OF FACTS (MEDI-CAL)

PLEASE USE INK

1. Applicant's name (print)	First	Middle	Last	COUNTY USE ONLY Case name: State No.: App./redetermination date: Verification of Identity Date _____ EW _____ Verification of SS No. 3A-1. _____ Date _____ EW _____ 3A-2. _____ 3B-1. _____ 3B-2. _____ 3B-3. _____ 3B-4. _____ 3B-5. _____ Tax Record Verification	
2. Home address	Number	Street	City		Zip Code
Mailing address (if different from above)					
Home phone	Work phone	Message phone	Person with whom to leave message		

3. FAMILY MEMBERS

3A. List yourself and your spouse if he/she is in the home or Medi-Cal is being asked for in his/her behalf.

Name	Sex	Birthdate (Mo/Day/Yr)	Marital Status					Living With Applicant		Medi-Cal Requested	
			Single	Married	Divorced	Separated	Widowed	Yes	No	Yes	No
1. Yourself		Birthdate									
SS No.		Birthplace									
						Date					
2. Your Spouse		Birthdate									
SS No.		Birthplace									
						Date					

3B. List all your and your spouse's unmarried children under 21 (be sure to list unborn children even if you plan to terminate pregnancy). Also, include any children out of the home for whom you are asking for Medi-Cal or whom you claim as a deduction for income tax purposes.

	Sex	Birthdate	Birthplace	PARENTS		Parent Is: (if applies)			Child Living In Home		Medi-Cal Req. For Child	
				1) Father's Name	2) Mother's Name	Deceased	Absent	Social Security No.	Yes	No	Yes	No
1. Child's Name		Birthdate		(1)								
SS No.		Birthplace		(2)								
2. Child's Name		Birthdate		(1)								
SS No.		Birthplace		(2)								
3. Child's Name		Birthdate		(1)								
SS No.		Birthplace		(2)								
4. Child's Name		Birthdate		(1)								
SS No.		Birthplace		(2)								

Section 1137 of the Social Security Act requires that you provide Social Security numbers (SSNs) for yourself and your family members. Your SSNs will be verified and will be used in a computer match to check the income and resources you report with information from welfare, state employment, income tax, Social Security Administration, and other agencies.

3C. Did you or any family member use a different name than the one listed above when each of you applied for your Social Security number(s)? Yes No If yes, list names.

3D. Are you or any family member for whom you are asking for Medi-Cal claimed as a deduction for income tax purposes by someone else? Yes No

3E. Do you or any family member for whom you are asking for Medi-Cal claim as a deduction for tax purposes anyone who does not live in the home with you? Yes No

3F. List the names and addresses of all persons listed in 3A or 3B if they are not living in your home.

Name	Address

4. Is there anyone other than you or your immediate family members living with you, such as roommate, housemate, or relative? Yes No If yes:

Name	Relationship

5A. Are you or any family member asking for Medi-Cal living or currently staying outside California? Yes No If yes: Date left California _____ Date expected to return _____
Reason for absence: _____

B. Do you or any family member have a home outside California? Yes No
If yes, are you or any family member working or looking for work in California? Yes No
If no, explain why you are in California. _____

6. ARE ANY OF THE PERSONS LISTED IN 3A OR 3B ALIENS? Yes No
If YES, complete:

Name of Alien	Alien Registration Number

7. Have you or any family member ever applied for or received
AFDC Cash Assistance Yes No Medi-Cal Yes No Food Stamps Yes No
SSI/SSP Check Yes No Other Welfare Benefits Yes No
If you answered yes on any item, complete the following:

Name of Person(s) Who Applied For or Received Aid	Type of Aid	Date of App. (Mo/Day/Yr)	Place of Application County/State	Date Last Re- ceived (if no longer receiving) (Mo/Day/Yr)	Reason For Discontinuance

8. If you or any family member were *not* receiving Medi-Cal in the last three months, did you or those family members receive any medical care? Yes No If yes:

Name of Person Receiving Medical Care	Month(s) of Care	Payments Made For Care		Do You Wish Medi-Cal For Those Months	
		Yes	No	Yes	No

9A. Are you or any family member asking for Medi-Cal:
65 or over? Yes No If yes, name(s) _____
Blind? Yes No If yes, name(s) _____

B. Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of your needs? Yes No If yes:

Family Member(s)	Type of Problem(s)	Begin. Date of Prob.(s)	Expected Recovery Date

C. If the problem described in 9B was caused by an injury or accident, are you seeking compensation through an insurance settlement or lawsuit? Yes No

COUNTY USE ONLY

Where required, date CA 6 signed.

- Four-month continuing eligibility?
- SGA disabled?
- Pickle/Title II disregard?
- 30 + 1/3 earnings exemption?
- \$30 savings exemption?
- Retroactive application
 - Retro only
 - Retro and cont.
 - MC 210 A
 - Verification of disability/blindness (list)

Date Verified EW

Disability referral

Date Sent

Referral to Medi-Cal recovery

10. Complete the following information about your living arrangements:
- Rent a room, apartment, house, or trailer \$_____ Rent
 - Pay for room and board \$_____ Room and board
 - Work in exchange for room and board
 - Receive free room
 - Receive free room and board
 - Live in a board and care facility
 - Live in a nursing home or hospital Name: _____
Date entered _____ Do you intend to return home? _____
 - Live in and own/buying a trailer, mobile home, boat, or motor vehicle which is *not* taxed as real property by the county.
Description: _____
Estimated value \$_____ Amount owed \$_____ Monthly payment \$_____
 - Live in and own/buying a home or a trailer or mobile home which is taxed as real property by the county.
Assessed value \$_____ (from tax statement) Amount owed \$_____ Monthly payment \$_____
Land home is located on includes more than one parcel. Yes No If yes, complete 11.
Land home is located on includes more than one acre. Yes No If yes, complete 11.
 - Other living arrangements. Describe: _____

COUNTY USE ONLY
(For LTC Applicants)
Verification of exemption as "principal residence"

Date Verified _____ EW _____

Verification that will return home in six months
Yes No

Verification of property

Date Verified _____ EW _____

In-kind income
Type _____
\$ _____

11. Do you or any member of your family own real property in which you do not now live (for example, land or buildings, or a trailer or mobile home which is taxed as real property by the county)?
Yes No If yes:
- Where is the property located? (address) _____
- Description: _____
- Owner: _____
- If Yes, do you intend to return to that property to live there in the future? Yes No
(If you later change your mind, you must notify the county within 10 days)
- If you do not intend to return to the property, does anyone live there now? Yes No
- If so, who lives there now? _____
- What is their relation to you? _____
- How long have they lived there? _____
- Is the property currently listed for sale? Yes No
- Full value (from tax statement) \$_____ Amount owed \$_____ Rent collected each month \$_____
- Expenses on property:
- Interest \$_____ Yearly Monthly Insurance \$_____ Yearly Monthly
 - Taxes & Assessments \$_____ Yearly Monthly Upkeep & Repairs \$_____ Yearly Monthly
 - Utilities \$_____ Yearly Monthly

Verification of "good cause" for unutilized property

Date Verified _____ EW _____

Verification of income and expenses (list):

Date Verified _____ EW _____

12. Do you or any family member have a life estate (right to the use of) in any property? Yes No
If yes, describe: _____

Revocable
 Irrevocable

13. Do you or any family member own a motor vehicle (including cars, trucks, motorcycles, etc.)?
Yes No If yes, list:

Make and Model	Year	Class (From Registration)	Owner	Amount Owed	Used For Transportation	
					Yes	No
				\$		
				\$		
				\$		
				\$		
				\$		

Verification of nonexempt vehicles

Verification of nonexempt personal property

Date Verified _____ EW _____

NOTE: If you think the value the Department of Motor Vehicles will give the items listed in 13-14 will be too high, you may provide three appraisals of the actual value and the average will be used.

14. Do you or any family member own boats, campers (do not include trucks), motor homes, mobile homes, or trailers which are not used as a home and are not taxed as real property by the county?
 Yes No If yes, list:

Description	Year	Class (if Registered)	Owner	Purchase Price	Amount Owed	Only Means of Transportation	
						Yes	No
				\$	\$		
				\$	\$		
				\$	\$		
				\$	\$		

COUNTY USE ONLY
 Verification of personal property
 Date Verified _____ EW _____

Total value of nonexempt property verified
 \$ _____

15. DO YOU OR YOUR FAMILY HAVE ANY OF THE PROPERTY ITEMS LISTED BELOW?
 Check each item. If YES, explain below.

- | | | | | | |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| A. Checks (at home or elsewhere) | <input type="checkbox"/> | <input type="checkbox"/> | I. Notes, mortgages, trust deeds, sales contracts | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Cash (on hand or elsewhere) | <input type="checkbox"/> | <input type="checkbox"/> | J. Trust fund | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Checking account | <input type="checkbox"/> | <input type="checkbox"/> | K. Stocks, bonds, or certificates | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Savings account | <input type="checkbox"/> | <input type="checkbox"/> | L. Other resources which can be quickly changed into cash (specify) _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Credit union account | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| F. Certificates of deposit | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| G. Treasury bills | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| H. Money market funds | <input type="checkbox"/> | <input type="checkbox"/> | | | |

For A, B, C, D, and/or E
 Income in the month included?
 Yes No If yes, amount:
 \$ _____

For A, B, and/or C
 Income from business or self-employment included? Yes No
 If yes, amount:
 \$ _____
 (See 26C)

Type of Resource	Owner	Current Value	Name and Address of Banks, etc.	Account Number
		\$		
		\$		
		\$		

16. Do you or any family member have life insurance? Yes No If yes, list:

Insurance Company	1. Person Insured		Face Value of Insurance	Policy Number	Date Policy Issued	Current Cash Value
	2. Policy Owned by					
A.	1. _____		\$			\$
	2. _____					
B.	1. _____		\$			\$
	2. _____					
C.	1. _____		\$			\$
	2. _____					

Date Verified _____ EW _____
 Trust fund not court ordered
 Court petition
 Date _____
 Approved Denied
 Total nonexempt CSV
 \$ _____

17. Do you or any family member own a burial reserve or trust? Yes No

If yes, purchase price \$ _____ Amount owed \$ _____
 \$ _____ \$ _____
 For whom purchased: _____
 From whom purchased: _____

Date Verified _____ EW _____
 Current value
 \$ _____

18. Do you or any family member own a burial plot, vault, or crypt? Yes No

For use of immediate family? Yes No Yes No
 If for use of anyone other than a member of the immediate family, complete the following:
 Description: _____ Owned by: _____
 Estimated value \$ _____ Amount owed \$ _____
 Location: _____

Date Verified _____ EW _____

19. Do you or any family member own items of jewelry valued at more than \$100 each? (Do not include wedding and engagement rings or heirlooms.) Yes No If yes, list:

Description	Estimated Value	Amount Owed
A.	\$	\$
B.	\$	\$

COUNTY USE ONLY

Heirlooms?
Total nonexempt appraised value:
\$

20. Do you or any family member own business equipment, tools, inventory, or material (including livestock or poultry not for personal use)? Yes No If yes, list:

Description	Estimated Value	Amount Owed
A.	\$	\$
B.	\$	\$
C.	\$	\$

21. Have you or any family member transferred, sold, or given away any property (including money) during the past two years? Yes No If yes, list:

Description of Item	Date of Transfer Sale, or Gift	Value	Amount Received
A.		\$	\$
B.		\$	\$

Disposition of proceeds:
Note: Refer to transfer of property regs. in Title 22.

22. Do you or any family member have any of the following sources of unearned income? Check yes or no for each item. If yes, explain below. Include loans, date loan received, and whether or not loan is repayable in "Other."

A. TYPE OF INCOME		Yes	No			Yes	No
Cash grant (welfare), e.g., SSI/SSP (check), AFDC, GR, or GA		<input type="checkbox"/>	<input type="checkbox"/>	Veteran's benefits including GI Bill		<input type="checkbox"/>	<input type="checkbox"/>
Social Security: i.e., Retirement, Survivors, Disability		<input type="checkbox"/>	<input type="checkbox"/>	Military retirement		<input type="checkbox"/>	<input type="checkbox"/>
Railroad Retirement		<input type="checkbox"/>	<input type="checkbox"/>	Military allotment		<input type="checkbox"/>	<input type="checkbox"/>
Nonmilitary retirement or pension		<input type="checkbox"/>	<input type="checkbox"/>	Child support		<input type="checkbox"/>	<input type="checkbox"/>
Unemployment Insurance Benefits (UIB)		<input type="checkbox"/>	<input type="checkbox"/>	Alimony		<input type="checkbox"/>	<input type="checkbox"/>
Disability insurance: check one: <input type="checkbox"/> state <input type="checkbox"/> private		<input type="checkbox"/>	<input type="checkbox"/>	Payment from roomers		<input type="checkbox"/>	<input type="checkbox"/>
Workers' Compensation		<input type="checkbox"/>	<input type="checkbox"/>	Monetary gifts/contributions		<input type="checkbox"/>	<input type="checkbox"/>
				Interest income and dividends		<input type="checkbox"/>	<input type="checkbox"/>
				Other (itemize):		<input type="checkbox"/>	<input type="checkbox"/>

Type of cash grant:
Verification (list):
SSA 1610/CA 810
CA 5
Other

B. Name of Person Receiving Income	Type of Income	Date Received (or Expected)	Amount	How Often? (Weekly, Monthly)

C. Do you receive or expect to receive a cost-of-living increase to this income one or more times a year? Yes No If yes, give date of last and next cost-of-living increase.
Last _____ Next _____

Date Verified EW

23. Do you or any family member receive any of the following items free or in exchange for work you do?

A. Rent or housing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Who receives:	From whom:
B. Food	Yes <input type="checkbox"/> No <input type="checkbox"/>	Who receives:	From whom:
C. Utilities	Yes <input type="checkbox"/> No <input type="checkbox"/>	Who receives:	From whom:
D. Clothing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Who receives:	From whom:

Verification (list):

Date Verified EW

Total Value \$

24. Do you or any family member pay child support or alimony under a court order or based on an agreement with the district attorney? Yes No If yes, complete the following:

Amount Paid	By Whom	To Whom

25. Have you or any family member been employed at any time during this month? Yes No If yes, complete the following:

A.

1. Working member's name			
2. Employer's name			
3. Address of employer			
4. Days of work per week		Days	Days
5. Hours of work per week		Hrs.	Hrs.
6. How often paid (every week, twice a month, every two weeks, etc.)			
7. Day of the week you are paid			
8. Gross (total) earnings per pay period (before deductions) (include tips). If self-employed, write self-employed here and complete No. 26.			
9. Occupation			

B.

1. Do you pay child care necessary for work? Yes No \$ _____ monthly amount

2. Do you pay for the care of an incapacitated adult living in your home in order to be able to work? Yes No \$ _____ monthly amount Name _____ Relationship _____

C. Anticipated income. If your income changes from month to month, show your actual gross income for the current month in Month 1 and your estimated gross income for the following two months in Month 2 and Month 3.

Name and Occupation	Month 1	Month 2	Month 3
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$

D. Additional Information. Explain reasons for entries in C. Also, state any facts concerning your employment which may affect future months (for example, temporary employment).

26. Are you or any family member self-employed? Yes No If yes, complete the following. If no, proceed to question 27.

A. Name of business _____
 Type of business _____
 Location _____

B.

Adjusted Gross Income From Last Tax Statement	Has Income Changed Since Last Tax Statement		If No Tax Statement or Change in Income:	
	Yes	No	Estimated Yearly Gross Profit	Estimated Yearly Business Expenses
\$			\$	\$

C. Cash on Hand for Business

Cash on Hand for Business	Money in Checking Accounts for Business	Average Monthly Cash Expenditures for Business
\$	\$	\$

COUNTY USE ONLY

Court Order
 Amount: _____
 Date: _____
 City, State: _____

Verification (list)
 Wage stubs
 Tips

Verification of dependent care
 Date Verified _____ EW _____

Verification
 Tax return
 Business records
 Date Verified _____ EW _____

Net profit from self-employment:
 \$ _____

27. COMPLETE ONLY IF THE FAMILY INCLUDES CHILDREN UNDER 21.

COUNTY USE ONLY

Is a parent living in the home unemployed or working less than 100 hours per month? If yes, COMPLETE THE FOLLOWING FOR THE CHILD(REN)'S PARENT(S) WHO IS/ARE LIVING IN THE HOME:

If Unemployed, Last Day Worked	Working Less Than 100 Hours		In School Or Training		Actively Seeking Full-Time Employment		Date Began Seeking Employment
	Month/ Day / Year	Yes	No	Yes	No	Yes	
/ /							/ /

First Parent's Earnings

YR.	QUARTER			
	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec
\$	EARNINGS			
\$				
\$				

B. FIRST PARENT (name _____).
List employment and training history for the past five years. Begin with this person's last job or training.

Name of Employer or Training Program	Work or Training / Check	When Employed From / / To / /	Amount Paid	Name of Employer or Training Program	Work or Training / Check	When Employed From / / To / /	Amount Paid
1.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	7.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
2.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	8.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
3.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	9.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
4.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	10.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
5.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	11.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
6.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	12.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly

Total Earnings \$ _____

C. SECOND PARENT OR OTHER SPOUSE (name _____).
List employment and training history for the past five years. Begin with this person's last job or training.

Second Parent's Earnings

Name of Employer or Training Program	Work or Training / Check	When Employed From / / To / /	Amount Paid	Name of Employer or Training Program	Work or Training / Check	When Employed From / / To / /	Amount Paid
1.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	7.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
2.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	8.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
3.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	9.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
4.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	10.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
5.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	11.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly
6.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	12.	<input type="checkbox"/> Work <input type="checkbox"/> Training	From / / To / /	\$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly

YR.	QUARTER			
	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec
\$	EARNINGS			
\$				
\$				

Total Earnings \$ _____

D. HAS EITHER PERSON LISTED IN 27B OR C RECEIVED UNEMPLOYMENT INSURANCE BENEFITS (UIB) WITHIN THE LAST 12 MONTHS? Yes No If YES, complete:

COUNTY USE ONLY
UIB:
 Eligible Referral
 Eligible Referral

Name of Person	Dates Received
1.	
2.	

COUNTY USE ONLY

FIRST PARENT	YEAR	19 _____				19 _____				19 _____				19 _____			
	QUARTER	Jan-Mar	Apr-Jun	July-Sept	Oct-Dec												
	DATE OF APPLICATION																
	EARNINGS																
	TRAINING																

Quarters _____

SECOND PARENT	YEAR	19 _____				19 _____				19 _____				19 _____			
	QUARTER	Jan-Mar	Apr-Jun	July-Sept	Oct-Dec												
	DATE OF APPLICATION																
	EARNINGS																
	TRAINING																

Quarters _____

Employment History

28A. Have either of the child(ren)'s parents living in the home quit or refused a job or training within the last 30 days? If yes, complete below. Yes No

Parent's Name	Amount of last paycheck	Last day of job/training mo. / day / yr.	Hours of work/training in last 30 days
Name and Address of Employer/Training Program		Reason for Leaving or Refusal	
		<input type="checkbox"/> Quit <input type="checkbox"/> Layoff <input type="checkbox"/> Fired <input type="checkbox"/> Refusal	

Employer statements
 Determination of "good cause" required

List Reasons Below

B. Are you or anyone in your family participating in a labor strike? Yes No
 Who _____ Date Person Went on Strike _____

Striker(s)

29. Are you or any family member in college or attending a similar educational institution: Yes No
 If yes, complete the following: Full-Time Part-Time

COUNTY USE ONLY

Parent's Name	Student:	Student:	Student:
A. 1. Name of institution			
2. Status of student	Grad <input type="checkbox"/> Undergrad <input type="checkbox"/>	Grad <input type="checkbox"/> Undergrad <input type="checkbox"/>	Grad <input type="checkbox"/> Undergrad <input type="checkbox"/>
B. Grants, loans, scholarships, fellowships			
1. Amount received	\$	\$	\$
2. Source(s) of grants, loans, etc.			
3. How often received			
C. Expenses Per Term			
1. Is term a semester, quarter, year			
2. Tuition/fees	\$	\$	\$
3. Books, equipment, and supplies	\$	\$	\$
4. Child care necessary for school	\$	\$	\$
5. Transportation to school—child care			
a. Round trip miles per day			
b. School attended how many days per week			
c. Type of transportation used (own car, someone else's car, car pool, bus, etc.)			
d. Costs (per month)			
• Amount paid by student (if doesn't use own car)	\$	\$	\$
• Amount paid by riders	\$	\$	\$
e. Parking, tolls, etc.			
f. Is public transportation (bus, train, etc.) available	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cost \$	Yes <input type="checkbox"/> No <input type="checkbox"/>

Verification (list):
Date Verified EW

Exempt:
 Entire amount
 Only expenses

Transportation costs allowed: (show computation)

30. Do you or any family member have Medicare coverage? Yes No If yes, list:

Person Covered	Medicare Claim Number	Monthly Premium	
		Deduction From Check	Paid by You
A.		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
B.		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
C.		Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Date Verified EW

31. Do you or any family member have health or hospitalization insurance, including insurance paid by an employer or absent parent? This information will not affect your eligibility for Medi-Cal. Yes No
 If yes, complete the following:

Coverage (Check)	Person(s) Insured	Monthly Premium Paid
<input type="checkbox"/> CHAMPUS/CHAMPVA		\$
<input type="checkbox"/> Veterans Administration coverage (50% or above disability rating)		\$
<input type="checkbox"/> Kaiser		\$
<input type="checkbox"/> Ross-Loos (INA)		\$
<input type="checkbox"/> Blue Shield		\$
<input type="checkbox"/> Blue Cross		\$
<input type="checkbox"/> Other		\$

Date HRB 2 completed

Other health coverage code entered

Verification (list)

Date Verified EW

32A. Have you or any family member made a payment for health care service you received or you will receive during a period for which you are asking for Medi-Cal benefits? Yes No

32B. Has a lien been recorded against your property or the property of a family member as security for health care services received or to be received during a period for which you are asking for Medi-Cal benefits? Yes No

32C. If yes to 32A or 32B, complete below.

Amount Of Payment Or Lien	Payment Made To Or Lien Recorded By	Date And Type Of Medical Care Received Or To Be Received
\$		

33A. Have you or any family member ever been in U. S. military service? Yes No

B. Are you or any family member the spouse, parent, or child of a person who has been in U. S. military service? Yes No

34. Have you or any family member applied for or do you or any family member think you should get payment/s you are not now receiving? Yes No If yes, complete the following:

Kind of Payment	Person Possibly Eligible	Date of Application Month/Day/Year	Date Expected Month/Day/Year
Social Security			
Disability payments			
Veteran's payments			
Unemployment Benefits			
Workers' Compensation			
Medicare			
Pending suit or insurance settlement for accident or injury			
Other: Describe			

35. Services (these questions do not affect your eligibility for Medi-Cal)

A. Are you interested in physical examinations for any family member under 21 through the Child Health Disability Prevention Program? Yes No

B. Are you interested in information on the Family Planning Program? Yes No

C. Are you interested in talking to a social services worker about other services which may be available to you? Yes No If yes, explain:

COUNTY USE ONLY

Payment or lien used to bring property within property limits
Yes No

If yes:
 Notice to provider

CA 5

CA 5

Date Verified EW

Medi-Cal recovery referral

Date _____

Date of Accident/Injury

Medi-Cal recovery referral

Date _____

CHDP brochure given

Date _____

CHDP referral

Social services referral

36. Additional information. Please give the item number in the column to the left.

**BE SURE YOU HAVE READ EVERY ITEM AND ANSWERED ALL THE QUESTIONS.
READ THE FOLLOWING CAREFULLY BEFORE SIGNING.**

- I agree to tell the county welfare department within TEN DAYS if there are any changes in my (or the person's on whose behalf I am acting) income, possessions, or expenses or in the number of persons in the household or of any change of address or of any change in other health insurance coverage; and I agree to meet all other responsibilities explained in the "Medi-Cal Responsibilities Checklist" I have received.
- I understand that I must report immediately the death of a member of my household or the person on whose behalf I am acting.
- I understand that the information I put on this form will be checked, and that I must cooperate fully in any investigation required for quality control.
- I understand that Section 700.1 of the Probate Code and Section 14009.5 of the Welfare and Institutions Code provide for the recovery of all Medi-Cal benefits received after age 65 from the estate of a Medi-Cal beneficiary if there is no surviving spouse, minor children, or blind or totally disabled children.
- I understand that any information gathered is confidential and not open to inspection other than for purposes directly connected with the administration of the Medi-Cal program.
- I understand that if I am dissatisfied with any action or inaction taken by the county welfare department, I have the right to a state hearing, and that I must request such hearing within 90 days of the action.
- I understand that in accordance with Section 14006(b) of the Welfare and Institutions Code, the State may record a lien against my property as reimbursement for the cost of medical care.

IF YOU DO NOT UNDERSTAND THESE STATEMENTS OR IF YOU HAVE ANY QUESTIONS, ASK YOUR COUNTY WORKER TO EXPLAIN.

I REALIZE THAT IF I DELIBERATELY MAKE FALSE STATEMENTS OR WITHHOLD INFORMATION, I (OR THE PERSON ON WHOSE BEHALF I AM ACTING) MAY LOSE MEDICAL ELIGIBILITY AND/OR I CAN BE PROSECUTED FOR FRAUD.

I DECLARE UNDER PENALTY OF PERJURY THAT THE ANSWERS I HAVE GIVEN ARE CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

Signature of Applicant		Date
Signature of Person Acting for Applicant	Relationship	Date
Signature of Witness (If Applicant Signed With Mark)		Date
Signature of Person Helping Applicant Complete Form	Address	Date
COUNTY USE ONLY		EW Signature
		Date

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL

I, _____ am applying for Medi-Cal benefits from
 _____ County Welfare Department (on behalf of
 _____). I fully understand that
 I have the following **RIGHTS AND RESPONSIBILITIES** listed on this form in order to be found
 eligible for Medi-Cal and to maintain that eligibility.

I HAVE THE RIGHT:

- To ask for an interpreter to help me in applying for Medi-Cal if I have difficulty in speaking or understanding the English language.
- To be treated fairly and equally regardless of my race, color, religion, national origin, sex, age, or political beliefs.
- To apply for Medi-Cal and to be told *in writing* whether or not I qualify for any Medi-Cal program, even if the county representative tells me during this interview that it appears I am not eligible at this time.
- To apply as a disabled person if I think I am disabled.
- To review manuals containing the rules and regulations of the Medi-Cal program if I want to question the basis on which my eligibility is approved or denied.
- To receive a Medi-Cal card as soon as possible if I have a medical emergency or I am pregnant.
- To have all information that I give to the county welfare department kept in the strictest confidence.
- To be told about the Child Health and Disability Prevention (CHDP) Program and to request help in receiving services under that program.
- To be told about the rules for retroactive Medi-Cal eligibility.
- To qualify for Medi-Cal by reducing my property reserve to within the Medi-Cal property limit by the last day of any month, including the month of application. I have the right to an explanation of possible ways that I may spend my excess property as long as I receive adequate consideration in return.
- To ask for and receive information about the Family Planning Program and to be told if I am eligible for services under that program.
- To speak to a social service worker about other public or private services or resources that may be available to me.
- To be told about Medi-Cal Prepaid Health Care Plan (HCP) coverage.
- To lower any share of cost I may have by providing past unpaid medical bills (that I still owe).
- MY SPOUSE AND I HAVE THE RIGHT TO divide our countable (nonexempt) community property by written agreement into equal shares of separate property if either of us entered long-term care prior to September 30, 1989.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDICAL (Cont.)

- If I enter long-term care on or after January 1, 1990, my spouse at home has the right to keep a maximum of \$62,580 in 1990 of our countable separate and community property. This amount will increase every January.

I HAVE THE RIGHT TO a state hearing if I am dissatisfied with an action taken (or not taken) by the county welfare department or the State Department of Health Services. If I wish to ask for a state hearing, I must do so within **90 days** of the date the Notice of Action was mailed to me. If I do not receive a Notice of Action, I must request a hearing within **90 days** from the date I discover the action or inaction with which I am dissatisfied. The date of discovery is the date I know, or should have known, of the action. The best way to request a hearing is to contact the nearest county welfare department.

MEDICAL APPLICANT/BENEFICIARY RESPONSIBILITIES

I HAVE THE RESPONSIBILITY TO complete a status report when provided by the county and to return the completed status report to the county by the deadline given on the report.

I HAVE THE RESPONSIBILITY TO notify my county representative **WITHIN TEN (10) DAYS** whenever:

- Income received by me or any member of my family increases, decreases, or stops. This includes Social Security payments, loans, settlements, or income from any other source.
- I plan to change or have already changed my residence or mailing address (including moving out of state) or plan to be away for more than seven (7) days.
- A person, including a newborn child, whether or not related to me or my family, moves into or out of my home.
- I, my spouse, or any member of my family enters or leaves a nursing home/long-term care facility.
- I receive, transfer, give away, or sell any item of real or personal property and whenever someone gives me or a member of my family such things as a car, house, insurance payments, etc.
- I have any expenses which are paid for by someone other than myself.
- An absent parent returns to the home or a member of my family becomes pregnant.
- I or a member of my family becomes employed, changes employment, or is no longer employed.
- I have a change in expenses related to employment or education (for example: child care, transportation, etc.).
- I or a member of my family becomes physically or mentally impaired so that I/he/she cannot be employed (this would include a child in the family who may not seek employment in the future due to any impairment).
- I or a member of my family applies for disability benefits under the SSI/SSP program, Social Security program, VA, or Railroad Retirement.
- One of my children drops out of school or returns to school.
- The immigration status or citizenship of any family member has changed.
- I or a member of my family has a change in health insurance coverage.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Cont.)

I HAVE THE RESPONSIBILITY:

- To sign and date my Medi-Cal card when I receive it and to ensure that it is used only to obtain necessary health care services for myself.
- To apply for and provide a Social Security number for myself and/or any member of my family who wants FULL Medi-Cal benefits. I must cooperate with the Social Security Administration in clearing up any questions or my Medi-Cal eligibility will be denied or discontinued.
- To apply for Medicare benefits if I am blind, disabled, or 64 years and 9 months of age or older and eligible for these benefits. I am responsible for informing my providers that I have both Medi-Cal and Medicare coverage.
- To apply for any income which may be available to me or my family members.
- To report to the county department, and to the health care provider, any health care coverage/insurance I carry or am entitled to use. If I willfully fail to disclose this information, I am guilty of a criminal offense.
- To use any full scope health care insurance plans I have before using Medi-Cal. Such plans include Kaiser, CHAMPUS, and Ross Loos; or any other health care plan/insurance identified by the county welfare department or the State of California. (Medi-Cal will not pay for any service paid for and/or provided by any medical insurance plans.)
- To report to the county department when Medi-Cal will be billed for health care services received as a result of an accident or injury caused by some other person's action or failure to act.
- To take my Medi-Cal card to my medical provider when I am sick or have an appointment. In emergency situations when a card is not in hand, I have the responsibility to get the card to the medical provider as soon as possible.
- To cooperate with the State of California if my case is selected for review by the quality control review team. If I refuse to cooperate, my Medi-Cal benefits will be discontinued.
- To cooperate with the State or county in establishing paternity and identifying any possible medical coverage I or my family may be entitled to, including coverage or support through an absent parent.

PRIVACY AND CONFIDENTIALITY NOTIFICATION

Sections 14011 and 14012 of the Welfare and Institutions Code authorize county welfare departments to collect certain information from you to determine if you or the persons you represent are eligible for the Medi-Cal program. The information you provide is confidential and may only be disclosed to certain individuals or organizations and then only to administer the Medi-Cal program. This information will be used by the county welfare department to establish initial and ongoing Medi-Cal eligibility; by the State's fiscal intermediaries for claims processing; by the Department of Health Services for Medi-Cal card production and overpayment recovery actions; by the United States Department of Health and Human Services for audit and quality control reviews; for Medicare Buy-In and Social Security Account Number verification; by the United States Department of Immigration and Naturalization Service for resident alien status verification; and by medical providers of services and health maintenance organizations for eligibility certification.

Providing this information is mandatory. Failure to do so will result in your ineligibility for Medi-Cal benefits. However, if you are applying for restricted Medi-Cal benefits, you may or may not have to tell us your Social Security number, birthplace, alien number, and alien/citizen status. You have the right to look at your information and may do so at the county welfare office during regularly scheduled office hours.

IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDI-CAL (Cont.)

MEDI-CAL APPLICANT/BENEFICIARY UNDERSTANDING

I UNDERSTAND that failure to provide necessary information or deliberately giving false information can result in denial or discontinuance of Medi-Cal benefits and an investigation of my case for suspected fraud.

I UNDERSTAND that the information I provide will be checked by computer with information provided by employers, banks, Social Security Administration, welfare, and other agencies.

I UNDERSTAND that if I request a Medi-Cal provider to provide a service not covered by my health insurance plan, I am responsible for obtaining written verification from my health plan that it does not offer the Medi-Cal covered services.

I UNDERSTAND that if I do not report changes promptly and, because of this, I receive Medi-Cal benefits that I am not eligible for, I may be responsible to repay the State Department of Health Services.

I UNDERSTAND that after my death the State has the right to recover from my estate all Medi-Cal benefits received after age 65 unless I leave a surviving spouse, minor children, blind or permanently and totally disabled children, or unless it would cause a hardship to my heirs. I understand that Probate Code, Sections 2315 and 9202, give the State authority to do this.

I UNDERSTAND that, as a condition of Medi-Cal eligibility, all rights to medical support and/or payments for myself and all others for whom I have legal authority to assign, are automatically, by operation of law, assigned to the State.

I UNDERSTAND that, as part of the Medi-Cal application process, I will be evaluated for potential eligibility under other medical assistance programs.

I UNDERSTAND that based on my income, I may be required to pay or be billed for a portion of my medical expenses before I can receive a Medi-Cal card.

I hereby state that the information on this cover sheet has been reviewed by me with the county representative and that I fully understand my rights and responsibilities to have my eligibility determined for Medi-Cal and to maintain that eligibility.

Applicant/Representative's Signature

Date

Interpreter's Signature

Date

I have explained to the applicant the rights, responsibilities, and other information listed on this form.

Eligibility Worker's Signature

Telephone Number

Date



STATEMENT OF FACTS (MEDI-CAL)

If you are completing this form for someone else, the term "applicant" and "you" means the person you are applying for. "Family Member" means applicant, spouse, or applicant's or spouse's children under 21. If you need more space, use ④.

INSTRUCTIONS: Print all answers in ink (black ink is best). If you have problems with any questions, your worker will help you. Use receipts and records to help you answer questions. Bring the receipts and records with you to the interview to support your answers.

① Name of Applicant or Caretaker/Relative of Child(ren) for whom Medi-Cal is being requested Home Address (Number, Street, City, State, and ZIP Code) Mailing Address (If Different From Above)	Telephone Number(s) Home: _____ Work: _____
---	---

② List adult family members living in the home. Also, complete for a related caretaker of the child(ren) if he/she wants Medi-Cal.			COUNTY USE ONLY					
A. Applicant or Caretaker's Name (First, Middle, Last)	For This Person, Do You Want (check one) <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> Restricted Medi-Cal <input type="checkbox"/> No Medi-Cal		ID	Depriv. Verif.	SSN	Citizen/ Alien Verif.		
Social Security Number* Alien Number*	Citizen/Alien Status (check one)* <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> PRUCOL <input type="checkbox"/> Refugee <input type="checkbox"/> Legal Alien							
Birthplace (City/State)* Marital Status (check one) _____ (Date) <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Separated <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced						<input type="checkbox"/> MC 13 <input type="checkbox"/> MC 845		
Sex Birthdate Relationship to Children in ③ Below (parent, aunt, etc.) <input type="checkbox"/> Male <input type="checkbox"/> Female								
B. Other Adult's Name (First, Middle, Last)			For This Person, Do You Want (check one.) <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> Restricted Medi-Cal <input type="checkbox"/> No Medi-Cal		ID	Depriv. Verif.	SSN	Alien Verif.
Social Security Number* Alien Number*		Citizen/Alien Status (check one)* <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> PRUCOL <input type="checkbox"/> Refugee <input type="checkbox"/> Legal Alien						
Birthplace (City/State)* Marital Status (check one) _____ (Date) <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Separated <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced								<input type="checkbox"/> MC 13 <input type="checkbox"/> MC 845
Sex Birthdate Relationship to Children in ③ Below (parent, aunt, etc.) <input type="checkbox"/> Male <input type="checkbox"/> Female								

③ List each child for whom you want Medi-Cal. List all other children living in the home or being claimed by you as a tax dependent. List unborn children.			* Either Parent (✓):				ID	Depriv. Verif.	SSN	Citizen/ Alien Verif.	
A. Child's Name (First, Middle, Last)	For This Person, Do You Want (check one) <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> No Medi-Cal <input type="checkbox"/> Restricted Medi-Cal		Decided	Unemployed	Unemployed						
Social Security Number* Alien Number*	Citizen/Alien Status (check one)* <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Legal Alien <input type="checkbox"/> PRUCOL								<input type="checkbox"/> MC 13 <input type="checkbox"/> MC 845		
Birthplace (City/State)* Birthdate Mother's Name											
Sex Full-time Student? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Yes <input type="checkbox"/> No	Father's Name										
B. Child's Name (First, Middle, Last)			For This Person, Do You Want (check one) <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> No Medi-Cal <input type="checkbox"/> Restricted Medi-Cal		Decided	Unemployed	Unemployed	ID	Depriv. Verif.	SSN	Citizen/ Alien Verif.
Social Security Number* Alien Number*		Citizen/Alien Status (check one)* <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Legal Alien <input type="checkbox"/> PRUCOL									
Birthplace (City/State)* Birthdate Mother's Name											<input type="checkbox"/> MC 13 <input type="checkbox"/> MC 845
Sex Full-time Student? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Yes <input type="checkbox"/> No		Father's Name									
C. Child's Name (First, Middle, Last)			For This Person, Do You Want (check one) <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> No Medi-Cal <input type="checkbox"/> Restricted Medi-Cal		Decided	Unemployed	Unemployed	ID	Depriv. Verif.	SSN	Citizen/ Alien Verif.
Social Security Number* Alien Number*		Citizen/Alien Status (check one)* <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Legal Alien <input type="checkbox"/> PRUCOL									
Birthplace (City/State)* Birthdate Mother's Name											<input type="checkbox"/> MC 13 <input type="checkbox"/> MC 845
Sex Full-time Student? <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Yes <input type="checkbox"/> No		Father's Name									

IF YOU ARE REQUESTING MEDICAL SERVICES FOR MORE THAN THREE (3) CHILDREN, CONTINUE ON REVERSE.
 * Please read the "Citizenship/Immigration Status Information for Applicants and Beneficiaries of Medi-Cal" before completing this section.

3) Continued—List additional children for whom you want Medi-Cal. List all other children living in the home or being claimed by you as a tax dependent. List unborn children.

Is Either Parent (✓): COUNTY USE ONLY

D. Child's Name (First, Middle, Last)			For This Person, Do You Want (check one) <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> No Medi-Cal <input type="checkbox"/> Restricted Medi-Cal		Deceased	Incapacitated	Absent	Unemployed	ID	Deprtv. Verif.	SSN	Citizen/ Alien Verif.
Social Security Number*	Alien Number*	Citizen/Alien Status (check one)* <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Legal Alien <input type="checkbox"/> PRUCOL										
Birthplace (City/State)*	Birthdate	Mother's Name										
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Father's Name						<input type="checkbox"/> MC 13	<input type="checkbox"/> MC 845			
E. Child's Name (First, Middle, Last)			For This Person, Do You Want (check one) <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> No Medi-Cal <input type="checkbox"/> Restricted Medi-Cal		Deceased	Incapacitated	Absent	Unemployed	ID	Deprtv. Verif.	SSN	Citizen/ Alien Verif.
Social Security Number*	Alien Number*	Citizen/Alien Status (check one)* <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Legal Alien <input type="checkbox"/> PRUCOL										
Birthplace (City/State)*	Birthdate	Mother's Name										
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Father's Name						<input type="checkbox"/> MC 13	<input type="checkbox"/> MC 845			
F. Child's Name (First, Middle, Last)			For This Person, Do You Want (check one) <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> No Medi-Cal <input type="checkbox"/> Restricted Medi-Cal		Deceased	Incapacitated	Absent	Unemployed	ID	Deprtv. Verif.	SSN	Citizen/ Alien Verif.
Social Security Number*	Alien Number*	Citizen/Alien Status (check one)* <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Legal Alien <input type="checkbox"/> PRUCOL										
Birthplace (City/State)*	Birthdate	Mother's Name										
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Father's Name						<input type="checkbox"/> MC 13	<input type="checkbox"/> MC 845			
G. Child's Name (First, Middle, Last)			For This Person, Do You Want (check one) <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> No Medi-Cal <input type="checkbox"/> Restricted Medi-Cal		Deceased	Incapacitated	Absent	Unemployed	ID	Deprtv. Verif.	SSN	Citizen/ Alien Verif.
Social Security Number*	Alien Number*	Citizen/Alien Status (check one)* <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Legal Alien <input type="checkbox"/> PRUCOL										
Birthplace (City/State)*	Birthdate	Mother's Name										
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Father's Name						<input type="checkbox"/> MC 13	<input type="checkbox"/> MC 845			
H. Child's Name (First, Middle, Last)			For This Person, Do You Want (check one) <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> No Medi-Cal <input type="checkbox"/> Restricted Medi-Cal		Deceased	Incapacitated	Absent	Unemployed	ID	Deprtv. Verif.	SSN	Citizen/ Alien Verif.
Social Security Number*	Alien Number*	Citizen/Alien Status (check one)* <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Legal Alien <input type="checkbox"/> PRUCOL										
Birthplace (City/State)*	Birthdate	Mother's Name										
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Father's Name						<input type="checkbox"/> MC 13	<input type="checkbox"/> MC 845			
I. Child's Name (First, Middle, Last)			For This Person, Do You Want (check one) <input type="checkbox"/> Full Medi-Cal <input type="checkbox"/> No Medi-Cal <input type="checkbox"/> Restricted Medi-Cal		Deceased	Incapacitated	Absent	Unemployed	ID	Deprtv. Verif.	SSN	Citizen/ Alien Verif.
Social Security Number*	Alien Number*	Citizen/Alien Status (check one)* <input type="checkbox"/> U.S. Citizen <input type="checkbox"/> Undocumented Alien <input type="checkbox"/> Refugee <input type="checkbox"/> Legal Alien <input type="checkbox"/> PRUCOL										
Birthplace (City/State)*	Birthdate	Mother's Name										
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Full-time Student? <input type="checkbox"/> Yes <input type="checkbox"/> No	Father's Name						<input type="checkbox"/> MC 13	<input type="checkbox"/> MC 845			

* Please read the "Citizenship/Immigration Information for Applicants and Beneficiaries of Medi-Cal before completing this section."

<p>4. Does anyone want aid because of pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No • If "yes," complete the information below:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Name of pregnant person</td> <td style="width:33%;">Expected date of birth</td> <td style="width:33%;">Name of father of unborn child</td> </tr> <tr> <td colspan="3">Check the boxes that apply to the father of the unborn child.</td> </tr> <tr> <td style="text-align:center"><input type="checkbox"/> Deceased</td> <td style="text-align:center"><input type="checkbox"/> Incapacitated</td> <td style="text-align:center"><input type="checkbox"/> Absent <input type="checkbox"/> Unemployed</td> </tr> </table>	Name of pregnant person	Expected date of birth	Name of father of unborn child	Check the boxes that apply to the father of the unborn child.			<input type="checkbox"/> Deceased	<input type="checkbox"/> Incapacitated	<input type="checkbox"/> Absent <input type="checkbox"/> Unemployed	<p>COUNTY USE ONLY</p> <p><input type="checkbox"/> Date of Verification</p> <p><input type="checkbox"/> Expedited MC Card</p>									
Name of pregnant person	Expected date of birth	Name of father of unborn child																	
Check the boxes that apply to the father of the unborn child.																			
<input type="checkbox"/> Deceased	<input type="checkbox"/> Incapacitated	<input type="checkbox"/> Absent <input type="checkbox"/> Unemployed																	
<p>5. Did you or any family member use a different name than the one listed when each of you applied for your Social Security Number(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No • If "yes," list the names used:</p>																			
<p>6. Are you or any family member claimed as a deduction for income tax purposes by a person who does not live with you? <input type="checkbox"/> Yes <input type="checkbox"/> No • If "Yes," list their name, address, and relationship to you.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Name</td> <td style="width:33%;">Address</td> <td style="width:33%;">Relationship</td> </tr> <tr> <td>Name</td> <td>Address</td> <td>Relationship</td> </tr> </table>	Name	Address	Relationship	Name	Address	Relationship													
Name	Address	Relationship																	
Name	Address	Relationship																	
<p>7. Is there anyone else living in the home not listed in question 2 or 3? <input type="checkbox"/> Yes <input type="checkbox"/> No • If "yes," list their name(s) and relationship to you.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Name</td> <td style="width:33%;">Address</td> <td style="width:33%;">Relationship</td> </tr> <tr> <td>Name</td> <td>Address</td> <td>Relationship</td> </tr> </table>	Name	Address	Relationship	Name	Address	Relationship													
Name	Address	Relationship																	
Name	Address	Relationship																	
<p>8. A. Are you or any family member asking for Medi-Cal living or currently staying outside California? <input type="checkbox"/> Yes <input type="checkbox"/> No • If "yes," list their name(s) and relationship to you.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%;">Name</td> <td style="width:33%;">Address</td> <td style="width:33%;">Relationship</td> </tr> <tr> <td>Name</td> <td>Address</td> <td>Relationship</td> </tr> </table> <p>B. Do you or any family member have a home outside California? <input type="checkbox"/> Yes <input type="checkbox"/> No • If "Yes," are you or any family member working or looking for work in California? <input type="checkbox"/> Yes <input type="checkbox"/> No • If "No," explain why you are in California.</p> <p>C. Do you and your family plan to continue living in California? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	Name	Address	Relationship	Name	Address	Relationship	<p>If "Yes," see question 20.</p>												
Name	Address	Relationship																	
Name	Address	Relationship																	
<p>9. Have you or a family member changed citizen/allen status in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No • If "Yes," list their name(s) and date(s) their status changed.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:70%;">Name</td> <td style="width:30%;">Date Status Changed</td> </tr> <tr> <td>Name</td> <td>Date Status Changed</td> </tr> <tr> <td>Name</td> <td>Date Status Changed</td> </tr> </table>	Name	Date Status Changed	Name	Date Status Changed	Name	Date Status Changed	<p><input type="checkbox"/> Verification on file. Type:</p>												
Name	Date Status Changed																		
Name	Date Status Changed																		
Name	Date Status Changed																		
<p>10. Have you or any family member ever applied for or received:</p> <table style="width:100%;"> <tr> <td>AFDC Cash Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>SSI/SSP check <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Medi-Cal <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Other Welfare Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Food Stamps <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Medical Premium Payment Benefits (QMB) <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table> <p>• If you answered "Yes" to any of the above items, complete the following:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:40%;">Name of person who applied for or received aid</td> <td style="width:30%;">Type of aid applied for or received</td> <td style="width:30%;">Date of application</td> </tr> <tr> <td>Name of person who applied for or received aid</td> <td>Type of aid applied for or received</td> <td>Date of application</td> </tr> <tr> <td>Name of person who applied for or received aid</td> <td>Type of aid applied for or received</td> <td>Date of application</td> </tr> <tr> <td>Name of person who applied for or received aid</td> <td>Type of aid applied for or received</td> <td>Date of application</td> </tr> </table>	AFDC Cash Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No	SSI/SSP check <input type="checkbox"/> Yes <input type="checkbox"/> No	Medi-Cal <input type="checkbox"/> Yes <input type="checkbox"/> No	Other Welfare Benefits <input type="checkbox"/> Yes <input type="checkbox"/> No	Food Stamps <input type="checkbox"/> Yes <input type="checkbox"/> No	Medical Premium Payment Benefits (QMB) <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of person who applied for or received aid	Type of aid applied for or received	Date of application	Name of person who applied for or received aid	Type of aid applied for or received	Date of application	Name of person who applied for or received aid	Type of aid applied for or received	Date of application	Name of person who applied for or received aid	Type of aid applied for or received	Date of application	
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11 If you or any family member were not receiving Medi-Cal in the three months before application, did you or those members receive any medical care during that time? Yes No
 • If "Yes," please complete the following:

Name of Person Who Received Medical Care	Month(s) of Care	Payments Made for Care?		Do You Wish Medi-Cal for Those Months?	
		Yes	No	Yes	No

COUNTY USE ONLY

Retroactive application
 Retro only
 Retro and cont.
 MC 210A
 Verification of Disability/Blindness
 List: _____

12 A. Are you or any family member asking for Medi-Cal:
 65 or Over? Yes No If "Yes," name(s): _____
 Blind? Yes No If "Yes," name(s): _____

B. Do you or any family member have a physical or emotional problem which makes it difficult to work or take care of your needs? Yes No
 • If "Yes," please complete the following:

Name of Person with Problem	Type of Problem(s)	Beginning Date of Problem(s)?	Expected Recovery Date If Known

Buy-In
 DHS 6166 Sent _____

Presumptive
 DED Packet

C. Was the problem listed in (2B) above caused by an injury or accident? Yes No
 • If "Yes," have you filed a lawsuit or insurance claim? Yes No

Referral to Medi-Cal Recovery

13 A. Do you or any family member have any of the property/resources listed below? Check item either "Yes" or "No."
 • Include all resources owned, used, controlled, shared, or held jointly with or for another person(s).
 • Include resources on which persons listed in 2 and 3 are named (even for convenience only).
 • The county will determine whether or not the resources count.

Yes	No	Property/Resource
<input type="checkbox"/>	<input type="checkbox"/>	Cash (on hand or elsewhere)
<input type="checkbox"/>	<input type="checkbox"/>	Uncashed checks (on hand or elsewhere)
<input type="checkbox"/>	<input type="checkbox"/>	Savings accounts—children's and adult's
<input type="checkbox"/>	<input type="checkbox"/>	Checking accounts—whether or not they are used
<input type="checkbox"/>	<input type="checkbox"/>	Credit union accounts
<input type="checkbox"/>	<input type="checkbox"/>	Stocks or bonds
<input type="checkbox"/>	<input type="checkbox"/>	Certificate of deposit
<input type="checkbox"/>	<input type="checkbox"/>	Money market accounts
<input type="checkbox"/>	<input type="checkbox"/>	Trust funds (whether or not available)
<input type="checkbox"/>	<input type="checkbox"/>	Notes, mortgages, trusts, deeds, contract of sale, etc.
<input type="checkbox"/>	<input type="checkbox"/>	IRA or Keogh plans
<input type="checkbox"/>	<input type="checkbox"/>	Retirement funds (such as PERS) available if you stop work
<input type="checkbox"/>	<input type="checkbox"/>	Employee deferred compensation plans
<input type="checkbox"/>	<input type="checkbox"/>	Other (type): _____

• If you answered "Yes" to any of the above, complete the section below:

Trust Fund Not Court-Ordered
 Court Petitioned
 Date: _____
 Current Month Income Included
 Resources Verified.
 List Documents: _____

Type of Resource	Owner of Resource	Account Number	Name and Address	Current Value
				\$
				\$
				\$

B. Have you or any family member closed or transferred a bank account during the last 30 months (2 1/2 years)? Yes No

• If "Yes," please complete the following:

Type of Account	Date Account(s) Closed or Transferred	Balance at Time of Closing or Transfer

COUNTY USE ONLY

LTC ONLY:
 Adequate consideration
 Spenddown

14 Do you or any of your family own life insurance? Yes No

• If "Yes," please complete the following:

Insurance Company	1. Person Insured	Face Value	Policy Number	Date Policy Issued	Current Cash Value
	2. Policy Owned By				
A.	1.	\$			\$
	2.				
B.	1.	\$			\$
	2.				
C.	1.	\$			\$
	2.				

Yes No CSV
 Exempt \$ _____
 Exempt \$ _____
 Exempt \$ _____
 Total CSV \$ _____

15 Do you or any family member own a burial plot, vault, or crypt? Yes No

• If "Yes," is it for use of immediate family? Yes No

Description: _____

Owned by: _____

Current Value: \$ _____ Amount Owed \$ _____

Location: _____

Exempt \$ _____

16 Do you or any family member own a burial reserve or trust? Yes No

• If "Yes," please complete the following:

Purchase Price	Amount Owed	Purchased	
		For Whom	From Whom
\$	\$		
\$	\$		
\$	\$		

Revocable
 Irrevocable
 Designated Funds
 Current Value \$ _____

17 A. List all vehicle(s) (even if not running) owned by you or your family. If none, state "none."

COUNTY USE ONLY

Make and Model	Year	Class (Registration)	Owner	Amount Owed	Used for Transportation?	
					Yes	No
				\$		
				\$		
				\$		
				\$		
				\$		

List exempt vehicle:

Verification of (nonexempt) vehicles

Verification of encumbrance

Verification of personal property

B. Do you or any family member own boats, campers (do not include trucks) motor homes, mobile homes, or trailers which are not used as a home and are not taxed as real property by the county? Yes No

Description	Year	Class (Registration)	Owner	Purchase Price	Used for Transportation?	
					Yes	No
				\$		
				\$		
				\$		
				\$		

NOTE: If you think the value the Department of Motor Vehicles will give the items listed in (17A) and (17B) will be too high, you may provide three appraisals of the actual value and the average will be used.

18 Do you or any family member own items of jewelry valued at more than \$100 each? Yes No
(Do not include wedding and engagement rings or heirlooms.)

Heirloom? _____

Total Nonexempt _____

Appraised Value \$ _____

Exempt

• If "Yes," please complete the following:

Description	Estimated Value	Amount Owed
	\$	\$
	\$	\$

19 Do you or any family member own business equipment, vehicles, tools, inventory or materials (including livestock or poultry not for personal use)? Yes No

• If "Yes," please complete the following:

Description	Estimated Value	Amount Owed
	\$	\$
	\$	\$
	\$	\$

20 A. Do you or any family member own, or are you buying, any of the items listed below? (Do not list property where you and your family are now living.) List property in any state or country and all land you own, have title to, or share title in.

Yes No Yes No

Houses Mobile homes taxed as real property

Lots Other (list):

Land

Trailers

Apartments

• If you answered "Yes" to any of the above, complete Section B below.

COUNTY USE ONLY

Verification of "Good Cause" for Nonutilization of Property

Verification of Income and Expenses (List):

B. Address or Legal Description of Property: _____

Name of Owner: _____

Does anyone live there now? Yes No How long have they lived there? _____

Name of person living there: _____ Relationship to you: _____

Do you plan to return to that property to live? Yes No
(You must notify the county within ten (10) days of any change in plans for living at the property.)

Is the property currently listed for sale? Yes No

Full value of property (from tax statement): \$ _____ Amount owed \$ _____

Rent collected each month from property: \$ _____

Expenses on property:

• Interest \$ _____ Yearly/Monthly • Insurance \$ _____ Yearly/Monthly

• Taxes and Assessments \$ _____ Yearly/Monthly • Upkeep and Repairs \$ _____ Yearly/Monthly

• Utilities \$ _____ Yearly/Monthly

21 Do you or any family member have a life estate interest in (right to use) any property? Yes No

• If "Yes," please complete the following:

Address of life estate property: _____

Do you or any family member have an income interest in a life estate? Yes No

Is the life estate producing income? Yes No

Revocable
 Irrevocable

22 Have you or any family member transferred, sold, or given away property (including money) during the past 30 months (2 1/2 years)? Yes No

• If "Yes," please list:

LTC ONLY
 Adequate consideration
 Irrevocable

Description of item Sold, Transferred, or Given Away	Date of Sale, Transfer, or Gift	Value	Amount Received
		\$	\$
		\$	\$
		\$	\$

26. Do you or any family member pay child support or alimony under a court order or based on an agreement with the District Attorney? Yes No

• If "Yes," please complete the following:

Amount paid: \$ _____ By whom: _____

Date last paid: _____ To whom: _____

COUNTY USE ONLY

COURT ORDER

Amount \$ _____

Date: _____

Verification of payment

27. A. Are you or any family members working or expecting to work in the next two (2) months? Yes No

If "Yes," please complete the information below.

NOTE: If self-employed, complete 27B below.

VERIFICATION (List):

Wage stubs

Tips

Child in school

Exempt earnings

Conversion Factor:

Actual

4.33

2.167

Person Working			
Employers Name	A		
Days Worked Weekly	2		
Hours Worked Weekly			
How Often Paid			
Day of Week Paid			
Gross Earnings (Before deductions) (Include tips/commissions)	\$	\$	\$
Occupation/Job Title			

ANTICIPATED INCOME. If your income changes from month to month, show your actual income for the current month in "Month 1" below, and your estimated gross income for the following two months in "Month 2" and "Month 3."

Name and Occupation	Month 1	Month 2	Month 3
	\$	\$	\$
	\$	\$	\$
	\$	\$	\$

B. If self-employed, please complete the following:

Adjusted gross income from last federal tax return: \$ _____

Has income changed since last federal tax return? Yes No

If income changed or no tax return, what was:

- Gross profit per year: \$ _____
- Business expenses per year: \$ _____
- Cash on hand for business: \$ _____
- Money in checking accounts for business: \$ _____
- Average monthly cash expenditures for business: \$ _____
- Average monthly cash drawn from business: \$ _____

NET PROFIT FROM SELF-EMPLOYMENT

Tax return on file

COUNTY USE ONLY

C. Does anyone who works pay for care of a child or disabled adult? Yes No

• If "Yes," please complete the information below.

Name of person (age 2 or under) receiving care			
Name of person (age 3 or over) receiving care			
Name of person paying for care			
Amount of payment and how often paid	\$ _____ every <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month	\$ _____ every <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month	\$ _____ every <input type="checkbox"/> day <input type="checkbox"/> week <input type="checkbox"/> month

Other person in MFBU who could provide care (MEM 50553.5)

Verified amount paid and age of person receiving care

D. If you are a working disabled person, do you have any medically-related expenses which are necessary for your employment, such as a wheelchair, etc.? Yes No

• If "Yes," please list any medically-related expenses below.

IRWE (QMB only)

Type of Expense	Amount
	\$
	\$
	\$

28. Have you or any family member stopped work or training in the last 30 days? Yes No

• If "Yes," please complete the following.

Name of Person	Hours of Work/Training in the Last 30 Days
Name and Address of Employer/Training Program	
Reason for Leaving Job/Training	Date Last Paycheck Received/Expected
Name of Person	Hours of Work/Training in the Last 30 Days
Name and Address of Employer/Training Program	
Reason for Leaving Job/Training	Date Last Paycheck Received/Expected

Employer statement

Good cause determination required

29. Are you or any family member participating in a labor strike? Yes No

• If "Yes," please complete the following:

Strike regulations apply

Name of Striker:	Date Strike Began
Name of Union:	
Name of Employer:	
Address of Employer:	

30. Has anyone applied for or received Unemployment Insurance Benefits (UIB) in the last 12 months? Yes NO

• If "Yes," please complete the following:

Name	Date Applied	Where? (County/State)	Date Last Received

31

A. EMPLOYMENT HISTORY: List all work and training in the past five (5) years. Include work done outside the United States and work done in exchange for something such as rent, food, utilities, or anything else.

FIRST PERSON—NAME: _____
Has the person worked or been in training in the past five (5) years? Yes No
• If "Yes," please complete the information below. Begin with the most recent job or training.

Name of Employer/Training Program	Work or Training (Check One)	Date of Employment/ Training	Amount Paid (Weekly/ Monthly)
	<input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____
	<input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____
	<input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____
	<input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____
	<input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____
	<input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____

B. SECOND PERSON—NAME: _____
Has the person worked or been in training in the past five (5) years? Yes No
• If "Yes," please complete the information below. Begin with the most recent job or training.

Name of Employer/Training Program	Work or Training (Check One)	Date of Employment/ Training	Amount Paid (Weekly/ Monthly)
	<input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____
	<input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____
	<input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____
	<input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____
	<input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____
	<input type="checkbox"/> Work <input type="checkbox"/> Training	From _____ To _____	\$ _____

COUNTY USE ONLY

Application Date: _____
24-month period: _____ to _____

Use the same 24-month period for each person

First Person's Earnings

YEAR	QUARTER				
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	

Total earnings: \$ _____

Principal Wage Earner

UIB:
 Must apply for
 Currently receiving
 Ineligible (specify reason): _____

Verification on file

Second Person's Earnings

YEAR	QUARTER				
	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	

Total earnings: \$ _____

Principal Wage Earner

UIB:
 Must apply for
 Currently receiving
 Ineligible (specify reason): _____

Verification on file

COUNTY USE ONLY

NOTE: Determine the connection with the labor force for the Principal Wage Earner (PWE) only.
CONNECTION WITH LABOR FORCE DETERMINATION

Principal Wage Earner (PWE): _____

Date of Application: _____ Quarter of Application: _____

PWE eligible to receive UIB in last 12 months? Yes No

Are there 6 quarters of work and/or training within any one of the 13 consecutive quarter periods? Yes No

REDETERMINATION: Federal eligibility was determined per MC 210 dated: _____

Year	Q1	Q2	Q3	Q4												
Quarter																
Work (\$50)																
Training (CWEP/WIN Demo/Gain)																
<p>← Earliest 13 quarters that end within one year →</p> <p>← Latest 13 quarters that end within one year →</p>																

32	<p>Is a parent living in the home unemployed or working less than 100 hours per month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● If "Yes," please complete the following:</p> <p>First Parent Month/Day/Year Yes No</p> <p>If unemployed, date last worked: _____ Working less than 100 hours per month? <input type="checkbox"/> <input type="checkbox"/></p> <p>Began seeking full-time employment when? _____ Actively seeking full-time employment? <input type="checkbox"/> <input type="checkbox"/></p> <p>Second Parent</p> <p>If unemployed, date last worked _____ Working less than 100 hours per month? <input type="checkbox"/> <input type="checkbox"/></p> <p>Began seeking full-time employment when? _____ Actively seeking full-time employment? <input type="checkbox"/> <input type="checkbox"/></p>	<p>COUNTY USE ONLY</p>												
33.	<p>Are you or any family member in college or attending a similar educational institution? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>● If "Yes," please complete the following:</p>	<p>See MEM 50447 for allowable education expenses.</p> <p>EXEMPT:</p> <p><input type="checkbox"/> Entire amount <input type="checkbox"/> Only expenses</p> <p>VERIFICATION (List):</p> <p>Transportation costs allowed (show computations):</p>												
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:35%; vertical-align:top;"> <p>A. Student's name(s)</p> <p>Name of institution(s)</p> <p>Status of student(s):</p> </td> <td style="width:30%; vertical-align:top;"> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Grad <input type="checkbox"/> Undergrad</p> </td> <td style="width:35%; vertical-align:top;"> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Grad <input type="checkbox"/> Undergrad</p> </td> </tr> <tr> <td style="vertical-align:top;"> <p>B. Grants, Loans, Scholarships, Fellowships:</p> <p>Amount received:</p> <p>Source(s) of grants, loans, etc.:</p> <p>How often received?</p> </td> <td style="vertical-align:top;"> <p>_____</p> <p>\$ _____</p> <p>_____</p> <p>_____</p> </td> <td style="vertical-align:top;"> <p>_____</p> <p>\$ _____</p> <p>_____</p> <p>_____</p> </td> </tr> <tr> <td style="vertical-align:top;"> <p>C. Expenses Per Term:</p> <p>Is term a semester, quarter, year?</p> <p>Tuition/fees</p> <p>Books, equipment, and supplies</p> <p>Child care necessary for school</p> </td> <td style="vertical-align:top;"> <p>_____</p> <p>_____</p> <p>\$ _____</p> <p>\$ _____</p> <p>\$ _____</p> </td> <td style="vertical-align:top;"> <p>_____</p> <p>_____</p> <p>\$ _____</p> <p>\$ _____</p> <p>\$ _____</p> </td> </tr> <tr> <td style="vertical-align:top;"> <p>D. Transportation to School/Child Care:</p> <p>Round trip miles per day</p> <p>School attended how many days per week</p> <p>Type of transportation used (own car, borrowed car, car pool, bus, etc.)</p> <p>Costs (per month):</p> <p>● Amount paid by student (not own car)</p> <p>● Amount paid by riders</p> <p>● Parking, tolls, etc.</p> <p>Is public transportation (bus, train, etc.) available?</p> <p>● If yes, indicate cost:</p> </td> <td style="vertical-align:top;"> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>\$ _____</p> <p>\$ _____</p> <p>\$ _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>\$ _____</p> </td> <td style="vertical-align:top;"> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>\$ _____</p> <p>\$ _____</p> <p>\$ _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>\$ _____</p> </td> </tr> </table>			<p>A. Student's name(s)</p> <p>Name of institution(s)</p> <p>Status of student(s):</p>	<p>_____</p> <p>_____</p> <p><input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Grad <input type="checkbox"/> Undergrad</p>	<p>_____</p> <p>_____</p> <p><input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Grad <input type="checkbox"/> Undergrad</p>	<p>B. Grants, Loans, Scholarships, Fellowships:</p> <p>Amount received:</p> <p>Source(s) of grants, loans, etc.:</p> <p>How often received?</p>	<p>_____</p> <p>\$ _____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>\$ _____</p> <p>_____</p> <p>_____</p>	<p>C. Expenses Per Term:</p> <p>Is term a semester, quarter, year?</p> <p>Tuition/fees</p> <p>Books, equipment, and supplies</p> <p>Child care necessary for school</p>	<p>_____</p> <p>_____</p> <p>\$ _____</p> <p>\$ _____</p> <p>\$ _____</p>	<p>_____</p> <p>_____</p> <p>\$ _____</p> <p>\$ _____</p> <p>\$ _____</p>	<p>D. Transportation to School/Child Care:</p> <p>Round trip miles per day</p> <p>School attended how many days per week</p> <p>Type of transportation used (own car, borrowed car, car pool, bus, etc.)</p> <p>Costs (per month):</p> <p>● Amount paid by student (not own car)</p> <p>● Amount paid by riders</p> <p>● Parking, tolls, etc.</p> <p>Is public transportation (bus, train, etc.) available?</p> <p>● If yes, indicate cost:</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>\$ _____</p> <p>\$ _____</p> <p>\$ _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>\$ _____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>\$ _____</p> <p>\$ _____</p> <p>\$ _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>\$ _____</p>
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34. Do you or any family member have Medicare coverage? Yes No
 • If "Yes," please complete the following:

Name of Person Covered	Medicare Claim Number	MONTHLY PREMIUM	
		Amount	Type of Payment
			<input type="checkbox"/> Deducted <input type="checkbox"/> Paid by State
			<input type="checkbox"/> Paid by you/family member
			<input type="checkbox"/> Deducted <input type="checkbox"/> Paid by State
			<input type="checkbox"/> Paid by you/family member

COUNTY USE ONLY

Potential QMB

Part A Part B

Pending _____
Date

Part A Part B

Pending _____
Date

35. Do you or any family member have any health insurance:
 • which is currently in effect? Yes No
 • available through a parent, employer, or absent parent which you have not applied for? Yes No
 • available which lapsed within the last 60 days? Yes No

This includes Medicare supplements, prepaid health plans/health maintenance organizations, CHAMPUS, VA, or private health insurance which includes dental, vision, prescriptions, outpatient services, physicians visits, and hospitalization insurance. Insurance which is paid by, or available through a parent, employer, or absent parent should also be included. Having health insurance will not affect your eligibility for Medi-Cal.

• If your answer is "Yes" to any of the above, please complete the following:

DHS 6155 completed and sent

Other health coverage code: _____

Name of Health Insurance	Person(s) Insured	Premium/How Often Paid
		Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly <input type="checkbox"/>
	Expiration Date: _____	Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Yearly <input type="checkbox"/>

36. A. Have you or any family member mortgaged property or taken out a loan against your property to pay for medical care you received or will receive during a period for which you are asking for Medi-Cal benefits? Yes No

B. Has a lien been recorded against your property or the property of a family member as security for medical care received or to be received during a period for which you are asking for Medi-Cal benefits? Yes No

C. If "Yes" was checked for 36A or 36B please complete the following:
 Amount of payment/mortgage or lien: \$ _____
 Mortgage or payment made to or lien recorded by: _____
 Date and type of medical care received or to be received: _____

Payment or lien used to bring property within property limits?
 Yes No
 If "Yes":
 Notice to provider

37. A. Have you or any immediate family member ever been in the U.S. Military service? Yes No

B. Are you or any immediate family member the spouse, parent, or child of a person who has been in the U.S. Military service? Yes No

38. Have you or any family member applied for (or think you should get) payment(s) you are not now receiving? Yes No

• If "Yes," please complete the following:

CA 5
 Medi-Cal recovery referral date: _____

Kind of Payment	Person Possibly Eligible	Date of Application (month/day/year)	Date Payment Expected (month/day/year)
Social Security			
Disability Payments			
Veteran's Payments			
Unemployment Benefits (UIB)			
Worker's Compensation			
Medicare			
Pending Settlement for Accident/Injury			
Other: (Describe)			

Date of accident/Injury: _____

CERTIFICATION

COUNTY USE ONLY

- I have read and received a copy of the MC 210 Cover Sheet attached to this form.
- I am aware of, understand, and agree to meet all my responsibilities as described on the MC 210 Cover Sheet.
- I understand that all of the statements, including benefit and income information, that I have made on this form are subject to investigation and verification.
- I understand that Section 1137 of the Social Security Act requires that I provide Social Security numbers (SSNs) for myself and any family members if I/we request full Medi-Cal benefits. I understand that my/our SSNs will be verified and will be used in a computer match to check the income and resources I/we report with information from welfare, state employment, income tax, Social Security Administration, and other agencies. I understand that this is done to make sure that my/my family's eligibility and share-of-cost level, if any, are correct.
- I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Statement of Facts is true and correct.

DHS 7068
"Representative Checklist"

Date: _____

Signature of Applicant

Date

Signature of Applicant

Date

Address of Person Acting for Applicant/Beneficiary

Phone Number of Person Acting for Applicant

It is the responsibility of the beneficiary and person acting for the applicant/recipient to report to the Eligibility Worker within ten (10) days any changes that occur.

Signature of Person Acting for Applicant/Beneficiary

Date

Signature of Person Acting for Applicant/Beneficiary

Date

Address of Person Acting for Applicant/Beneficiary

Phone Number of Person Acting for Applicant

COUNTY USE ONLY

EW Signature

Date

PROPOSED EXPANDED CHOICE GRIEVANCE SYSTEM*

I. SCOPE OF GRIEVANCE SYSTEM

A. Each Health Care Plan (HCP) must establish and maintain an internal system for receiving and resolving grievances, as described in Section II.

1. The California Medical Assistance Commission (CMAC) will ensure, prior to signing contracts with HCPs, that each HCP's grievance procedure meets the requirements noted in Section II.

2. The Department of Health Services (DHS) will ensure that HCPs operate internal grievance systems in compliance with these requirements at all times.

B. The Department of Health Services will establish and maintain a system for receiving and resolving grievances and appeals from HCP grievance decisions, as described in Sections III-VI. The DHS system also involves analyzing the nature of grievances raised about HCPs and implementing remedial measures.

1. While it is expected that most grievances will initially be resolved by the HCP internal grievance systems, direct resort to the DHS system will be available: (a) in urgent situations, (b) where direct resort is otherwise appropriate, and (c) where the enrollee insists.

2. An enrollee's right to request and obtain a Medi-Cal Fair Hearing is not abridged by these procedures.

* Prepared by Geraldine Dallek, Health Policy Analyst, and Michael Parks, Staff Attorney, National Health Law Program.

3. An enrollee's right to seek judicial relief in any court of competent jurisdiction is not abridged by these procedures.

C. As used in these provisions, the term "grievance" includes any complaint about actions or failures to take action by HCPs or their employees, contractors or contractors' employees.

. HEALTH CARE PLAN GRIEVANCE SYSTEMS

A. Each HCP must maintain an internal grievance system which meets Knox-Keene requirements.

B. Each HCP will forward a copy of its grievance log to the DHS Grievance Unit (Section IV B) monthly. This monthly log will contain a written record of each grievance filed with the HCP, including the date the grievance was filed, identification of the individual recording the grievance, the nature of the grievance, the resolution of the grievance including any remedial action taken, the date of the resolution, and the date the grievant was notified.

II. THE DEPARTMENT OF HEALTH SERVICES GRIEVANCE SYSTEM

A. DHS will establish a grievance system external to the HCP's grievance system. As discussed in Sections IV-VI, this system will be responsible for:

1. Assisting enrollees in using the Expanded Choice (EC) grievance system.

2. Receiving, reviewing, and referring or resolving complaints and grievances received directly from Expanded Choice enrollees.

3. Reviewing enrollee grievances filed directly with DHS as well as those documented in the grievance logs sent by HCPs.
4. Analyzing causes of grievances, as well as their resolutions, and recommending changes which need to be made in the operation of HCPs in light of those analyses.

IV. THE STAFFING OF THE DHS GRIEVANCE SYSTEM

- A. DHS will establish a toll-free "hotline" operated by Expanded Choice Enrollment Workers (ECWs).*
 1. The hotline will be adequately staffed to ensure that callers reach a hotline worker within a reasonable time.
 2. ECWs (as described in Section V A) will be responsible for:
 - a. providing advice and assistance to HCP enrollees who have questions or raise problems about the care they receive.
 - b. maintaining records of all complaints and grievances received and sending a copy of those records to the DHS Grievance Unit.
- B. DHS will establish a Grievance Unit located within DHS offices in areas where EC is implemented.

* We recommend that the EC Enrollment Contractor staff be assigned the responsibility of initially handling and referring formal grievances to the DHS grievance Unit because: they will already be handling enrollments, disenrollments, exemptions, and plan changes; they will be conveniently located in local offices; and they will generally be called by HCP enrollees to answer questions. If ECWs are not given this responsibility, DHS should hire new staff to provide hotline referrals.

1. This unit will consist of contract monitors (who already have the responsibility of monitoring access to and quality of care provided by HCPs on a continuous basis), a Medical Director appointed by DHS, and adequate support staff.
2. The Contract Monitors will be responsible for:
 - a. Investigating and proposing a written solution to all formal grievances received from the ECWs;
 - b. Referring grievances concerning medical questions to the Medical Director (see below);
 - c. Reviewing the grievance logs received from all HCPs monthly;
 - d. Preparing a monthly summary by HCP of all complaints and grievances received (from the HCP logs, the complaint information forms and direct grievance referrals). This summary will show the number of complaints and grievances against each plan by type of grievance, at what stage in the grievance process at which a resolution was achieved; and a description of any major quality of care problem that came to light during the month as a result of the grievance process.

-- Reports from HCPs, ECWs, grievance unit staff, and grievance summaries will be prepared in a uniform manner.
3. The Medical Director (who may be appointed from the Audit and Investigations Unit of DHS) will be responsible for:
 - a. the quality of care provided by the EC program;
 - b. the overall operations of the Grievance Unit, including:

- resolving grievances which raise medical issues;
- reporting monthly to both the Community Advisory and the Medical Advisory Boards on grievances and quality of care provided by Expanded Choice;
- convening a joint meeting of representatives of both the Community Advisory Board and the Physician Advisory Board to hear formal Grievance Appeals, as provided in Section V C.

V. GRIEVANCE PROCEDURES

A. Hotline Unit

1. Hotline workers (ECWs) will determine the nature of all complaints and grievances and will counsel enrollees on immediate steps to deal with their concerns.
2. All EC enrollees can contact a ECW in person, by telephone, or in writing.
3. Because it is expected that the HCP's internal grievance process should be the primary point of resolution for the majority of enrollees' complaints, enrollees with complaints will be urged to file a grievance with their HCP unless:
 - a. it is the judgment of the ECW that the problem raised by the enrollee is a serious one requiring immediate resolution;
 - b. the enrollee has already gone through the HCP's grievance system;
 - c. the enrollee is fearful of a confrontation with the HCP over the complaint;

- d. There is other good cause from which it is reasonable to conclude that direct resort to the DHS grievance system is appropriate.
4. It will, however, be made clear to the enrollee that (s)he does not first have to go through the HCP's grievance system before appealing to the DHS grievance unit.
5. The ECW will explain the various options open to an enrollee with a complaint:
 - a. filing a formal grievance with the HCP;
 - b. filing a formal grievance with the DHS Grievance Unit;
 - c. disenrollment from the plan without filing a grievance with the DHS Grievance Unit;
 - d. disenrollment from the plan but still filing a formal complaint with the DHS Grievance Unit;
 - e. making a direct request for a fair hearing.
 - f. when appropriate, seeking a medical exemption from Expanded Choice.
6. All enrollees who wish to file a formal grievance with the DHS Grievance Unit will be given or sent a written description (in English and Spanish) of how the grievance process works.
7. All complaints will be logged on a complaint information form which will include the name of the enrollee, the date the complaint was received, the plan in which the individual is enrolled, the nature of the complaint, and the disposition of the complaint.

- a. All complaint information forms will be forwarded within two working days to the DHS Grievance Unit whether or not a formal grievance is filed.
 - b. The complaint information form will contain one of the following notations: (1) Enrollee referred to HCP Internal Grievance System; (2) Enrollee refused HCP and DHS grievance systems and changed HCPs; (3) Enrollee dissatisfied with the HCP grievance decision and requests a change of plans; (4) Enrollee dissatisfied with the HCP grievance decision and requests DHS grievance investigation; (5) Enrollee wishes to bypass HCP Grievance System and requests HHS grievance investigation; (6) Enrollee wishes to go directly to a Fair Hearing.
 - c. If the complaint information form contains a notation of a request for a DHS grievance investigation, the form becomes a formal grievance request.
8. If, in the view of ECWs, an urgent situation exists, they will immediately telephone the DHS grievance unit directly, explaining the issues so that an investigation can begin immediately.
 9. If a formal DHS grievance investigation is requested, a medical release form (written in English and Spanish, and in another language when needed) must be signed by the enrollee filing the grievance. Grievance investigations can begin, but no medical data can be obtained, without a signed medical authorization release.

10. The ECW will assist enrollees in filling out required forms.

a. The ECW will, if a complaint is presented in person, record relevant information, and, if a formal grievance is lodged with DHS, provide the enrollee with a written description of the grievance system and request that the medical release form be signed.

Copies of both the complaint form and the release will be given to the enrollee and sent to the DHS Grievance Unit.

b. If a complaint is received by telephone or letter, the ECW will send a copy of the completed complaint information form, the grievance information, and an authorization release form (if a formal DHS grievance is requested) to the enrollee within two working days. Enrollees will be asked to send the signed medical authorization release form directly to the appropriate Contract Monitor.

B. DHS Grievance Unit

1. Contract Monitors will receive copies of all complaint information forms, as well as all emergency referrals from ECWs, concerning the HCPs they are responsible for monitoring.

2. All grievances concerning medical problems will be referred to the Medical Director immediately. Examples of medical issues include:

- a. services provided out-of-plan which the plan determines are medically unnecessary and will not reimburse;
 - b. refusal by the case manager to refer an enrollee to a specialized provider;
 - c. disagreement between the enrollee and case manager over the need for special medicines or durable medical equipment;
 - d. discontinuance of specialized referral services such as speech therapy;
 - e. transfer of an enrollee to a nursing home although (s)he or a family member believes enrollee should be sent home with home health and in-home supportive services.
3. Non-medical complaints will be handled by the Contract Monitor. Examples of non-medical complaints include:
- a. rudeness by case manager or other HCP employees;
 - b. excessive waiting time for enrollee to get an appointment with the case manager or other provider;
 - c. excessive waiting time for enrollee to be seen by provider;
 - d. refusal by the BCP to allow the enrollee to change case managers, or unnecessary delay by the HCP in approving such a change.
4. Contract Monitors will assist the Medical Director in obtaining information if assistance is requested.
5. All medical complaints will be prioritized and investigated.

- a. Final decisions on all non-urgent medical complaints (i.e., the enrollee has already changed plans, an elective procedure is at issue, out-of-plan services will not be reimbursed) and all non-medical complaints must be made and the enrollee notified in writing within 15 days of receipt of the complaint information form.
- b. All urgent medical complaints must be decided and the enrollee so notified within three (3) working days of receipt of the phone or written notification by the ECW, and sooner if, in the judgment of the Medical Director, an emergency exists.

6. Enrollees will be notified in writing of the decision of the Grievance Unit and the reason for the decision. The notice will contain information on the enrollee's appeal rights.

7. Enrollees can appeal all DHS Grievance Unit decisions to a Fair Hearing or to the EC Grievance Review Board (see below).

C. Grievance Review Board

1. The Grievance Review Board will be composed of three representatives from the Community Advisory Board and three representatives from the Provider Advisory Board.
2. The Grievance Review Board will meet whenever necessary to hear all grievance appeals of DHS Grievance Unit decisions.
3. The Grievance Review Board will be convened by the Medical Director and must meet within 5-10 days of the Medical Director's request at a time and location convenient to the enrollee.

4. The Grievance Review Board will hear testimony from interested parties, including the Medical Director or his or her representative, HCP Plan representative, the enrollee and/or his or her representative and other medical experts if called.
5. The Board will make its findings and will propose a resolution to the grievance in writing to the enrollee within 15 working days of the hearing.
6. The enrollee will be notified that (s)he can, if dissatisfied with the Board's decision, ask for a Fair Hearing.
7. Board hearings will be closed to the public except when the enrollee requests a public review and such review does not compromise privileged information.

VI. GRIEVANCE REPORTS

- A. Monthly reports will be prepared by the Contract Monitors summarizing the frequency and the nature of all grievances and their resolution.
- B. These monthly reports will be distributed to the following:
 1. The Medical Director;
 2. Appropriate DHS Investigations and Audit staff;
 3. The Community Advisory Board;
 4. The Provider Advisory Board;
 5. The Department of Corporations;
 6. All ECWs;
 7. All HCPs.
- C. Monthly grievance reports for all HCPs will be provided to the public upon request.

- D. At least once a month, a Contract Monitor or Medical Director will discuss and evaluate grievance trends and review grievances at a Community Advisory Board and Provider Advisory Board Meeting.
- E. If, in the judgment of the Medical Director, a grievance raises serious quality of care issues, the Medical Director will refer the issue to the Board of Medical Quality Assurance, the DHS facility licensure divisions, DHS Division of Audits and Investigations, the Department of Corporations, and other appropriate agencies.

I. ENROLLEE EDUCATION

- A. Enrollees will be provided with written and/or information on how to use the grievance process in the following ways:
 1. eligibility determination and redeterminations for Medi-Cal;
 2. mailings to newly enrolled SSI recipients;
 3. ECW presentations (both individual and group);
 4. when an enrollee requests a change of plans;
 5. posted signs at Welfare and SSA offices;
 6. distribution of grievance information to community organizations;
 7. written information distributed by all HCPs to enrollees at the time of enrollment;
 8. printed hotline number on the enrollee's HCP card.

LITTLE HOOVER COMMISSION FACT SHEET

The Little Hoover Commission, formally known as the Commission on California State Government Organization and Economy, is an independent state watchdog agency that was created in 1962. The Commission's mission is to investigate state government operations and through reports and recommendations promote efficiency, economy and improved service.

By statute, the Commission is a balanced bipartisan board composed of five citizen members appointed by the Governor, four citizen members appointed by the Legislature, two Senators and two Assembly members.

The Commission holds hearings once a month on topics that come to its attention from citizens, legislators and other sources. But the hearings are only a small part of a long and thorough process:

- * Two or three months of preliminary investigations and preparations come before a hearing is conducted.
- * Hearings are constructed in such a way to explore identified issues and raise new areas for investigation.
- * Two to six months of intensive fieldwork is undertaken before a report, including findings and recommendations, is written, adopted and released.
- * Legislation to implement recommendations is sponsored and lobbied through the legislative system.
- * New hearings are held and progress reports issued in the years following the initial report until the Commission's recommendations have been assimilated.

Additional copies of this publication may be purchased for \$5.00 per copy from:
Little Hoover Commission
1303 J Street, Suite 270