

How Should We Close California's Budget Deficit?

We have a \$15 billion budget deficit – nearly 15% of the state's General Fund. The Governor has proposed deep cuts in Medi-Cal eligibility, services and payments to health care providers and health plans and somewhat smaller cuts in the Healthy Families program for uninsured children.¹ The recent Field poll reports that over three quarters of Californians strongly oppose these health program cuts and at the same time do not want to see their own taxes raised in order to help allay the state deficit.²

Medi-Cal covers the low-income aged and disabled, and low-income children and their parents. Medi-Cal spending per recipient and its payment rates for providers and health plans are among the lowest in the country.³ Our eligibility standards (except for pregnant women and uninsured children) are already quite low – 100% of the federal poverty level (\$20,000 for a family of four) and over 6.5 million California residents depend on the program.⁴ Utilization of covered services by children and adults is low as compared to other states across the country.⁵

The Governor's budget proposal for Medi-Cal would dismantle over a decade of bi-partisan progress in improving this vital health program. It would add red tape, return up to a million family members to emergency room based care and remove the family and work friendly incentives that were and are important achievements for both political parties.⁶

The proposal would over time cut about a million children and their families from the program by eliminating eligibility for two parent full time working families, slashing eligibility for working parents to 2/3rds of the federal poverty level and re-introducing red tape barriers that both parties agreed made little sense and gave the program an awful reputation with doctors, patients and health plans. This will add one million Californians to the 6.6 million already uninsured. Income eligibility for parents would be reduced from 100% of FPL to 68% of FPL. Two parent families would lose eligibility if the breadwinner is employed more than 100 hours a month. New legal immigrants would be restricted to emergency and perinatal coverage only. Eligibility for families would be re-assessed quarterly as opposed to annually. Many services for low-income adults would be terminated, most prominently adult dental care.

In votes last week, the Senate and Assembly Budget Committees rejected most of the proposed cuts and met the Governor half way on others.⁷ For example, the re-determinations of eligibility would occur semi-annually in the Senate version of the budget. The Governor's proposed increases in the premiums that Healthy Families parents pay for their children would be cut in half.⁸ Rates for plans and providers would be cut by 5% as opposed to 10%. An \$1800 annual cap on adult dental care would be imposed rather than eliminating the benefit entirely.

Revenues, revenues, revenues:

Without a revenue strategy, the Governor's proposed cuts and many others will be coming back for reconsideration in the budget conference committee. Part of the Governor's funding strategy had been to update the state lottery and use the anticipated revenues from modernization to partially fund the budget shortfall.⁹ The general response has been this is a good idea, but it will not generate the Governor's projected \$5 billion in new revenues.¹⁰ Another part of the Governor's strategy is to roll over a part of the deficit until the economy improves.¹¹ Multi-year budgeting makes sense to conform to the economic cycle; otherwise we are cutting spending, exacerbating the economic cycle and causing immense human suffering when times go bad. However the Governor's idea for multiple year budgeting is linked to a spending cap, which does pose problems. In the first place, California already has such a cap, known as the Gann limit, and there is no good and compelling reason to constitutionally bind future legislatures and voters to the taxing and spending predilections of this particular moment in the state's history. In the second place, California has a two-thirds vote majority requirement for taxes, budget spending and appropriations, that gives the minority party nearly fool proof veto power.

The Governor and Assembly Speaker Bass have each alluded to convening a bi-partisan commission to review and recommend changes in California taxes and state revenues.¹² It is time to do so; our revenues fluctuate like a roller coaster in good times and bad, and are wildly inequitable and outdated in the imposition of tax burdens. The tax reform commission would take place next year, but the budget crisis is now and its resolution cannot wait 'til next year.

We owe it to ourselves to have an honest discussion about state revenues. California is not a high tax state; it is roughly at the national median in tax burdens as a percent of income; however it has some of its taxes at the high end of the spectrum such as the state income tax and others at the low end such as the state's alcohol taxes and local property taxes.¹³ Nor is its public spending at the high end, by some measures our health and education spending are among the lowest in the nation.¹⁴ Nor is it true that taxes impede economic prosperity or economic recovery.¹⁵ Some of the best investments, whether public or private, are in social and physical infrastructure such as educating the state's children, keeping them healthy, in improved transportation, communications and public safety efforts to reduce violent deaths. Some of the worst expenditures are in heavy smoking, heavy drinking, heavy gambling and excessive eating of unhealthy foods and higher "sin" taxes might marginally discourage unhealthy behaviors and at a minimum help pay for the added social costs. The real issues are not public spending vs. private spending, nor is it taxes vs. public program cuts, but rather what are we spending, where are we cutting and what are we taxing.

Taxes: The options are changes in the state's income tax, sales tax, property tax, sin taxes and corporate taxes. While voters oppose increasing taxes, 80% think it is inevitable that we will need to so to resolve the deficit.¹⁶ Voters are most supportive of increasing tobacco and alcohol taxes, over 75% support; income taxes on higher income taxpayers, nearly 70% support; and on businesses, about 55% support. They are least willing to

increase residential property taxes, less than 25% support, and sales taxes, about 40% support.

Sin taxes are thus the most favored, and residential property taxes the most opposed by voters.¹⁷ Without a two-thirds vote from both houses or a November ballot initiative sponsored by a credible and powerful coalition, no taxes can pass.

The Legislative Analyst, the Governor and the Assembly Speaker have all suggested closing tax loopholes and tax equity proposals as part of the menu of finances to close the deficit.¹⁸

Fees: The options include increases in state higher education tuitions, increases in fees for hospitals, health plans and other entities licensed, regulated and in many cases subsidized by the state and federal governments and increases in fees for those individuals who use state parks and other public services. Have you noticed your sewer, water and trash collection fees from local government going up? The state may need to increase nearly all fees it charges for public services and add some new ones, although fees cannot exceed the cost of the service. Unlike taxes, user fees require a simple majority vote. Fees hit lower income users of state services the hardest, but can be adjusted based on ability to pay with sliding fee schedules possible up to the full cost of the service.

Federal, state and local government partnerships and shifts of responsibility:
The Bush administration published a series of directives whose impacts were to shift health program costs from the federal government to the states.¹⁹ Congress has been rescinding them; the major outstanding dispute on eligibility is the federal match for up to 14,000 Healthy Families children.²⁰ To this point Congressional leaders have not pushed for a temporary change in the Medicaid matching rate to give states some fiscal relief.²¹

The state of California could seek to solve its budget woes by shifting costs to counties and cities as it has done many times before. In general the state constitution requires the state government to pay for 100% of local costs incurred as responsibilities are shifted so local government administration would need to be more efficient and effective than the state. The LAO has proposed shifting some prison costs and responsibilities to local government²² on the assumption that localities can deliver these services at lower cost than the state of California; this may well be a good idea if local governments are willing to make some tough decisions on lower cost alternatives to incarceration. California could require a local match for state or federal and state programs, including Medi-Cal, as New York does.²³

The advantage of shifts to local government is that local taxpayers are more responsive at the ballot box to local crises.²⁴ The disadvantage is that California's local governments have weaker ability to raise revenues than the state does due to Proposition 13's strictures on local property taxes; furthermore the sharp decline in home values is beginning to impact local government revenues.

The state can also partner with county and local governments as the state does with public hospital counties for their Medi-Cal inpatient rates and DSH and safety net augmentations. Counties with large amounts of unmatched local health spending could be attractive partners with a win/win negotiation for the state and willing county partners.²⁵ Local First Five Commissions and their funding are also possible partners for the state as are county mental health programs with their realignment and Prop 63 funding.²⁶

Public-private partnerships: Other potential partners for the state are businesses and philanthropies. For example the Healthy Families programs could include a “buy-in” or “take-out” option for the dependents of small business employees.²⁷ Businesses have a strong self-interest in partnering with public high schools, community colleges and universities to improve the training of their workforces. Philanthropies have some common goals with the state, yet these partnerships are not often easy to negotiate.²⁸

Accountability and pay for performance: We all know from our own personal experience the difference between high and low performing employees, programs and institutions. There is nothing more frustrating to the voting public than schools that do not work, hospitals and clinics with long waits for poor quality care, bureaucracies that specialize in non-answers and red tape run-arounds, and public servants who just no longer care. This happens in both the public and private sectors, although you can choose your car mechanic but not your civil servant(s). We forget about all the public institutions that work well and the public employees that deliver exemplary service that we completely take for granted, and we remember indelibly those who do not, those who are rude and unpleasant or just incompetent. There is a need for increased accountability, merit pay, pay for performance, civil service reform (call it whatever you support), so that those who provide superior care and services are better recognized and reimbursed and those who provide poor quality care and services are paid less. In the health care area, this should apply to health plans, doctors, hospitals and clinics in the Medi-Cal and Healthy Families programs.²⁹

Streamlining: We have a multiplicity of publicly funded health programs, readily understandable to and navigable by the cognoscenti, but confusing and costly to the state, counties, providers, and plans and opaque to the public and potential subscribers due to their near-infinite variability. It is time to streamline them into one consistent set of rules and procedures.³⁰ This is a win/win with cost savings. Similarly clinics, hospitals, plans, TPAs (third party administrators) and many others report they are subject to multiple overlapping and ever-so-slightly different reporting and record-keeping from a myriad of government agencies and programs. This should be simplified to one consistent, computerized reporting and record-keeping system.

Infrastructure and managed care: Since its inception, Medi-Cal has been an acute hospital oriented program with less funding and support for primary care clinics and doctors.³¹ The managed care expansions helped to build a primary care infrastructure that has served patients and hospitals well by shifting the principal locus of care from the hospital ER to the primary care doc. The triple threat combination of rate, eligibility and service

cuts would do the most severe damage to the primary care network of clinics, family doctors and dentists. For example, the proposed eligibility cuts for working families and new immigrants and the quarterly status reports will leave in place reimbursement for most hospital-based care. Clinics will lose capitation payments for their newly ineligible patients, will lose reimbursement for adult dental services and will experience adverse selection as the sickest patients are the first to re-enroll while their capitation rates are based on a case mix of healthy and sicker patients that no longer applies. It will be nearly impossible to move forward with health reform if the primary care and managed care infrastructures for publicly insured patients are no longer in place.

Managed care in Medi-Cal saves money and improves care as compared to the Medi-Cal fee for service system.³² It is a better system for reducing unnecessary and inappropriate utilization that plagues the over-all health system. There is understandable controversy about expanding managed care from families and children to the aged and disabled population, which is sicker and has greater health needs, yet this is where the bulk of Medi-Cal spending occurs.³³ If it improves care as the studies indicate and is somewhat more cost effective, then it should be expanded. Some would argue that it destabilizes the public safety net, yet the safety net runs its own managed care systems that compete effectively with the private sector commercial plans, may be offering better care and are without doubt the pioneers in local pilot programs to extend care to the uninsured. The safety net plans would have at least 60% of this market and in some counties a far larger share. This is a large multi-year undertaking, but the first steps this year could be primary care case management and chronic disease case management, which can produce savings.³⁴

Competitive bidding and bulk purchasing: Federal law gives states the option to use competitive bidding and bulk purchasing for some services.³⁵ California should avail itself of this option for services such as durable medical equipment, labs, x-rays and some vision and hearing services.

Pharmacy benefits management (PBM): Pharmacy costs are a combination of price and utilization; an effective PBM would address both. Our current system concentrates on securing price discounts, but fails to redress the issues of over-utilization and substitution of less costly drug treatment as a strong well-run PBM could.³⁶

Health IT: There is bi-partisan agreement that wider adoption of health IT would save administrative costs, reduce duplicative testing and improve quality. It is costly to initially adopt electronic medical records and health IT, but there are substantial health program savings and better quality over time. Provider and plan reimbursement should be structured to reward those who are adopting and using health IT.³⁷

In summary, it needs to be said that a budget crisis is a terrible thing to waste. There are needed changes to state programs that can only be achieved in the context of a responsible bi-partisan solution to the fiscal crisis. On the other hand imposing untold human suffering by terminating and cutting eligibility and services for health programs

for low wage working families and devastating the vital health system infrastructure of clinics, doctors, plans and hospitals are acts unworthy of the Golden State, its citizens and its elected leaders from both parties.

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¹ The Governor's May 2008 revise proposed restoring \$1.8 billion to education funding, which still experiences a total cut of \$3 billion. The May revise proposed adding another \$2 billion to the health and human services cuts of January. Medi-Cal would be cut an additional \$800 million on top of the \$1.1 billion proposed in January. See January Governor's Proposed 2008-09 Proposed Budget and May Revision at www.Ebudget.ca.gov. See ITUP, Governor's Proposed FY 2008-09 Budget (January 2008) and Health Highlights of the Governor's May 2008 Revision at www.itup.org and California Budget Project, Governor's May Revision Borrows Against Future Lottery Revenues (May 2008) at www.cbp.org. State budget cuts have a multiplier effect, piling multiple damaging impacts on low-income families with cuts in public assistance, social services, medical assistance, and education.

² Mark DiCamillo and Mervin Field, Paradoxical Views about the State Budget Deficit, The Field Poll Release # 2275 (June 10, 2008) at www.chcf.org

³ California HealthCare Foundation, Medi-Cal 101, Medi-Cal Facts and Figures: A Look at California's Medicaid Program (May 2007) at www.chcf.org and Kaiser Commission on Medicaid and Medicare, State Health Facts. 50 State Comparison at www.kff.org

⁴ Ibid. Nineteen states, including near neighbors Washington, Arizona, New Mexico and Utah had significantly higher eligibility requirements. While California's eligibility standards for working parents exceed those in Alabama, Mississippi, Florida, Louisiana and Texas where eligibility standards are typically about 25% of the FPL, it is not just the major reform states such as Vermont, Maine, Massachusetts, Minnesota and Washington that have standards double and triple those in California, but Arkansas, Iowa, Indiana, Oklahoma's eligibility standards are double those in California as well.

⁵ See Snapshots of America's Families Part 11: Comparison of State Estimates to National Estimates, by Indicator and by Income, and Health Insurance, Access, and Health Status of Nonelderly Adults (Assessing the New Federalism, Urban Institute) at www.urbaninstitute.org

⁶ Immigrants for their first five years of legal residency will have coverage only for emergencies and perinatal care. Families will have to successfully fill out their paperwork four times a year to retain coverage; to the extent that documentation requirements are included the paper work burdens mount even higher. The program now allows two parent families to be eligible and work full time; under the new rules the breadwinner can work no more than 100 hours a month (five hours a day assuming 21 work days a month). The poverty level for a family of four is \$22,200 (\$11 an hour for full time work). For a family of two, the FPL is 14,000 (\$6.94 per hour for full time work). Half a million beneficiaries would lose coverage due to status reporting. Over 400,000 would lose coverage due to the decrease in eligibility standards and the re-imposition of the 100 hour standard.

⁷ California Budget Project, "How do the Budgets Compare?" A Comparison of the Governor's Revised Budget Proposal and the Assembly and Senate Spending Plans (June 16, 2008) at www.cbp.org

⁸ Ibid.

⁹ See Governor's Budget, May Revision 2008-09 at www.ebudget.ca.gov and Legislative Analyst's Office, Overview of the 2008-09 May Revision (May 19, 2008) at www.lao.ca.gov The LAO reports modernizing and securitizing the state lottery would generate \$5.6 billion in revenues over two years.

¹⁰ Ibid.

¹¹ Ibid. The Governor proposes \$5 billion for the revenue stabilization fund for this fiscal year. The LAO agrees that deposits should be made in a revenue stabilization account in good years, but recommends against the spending cap developed by the Governor.

¹² See Walters, Tax Reform gets a Boost from California's Budget Crisis, Sacramento Bee (May 21, 2008) www.sacbee.com

¹³ Our over-all state and local taxes are 11.5% of personal income, only slightly higher than the national average of 11%. Center for the Continuing Study of the California Economy, Is California a High Tax State? (October 2007) at www.ccsce.com and Washington Department of Revenue, Comparative State and Local Taxes Fiscal Year (June 2006) at www.dor.wa.gov. California has a very progressive income tax -- low tax personal income tax rates for moderate income tax payers and a pretty steep curve to higher rates for higher income taxpayers and a reasonably high threshold (\$47,671 for a family of four with two children) before any taxes are owed. California has high sales taxes; only seven states are higher, but many items of consumption are exempt from sales tax. The result is a narrow tax base with high marginal rates for both income and sales taxes. Our property tax rates have a ceiling of 1% due to Prop 13, but the effective rates are about 0.5% due to the state constitutionally mandated inequities of Prop 13 between new and long term property owners. Only five states have lower effective property taxes. Our corporate tax rates rank 12th, yet our corporate rates too are riddled with exemptions and deductions. Our cigarette and alcohol taxes rank 40th and 41st respectively. The cumulative percent on state and local taxes falls most heavily on low-income families and the burdens are least on the highest income taxpayers despite the high marginal tax rate on very high-income earners. See also California Budget Project, Who Pays Taxes in California (April 2007) at www.cbp.org and California Tax Reform Association, Tax Policy for the 21st Century (January 2005) at www.caltaxreform.org

¹⁴ California is 30% below the national average in Medicaid spending per beneficiary, one of the lowest in the nation. On the other hand, its Medi-Cal spending per state resident is only \$100 below the national average. This anomaly is partly due to higher than average enrollment and greater percentages of families in the program as compared to states with higher shares of more costly aged and disabled beneficiaries. See California HealthCare Foundation, Medi-Cal 101, Medi-Cal Facts and Figures: A Look at California's Medicaid Program (May 2007) at www.chcf.org and Kaiser Commission on Medicaid and Medicare, State Health Facts. 50 State Comparison at www.kff.org. California ranks 32nd in public school spending, has the 3rd highest teacher pay, among the very worst teacher pupil ratios (47th), the highest ratio (25%) of students learning the English language and very poor but improving results (only 6 states were worse) on standardized national testing. Our public school spending per \$1000 in personal income ranked 48th as recently as the mid 90s. The only areas of state and local spending where California ranks highly are corrections (4th), and police and fire (5th). www.ed-data.k12.ca.us See also US Census Bureau, Public Education Finances 2006 (April 2008) at www.census.gov

¹⁵ California is a high income, high growth state, built on technology and sound public investments in infrastructure. The fundamentals of our economic growth are well-educated labor and entrepreneurial risk-taking capital, innovation, and technological advances. It begins with a strong, well-educated and healthy workforce. Without effective public education programs and public health programs, our workforce cannot be productive and innovative; we will become a deteriorating economy within the nation and around the world.

¹⁶ Paradoxical Views about the State Budget Deficit, Field Poll Release # 2275 at www.chcf.org

¹⁷ Ibid. ITUP's views are that we should extend the sales tax to selected services, close some loopholes and exemptions and increase sin taxes in order to close the budget deficit, build in stricter performance accountability standards for educational and health services and help re-build our deteriorated overcrowded and time and productivity wasting transportation and communications infrastructure.

¹⁸ See LAO Revenue Raising Proposals at www.lao.ca.gov; Evan Halper, Governor's Staff Exploring New Taxes, Los Angeles Times (May 1, 2008), Halper, California Tax Proposals Target Beer-loving, Pornography Watching Yacht Owners, Los Angeles Times (May 8, 2008) and Judy Lin, California Budget Cutters Look at Tax Breaks, Sacramento Bee (March 23, 2008). A compendium of tax reform options are

detailed by the California Tax Reform Association in Tax Policy for the 21st Century: Resolving California's Long-Term Structural Deficit (January 6, 2005) at www.caltaxreform.org.

¹⁹ See End Runs on Medicaid, New York Times (May 28, 2008)

²⁰ The initial August 17, 2007 directive and its follow up letters sought to limit states ability to expand SCHIP and Medicaid programs to children and parents with incomes above 200% of FPL. Both the courts and the General Accounting Office have held that the directives were not lawful. California maintains its eligibility standards are lawful as they were approved state plan amendments.

²¹ In the past, states have pushed for and secured a reduction in their state match under Medicaid to give them some fiscal relief during economic downturns. Neither the states nor Congress have pushed hard for this relief this year.

²² See Legislative Analyst's Office, Alternatives to the Governor's Budgetary Reforms at www.lao.ca.gov. The proposals outlined by the Analyst would save nearly \$750 million in corrections spending.

²³ In New York, counties pay for about 17% of the state's \$46 billion Medicaid spending. Their contributions are capped so that the state is paying an increasing share of the growth in spending. See Deborah Bachrach et al, Administration of Medicaid in New York State: Key Players and their Roles (November 2006, United Hospital Fund) at www.uhfnyc.org. One of the drawbacks to a local match is that beneficiaries may be concentrated in certain poor counties with limited financial capacity to fund their Medi-Cal enrollment. In California, local match is discretionary with counties and California counties contribute about \$2 billion; for the most part these contributions come from counties with public hospitals that pay for their own match for Medi-Cal DSH, safety net pool and inpatient rate adjustments; the burden on these counties is growing.

²⁴ See Tim Gage et al, Health Care on the California Ballot: an Historical Review (Blue Sky Consulting Group, May 2007) at www.chcf.org The authors note that over half the local ballot measures funding specific health needs passed while none of the coverage expansion efforts on the state ballot passed between 1990 and 2006.

²⁵ For example, the CMSP counties spend well over \$200 million on care to the uninsured while San Diego and Orange together spend over \$100 million. It is worth some thought as to how county spending can be packaged to increase California's federal match. This has been the focus of a year's long convening under the auspices of the Blue Shield Foundation of California. See Peter Harbage, A Roadmap to Coverage (Blue Shield Foundation of California, March 2008). ITUP has a series of reports on the use of county matching funds at www.itup.org/reports under the 1115 waiver and the solutions headings. Counties with public hospitals may be close to or at their max in terms of matches for their local spending, but most of the 46 other counties have local spending on care to the uninsured that should be examined for matching opportunities. See Wulsin, Safety Nets and Coverage Expansions (Insure the Uninsured Project, July 2007) and Fox, 2006 Overview of the Uninsured: California (ITUP, December 2007) at www.itup.org/reports for a description and charts of county funding. The most obvious match is county spending on care to the uninsured and state DSH and other supplemental payments to private hospitals in those counties without a local hospital.

²⁶ First Five Commissions may wish to become more involved with Medi-Cal and Healthy Families so that their limited funds can be used to greater impact with federal matching. For example, their match could be used to provide pay for performance incentives at the state and local levels for plans and their networks that do extra-ordinary work in improving the health outcomes of children (0-5).

Prop 63 is also designated by voters to improve mental health services for those with severe mental illness. These funds can do more if better coordinated with federal matching opportunities and if local mental health has stronger incentives to coordinate and collaborate with community clinics and other local health facilities that provide for the physical health needs of their patients; these are often over-lapping patients and populations, and we need to stop providing their care in disconnected silos.

²⁷ The over-riding issue is to match employer and employee contributions with public funds for those who due to affordability have not taken the employer offer of coverage at work for themselves and especially for their dependent children and/or spouses. Take out refers to the ability to use the public subsidy to buy coverage through their employer. Buy-in allows an employee to use the employer's proffered contribution

to defray the costs of public coverage. A number of states have these programs in place with Rhode Island reporting significant savings. See ITUP's SB 480 paper on this option and the Urban Institute projection of \$40 million in potential savings at www.itup.org/reports. Two excellent Urban Institute papers discuss the potential impacts and challenges; to summarize them, these approaches may reach 14% of Healthy Families enrollees and hard to implement. See Anna Sommers and Stephen Zuckerman, Substitution of S-CHIP for Private Coverage: Results from a 2002 Evaluation in 10 States (Urban Institute, October 11, 2007) and Amy Lutsky and Ian Hill, Premium Assistance Programs Under S-CHIP: Not for the Faint of Heart (Urban Institute, May 16, 2003)

²⁸ California's leading health philanthropies played a vital role in helping the state to understand and design last year's health reforms. A similar concentrated effort may be needed to help state policy makers redress the state's budget deficit in ways that promote long term growth, health and prosperity.

²⁹ A series of recent articles document that pay for performance is still in its infancy and needs to be tweaked and adjusted based on experience, has improved quality, has reduced costs and is not yet a panacea but does have promise. Some of the salient points are that incentives are stronger if you implement it in a cost neutral fashion that takes from the lowest performers and redistributes to the top performers. Incentives should reward both high performance and improved performance while penalizing poor performance. Metrics for the pay for performance payments should be linked to demonstrable and measurable patient outcomes and cost efficacy, not to adherence to rote protocols that result in cookbook medicine. Rosenthal et al, Climbing up the Pay for Performance Learning Curve, Health Affairs November/December 2007; Wennberg et al, Extending the Pay for Performance Agenda, Part 1: How Medicare Can Improve patient Decision Making and Reduce Unnecessary Care and Part 2: How Medicare can Reduce Waste and Improve care of the Chronically Ill Health Affairs November/December 2007, and Curtin et al, Return on Investment in Pay for Performance: a Diabetes Case Study, Journal of Health care Management (November/December 2006). See the blog discussion at <http://healthaffairs.org/blog/2008/05/29/pay-for-performance-from-quality-to-value/>.

³⁰ The comments we received recommend that Medi-Cal, Healthy Families, County Health, CCS, AIM and other programs use a common set of rules and forms and procedures; Healthy Families was oft cited as the model. This is not easily done as the federal and state statutes and local ordinances governing each program are different and would need to be changed and/or waivers secured to use a common base. However much could be done short of statutory over-haul to simplify and better coordinate the fit of the programs for the benefit of subscribers, plans, providers, state and local administrators.

³¹ See Kaiser Family Foundation, State Health Facts 2007: Medicaid Physician Fee Index and Distribution of Medicaid Spending on Acute Care at www.statehealthfacts.org

³² Fifteen percent of Medi-Cal fee for service beneficiaries have no usual source of care as compared to 6% of Medi-Cal managed care enrollees; 10.5% of fee for service beneficiaries per 1000 experience preventable hospitalizations as compared to 6.1% of managed care enrollees. See CHCF, Medi-Cal Facts and Figures 2007 slide 30 at www.chcf.org

³³ Eighteen percent of Medi-Cal spending is for the 3.2 million managed care enrollees as compared to 82% for fee for service participants. Children and their parents are 75% of all enrollees, accounting for 38% of spending. Ibid. Mandatory enrollment of the aged and disabled in managed care only occurs in COHS counties and it appears to have worked well in those plans.

³⁴ Due to the carve outs for CCS, mental health and the exemptions of the aged and disabled, California has hamstrung itself in terms of capacity to manage the costs and improve quality of its highest cost populations. Primary care case management, which is in essence a capitated primary care gatekeeper and case manager with no capitation for the more costly specialty and hospital services, could be made mandatory for all the aged and disabled; the problem is that for the dually eligible, the Medi-Medis, the program interface between fee for service Medicare and managed care Medi-Cal would be very difficult to manage. Chronic disease case management appears to be easier to administer and coordinate between the two programs; while it holds promise to improve quality and would be particularly appropriate for the disabled, there are no case studies showing remarkable cost savings.

³⁵ See Section 1915(a) of the Social Security Act. A recent Medicare pilot showed 25% savings on durable medical equipment; Congress is being beseeched to prevent expansion of competitive bidding and bulk purchasing in Medicare by suppliers of durable medical equipment – evidence that these programs work. See Leonhardt, “High Medicare Costs Courtesy of Congress” and “Medicare Savings vs. the Lobbyists” New York Times, June 25, 2008

³⁶ PBM's appear to save 15% of pharmaceutical costs. The techniques employed by PBM's include: bulk purchasing and price discounts, substitution of generics, differential and tiered copays, formularies, disease management, drug UR and mail service drugs for chronic conditions. Not all these techniques are equally applicable in the Medi-Cal market. For a nice overview, see David Kreling, Cost Control for Prescription Drug Programs: PBM Efforts, Effects and Implications (August 8-2000) at

www.aspe.hhs.gov/health/reports/drugpapers

³⁷ Health IT is estimated to save up to \$80 billion nationwide, and it is an issue on which both parties agree, yet only 20% of American doctors are using the technology as compared to nearly 100% in England, the Netherlands, Australia and New Zealand. Google and Microsoft now offer this service on line. One of the barriers is the start-up cost of \$20,000. Those who have adopted the new technology report strong improvements in patient care. See Lohr, Most Doctors Aren't Using Electronic Medical Records, New York Times, June 19, 2008 and Our Pen and Paper Doctors June 24, 2008. It makes sense to pay those doctors who have embraced IT and are improving care and reducing costs more than those who have not.