

California Health Policy and Data Advisory Commission

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Approved Minutes
California Health Policy and Data Advisory Commission
December 13, 2004

The meeting was called to order at 10:07 a.m. by Chairman William S. Weil at the Sheraton Gateway Hotel in Los Angeles, California.

Commissioners**Present:**

William S. Weil, MD, Chairperson
William Brien, MD
Marjorie Fine, MD
Howard L. Harris, PhD
Sol Lizerbram, DO
Hugo Morris
Jerry Royer, MD, MBA

Absent:

M. Bishop Bastien
Janet Greenfield, RN
Paula Hertel, MSW
Corinne Sanchez, Esq.
Kenneth M. Tiratira, MPA

Staff Present:

CHPDAC: Jacquelyn Paige, Executive Director; and Rebecca Markowich, Executive Assistant

OSHPD: David Carlisle, MD, PhD, Director, OSHPD; Michael Kassis, Deputy Director, Healthcare Information Division; Dale Flournoy, Deputy Director, Cal- Mortgage Loan Insurance Division; George Fribance, Cal-Mortgage Loan Insurance Division; and Kenny Kwong, Healthcare Information

Also in Attendance: Vito Genna, Chair, Health Data and Public Information Committee; Jack Lewin, MD, Executive Vice President, California Medical Association; E. Richard Brown, PhD, UCLA

Dr. Weil introduced Dr. Jack Lewin, the Executive Vice President of the California Medical Association (CMA). Before coming to California, Dr. Lewin was the Director of Health for the State of Hawaii. There he instituted the program whereby all employed persons in Hawaii are covered by health insurance, which means 90-96% of the population in the State of Hawaii are insured.

California Medical Association's Legislative Agenda: Jack Lewin, MD, Executive Vice President, California Medical Association



When Medicare was first instituted in 1965, the average beneficiary only received three years of service. Since that time, we have gained a decade of life, and a tremendous improvement in quality of life.

Approximately \$1.5 trillion flows through healthcare, including healthcare jobs, pharmaceutical products, research, devices, etc. There are disparities that are unacceptable; that is, 45 million Americans do not have coverage during most of the year. About 90,000 persons die yearly related to system errors, medication and medical errors that are preventable. Costs are out of control, with no means at the moment of financing them.

The biggest problem is expectations of Americans to receive all healthcare benefits. Baby boomers will be expecting and demanding these services. There is a problem with how to finance healthcare. It has been pointed out that if the rate of insurance premiums continues unabated for the next five years, the average annual increase experienced in the last three years, the costs will consume one hundred percent of America's business profitability. There will be unprecedented cost shifting from business to employees, which will be the only way to maintain the viability of the business world.

CMA is concerned that the nation is not looking at the facts in terms of healthcare costs and the economic future of the nation at large. In California, during the past year about 15 emergency rooms have closed, as well a number of trauma centers, and there will be more closures. The uninsured population is seven million persons. In addition, there are three million people who are non-citizens, and are not covered. Most non-citizens receive medical care in the emergency room.

California is denying itself hundreds of millions of dollars of matching federal aid because the State has not been creative enough to put together services to maximize the match. By denying these federal dollars, the State will end up paying indirectly through emergency rooms and uncompensated care.

There are about 200 million legal border crossings from the Mexican border, as well as illegal crossings. The health consequences are significant because the communicable disease systems in Mexico are not as secure, so there has been an influx of tuberculosis and other infectious diseases. The counties bear the brunt of the healthcare costs of these populations.

There are insurance issues in California and physicians have argued about the definitions of medical necessity for many years. It is felt that the insurance definition is heavily weighed against the interest of the patient and often denies the kind of care a patient may need. It was thought for years that stressed relations between doctors and health insurers might be due to bureaucratic ineptness on the part of insurers or that system kinds of problems could be fixed. CMA decided that some of this was not accidental or bureaucratic but intentional and launched a lawsuit under civil fraud statutes. The lawsuits have been embraced by 19 states, with 800,000 doctors who are plaintiffs in these suits. Aetna and Cigna have settled and many other for-profit plans will settle.

Physicians are now being paid 70 or 80 percent of Medicare rates, so there are serious problems with access to Medicare. In addition, about half the doctors in the State say they can no longer take care of Medi-Cal patients.

As a result of the passage of Proposition 63, there is about one billion dollars annually available for mental health. The Proposition on stem cell research was controversial, but will bring money into the State and will be a positive thing. The biggest issue was Proposition 72, with the votes still being counted. The ad campaigns did not educate the public very effectively. The public is confused about how to finance healthcare in the future. CMA and labor are considering bringing it back to the table.

Hawaii's goal was to make sure that the employee paid for half of the insurance premium, and the employer paid for half. For low-income workers, there was a graduated scale. For very low income, the employer would pay about 70 or 80 percent. Because of the success of Hawaii's program, there is no measured disadvantage to business or entrepreneurship in Hawaii, based on health insurance.

CMA contributed about two million dollars to a ballot initiative in 1994 to try to have Hawaii's law enacted in California, but failed. Prop. 72 was a much more modest proposal, beginning with businesses of 50 or more. Probably the 80/20 cost split caused some businesses to be unsupportive. A sliding scale would seem more reasonable to ask the employee to pay a fair share of the premium.

The legislative agenda for 2005 will be as follows:

Approach the access to care agenda at the federal level, where it is thought there might be a chance of a more significant break through. Continue to press in California. There will be several access to care legislative bills, though not much opportunity to become law if they require State funds. The Chamber of Commerce is not expected to be supportive of any of these proposals. There will probably be a cap on the deductibility of health insurance. Most people's insurance would be under the cap and the Federal Government would have about 50 to 55 billion dollars that would otherwise be given out as tax deductions. That money could be given to programs such as Healthy Families, Medi-Cal, Medicaid, to expand enrollment and full coverage to the maximum eligible populations across the country. CMA's proposal is simply a wake-up call to the rest of the country to indicate we cannot wait around for the perfect solution.

MICRA is 28 years old and still works. "Jessie's Law" would raise the cap on non-economic damages. Malpractice is a relatively modest amount of two or three percent of the total budget, the legal cost. The real problem is that an obstetrician's premium is between \$60,000 to \$80,000 dollars in California. In Florida, it would be over \$200,000. It's a fight between trial lawyers and physicians. We need to protect MICRA.

CMA will help to restructure Medicaid to provide more efficiency in economy. Local county initiatives are demonstrating ways to improve the effectiveness of the State Medicaid dollars and some of those models should be used elsewhere in California. We need to think about how to best use Medicaid dollars and bring in more federal dollars.

CMA will work on California Performance Review issues and how to restructure the government.

Physicians will be asked to renew their contracts annually, and that the silent PPOs be abolished. CMA will work closely with the consumer-directed healthcare movement as more money is shifted to the patient to pay his own premium and healthcare costs.

CMA will work with the Federal Government to obtain more money for border health in California.

Protect the patient/physician relationship to make sure there is access to a physician.

Obtain insurance for uninsured remains a top priority.

CMA has a number of quality initiatives. One involves Medicare, with 2,000 doctors that will be involved in chronic disease care management. Another involves getting electronic health records into physicians' offices. There is \$110 million in the new Physician's Foundation, to be spent on electronic health records and other improvements in quality, patient safety, and efficiencies in the system.

Commissioner Morris asked if there is a study that compares the quality, cost and distribution of costs in different countries. Dr. Lewin said there is an ongoing study involving five European countries and the United States that has good data.

California will have a physician supply problem with respect to Medicare and Medicaid. There is good data, which needs to be studied.

With the closing of many hospitals, many physicians are joining private venture groups to buy hospital-owned/physician-owned hospitals. What will the impact be on the remaining hospitals that provide full service care, that take care of indigent, Medicare, and Medi-Cal patients? Dr. Lewin said there should be a law passed this year whereby the Attorney General has the right to intervene when there is a sale of a hospital, to investigate the prospects of the sales offers in terms of public benefits. The top priority should be to keep the hospital Emergency Room and services available to the community.

Dr. Lewin said he and Duane Dauner of the California Hospital Association have had several conversations about a proposed legislative bill that would limit physician investment in specialty hospitals, to try to curb the influx of these specialty hospitals. Some of the reasons for specialty hospitals relates to the fact that surgeons do not have enough Operating Room time or high quality tools and equipment to provide the highest quality.

OSHPD will be soon be measuring all the outpatient surgery centers' reports on outpatient surgeries. OSHPD can measure surgery performed in hospitals and in freestanding licensed surgical clinics, but not in medical practices.

Last year's Workers Compensation Reform Act does not cap any of the premiums, and the injured worker is having tough access to care. Some managed care techniques will be used to give money to physician networks and let the doctors shift the money around.

Commissioner Morris asked if an analysis had been done of the Kaiser-type approach to the division of money among the various disciplines and with the degrees of efficiency that are involved, and asked what would happen to State expenditures if that kind of approach to providing medical care was used. Dr. Lewin said Kaiser has the pharmacy and the hospital cost centers in one system, and physicians have a horizontal relationship with the insurance plan, where they are equal partners. It would be pretty hard to compete. They have a system that lends itself to winning in an economic competition within managed care.

There is now an era of unprecedented cost shifting that will increase from the health plan side to the patient, and from the employer to the patient. Patients will be picking up more and more of the cost.

Approval of Minutes: The minutes of the October meeting were approved.

Next Meeting Dates: The following meeting dates were selected for 2005:

Monday	February 7, 2005	Sacramento
Monday	April 11, 2005	San Diego
Monday	June 6, 2005	San Francisco

Executive Director's Report: The Governor's State of the State message will be given on January 5, 2005. The proposed budget will be announced a few days later.

There are ten new Senators and 24 new Assemblypersons.

The Healthy Families Advisory Panel of the Managed Risk Medical Insurance Board has five vacancies. Nominations are being solicited to fill the following vacancies: subscriber representative, subscriber representative with special needs, a licensed practicing dentist, health plan community representative, and an education representative. Applications must be submitted by close of business on December 17.

The annual Emergency Room Loss report has just been released called, "A System in Continued Crisis."

OSHPD has just announced the release of the "Community-Acquired Pneumonia Study." The report is available for review at www.oshpd.ca.gov.

Almost half of the hospitals are not meeting voluntary charity care guidelines. Legislation has been proposed to mandate that charity care be provided. Fines will be imposed for those that are not providing their share.

The Legislative Analyst's Office is recommending that OSHPD identify areas of shortage or over-supply of hospital beds.

OSHPD is beginning to collect data from emergency care centers and from surgery centers, increasing the number of collected records from 3.6 million to approximately 12-15 million.

OSHPD Director's Report: David M. Carlisle, MD, PhD, Director, Office of Statewide Health Policy and Development

There have not been many changes at OSHPD, just moving forward with current programs. The Governor is expected to submit a more detailed reorganization proposal made by the California Performance Review. It would be submitted to the Legislature after it goes through the Little Hoover Commission. It is expected that that OSHPD will be considered for incorporation into a new Department of Public Health.

The Facilities Division has been granted in the current year's budget about 47 positions to address the increased demand for hospital plan review. About three-quarters of those positions have been filled. The structural engineers and the fire/life safety officers remain difficult to fill, but the Office is still moving forward with aggressive attempts to fill the positions.

There was a recent publication from the District Hospital Association talking about a successful turn-around of Corcoran District Hospital. The Cal-Mortgage program has been an important partner to the hospital in maintaining its financial viability through some tough times.

In response to some pricing issues with regard to vitamin manufacturers, California successfully settled the litigation. Part of the settlement (\$1 million) has been received by the Health Professions Education Foundation. The Foundation will use those funds to augment the education and training of healthcare professionals in California. There has been a significant growth in the ability of the Foundation to receive third-party funding in support of its activities.

The mandatory Coronary Artery Bypass Graft reporting is moving forward, and the first report will be issued in 2005.

OSHPD is currently searching for an Executive Director of the Rural Health Policy Council. OSHPD has also received authorization from the Department of Finance in support of a public information/legislative affairs position.

Dr. Royer said CHPDAC and OSHPD have been quite concerned about the rising rate of C-sections in California, somewhere between 28 and 33 percent. There is a clinical variation in the State between 8 or 9 percent and a high of 50 or 60 percent in some hospitals. Several years ago, ACOG had a suggested target of 15 percent. There was much controversy about whether this was feasible, and many moved away from the 15 percent. Dr. Royer said when he was in St. Louis, a bonus was built in for any C-section that met the four criteria that ACOG had for C-sections. It was a nice incentive for the physician and brought the C-section rate down in sites where this was instituted.

Dr. Royer said there is data on C-sections but not much is known on the percentage of first deliveries. Dr. Royer said he received information from the Healthcare Information Resource Center of the Office that of the 151,000 C-sections in 2003, almost half of them were primary C-sections. That is where there is leverage. Good information from a couple of groups shows that any woman being admitted to the hospital before three centimeters

dilation stands a threefold greater chance of having a C-section. Induced labor increases the change of C-section by four times. If you reduce variation, that improves quality and the cost goes down. Dr. Royer thanked Dr. Carlisle and OSHPD for supplying this valuable information. It will make a direct impact on the quality, as we try to improve quality through reducing C-sections and the complications that come from them.

Dr. Weil noted that when payment was the same for a C-section as a vaginal delivery, the C-section rate dropped. It is also noted that women who have delivered through C-section surgery prefer subsequent deliveries are C-section deliveries.

Legislative Report: David M. Carlisle, MD, PhD, Director, OSHPD

AB 2632 exempted small projects from initial OSHPD Facilities Development Division review. This has a positive, minor effect on the plan review activities.

There was also a bill that permits hospitals to apply to OSHPD for a small projects annual building permit for projects totaling \$50,000 or less in cost. One permit can encompass a group of projects that come below that threshold.

AB 2876 modified the Disclosure Act to permit access to OSHPD's data sets, discharge data set in particular, to California hospitals, local health departments, local health officers, and federal health agencies. Previously, they were restricted to the public version of the data set. This will facilitate more efficient use of the data set and have a positive effect on healthcare in California.

AB 2973 was vetoed. This would have allowed hospitals to hire independent plan reviewers and have their plans reviewed before submission to OSHPD. There is nothing to stop institutions from doing this currently. There were personnel management issues, which made the bill difficult. Another bill will be introduced.

SB 379, relating to charity care, was vetoed. This is a major health policy issue.

The nosocomial bill, which would have required reporting of aggregate rates of nosocomial infections by hospitals in California, was vetoed. Nosocomial infection legislation will probably be reintroduced in 2005.

The last day to introduce legislation is February 18.

Regulations for Assessment Increase for Facilities: Mike Kassis, Deputy Director, Healthcare Information Division, OSHPD

OSHPD's data programs are funded by a fee, which is assessed to every hospital and long-term care facility in California. The fee is established in statute as a specific percentage applied to the reported gross operating expenditures. The assessment fee is due in July of each year. For several years the assessments were stable. The fee was raised for hospitals to amass a sufficient amount of funds to pay for the MIR-Cal project, which is the inpatient data collection system and the upcoming collection of data from emergency

departments and ambulatory surgery centers. Funds also paid for the new ALIRTS system, the online hospital utilization report funding.

These programs are now implemented, and the balance of the Fund continued to grow. The Legislative Analyst's Office thought the balance of about \$7 million was too high and should be adjusted down. As a result, the rate was lowered and regulations were implemented. Beginning July 2004, the assessment rate was lowered to a prudent reserve. It was thought that a reserve of \$4 million would allow OSHPD to propose some new program increases each year without having to wait for another cycle of fee collections.

As part of last year's budget discussions, the Legislature took action to eliminate funding for the Song-Brown Physician Training Program from the General Fund and, instead, pay for it with health data funds through a loophole in the law. In effect, this took the prudent reserve, which was expected to be about \$4 million in July 2005, down to about \$1 million or less. Any new legislation would have to be delayed one year before implementation because the funds would have to be amassed.

It is now proposed to raise the fee back up to the maximum for both long-term care and hospitals so that a prudent reserve can be amassed over the next couple of years. Dr. Royer made the motion to support or approve the increase in special fees. **The motion was seconded and carried.**

It was suggested that in addition to the support letter that a subsequent letter outline concern that the reserve be maintained at an appropriate level.

Long-Term Care Health Information: Kenny Kwong, Manager, Accounting and Reporting Systems Section, Healthcare Information Division

The Accounting and Reporting Systems Section collects: health facility level data (includes annual and quarterly financial disclosure reports from the State's 450 hospitals); financial disclosure report from about 1,250 long-term care facilities; and annual utilization reports from 4,300 hospitals, long-term care facilities, primary care clinics, specialty clinics, home health agencies and hospices (through ALIRTS program).

The long-term care annual financial disclosure report is an integrated disclosure and Medi-Cal cost report. Long-term care is provided in the freestanding environment, as well as in hospitals. The hospitals or freestanding LTC facilities that are licensed are either skilled nursing care, intermediate care, care for the mentally disordered, developmentally disabled sub-acute care and hospices. About 95 percent of the LTC facilities are licensed as skilled nursing.

In the hospital-based environment, LTC services are provided in skilled nursing units, intermediate care units, and sub-acute care. Approximately 50 percent of the general acute care hospitals provide some type of LTC, with probably over 99 percent being skilled nursing.

From freestanding long-term care facilities, OSHPD collects the annual financial disclosure report, the annual utilization report, and licensing information through the Department of Health Services.

In the hospital environment, LTC data are collected through financial disclosure reports, the annual utilization report, and through patient level data (MIR-Cal program).

Approximately 1,400 facilities provide some type of LTC. About 85 percent of the facilities would be considered freestanding LTC facilities; the other 15 percent are hospital-based. In the freestanding facilities, 87 percent are investor owned; the remaining 13 percent are not-for-profit.

Among the hospital-based facilities, the not-for-profit is the largest segment, with 56 percent. The investor and government facilities share the remaining 44 percent. Of the government facilities (county and district hospitals), over two-thirds of them are rural hospitals, probably providing LTC services in swing beds, which are acute care beds that are used for LTC services. There are two State-owned Veteran home hospitals included in the LTC freestanding facilities.

Medi-Cal is the largest payer: in the freestanding arena, over two-thirds of the patient days are Medi-Cal, whereas in the hospital-based arena, it is 58 percent. In the hospitals, Medicare is the second highest payer, with 30 percent of patient days.

LTC reporting was mandated beginning in 1977. In 1986, the report was consolidated into the Integrated Annual Financial Report and Medi-Cal Cost Report. The financial reporting requirements are specified in the California Code of Regulations. The reports are due four months after the fiscal year end of each facility. The regulations allow for 90-day extensions, granted in 30-day increments. There is a \$100 a day penalty for late reporting. The submission rate is now 99.5 percent.

In 1993, all reports began submitting to OSHPD by electronic means and disclosure of data can be produced in more user-friendly products.

The LTC Annual Utilization Report, required by statute, has been collected since 1976, part of a health planning program with OSHPD. Later, it was used to monitor the certificate of need process, which eventually was terminated.

In September 2003, a web-based application was developed (ALIRTS), which allowed facilities to begin submitting reports electronically. This reporting is based on a calendar year, January through December. There is a standard due date of February 15. There is no penalty for late reporting. In 2003, the submission rate was 91 percent. Staff has been working with the California Association of Health Facilities, California Hospital Association, and other organizations to explain the importance of the information and timely submission of the data. One of the uses of these data is to set the Medi-Cal reimbursement rate. CAHF is hoping to obtain federal matching funds to develop facility-specific rates. The reporting forms will be modified to ensure capturing the items needed to enable the legislation. Another use of the data is to monitor nurse-to-patient staffing ratios and to measure quality of care.

Commissioner Morris requested that the old fact books be compared with the new data sets to permit comparison over time.

“Using the California Health Interview Survey to Improve Health Policy” -- E. Richard Brown, PhD, UCLA

The California Health Interview Survey (CHIS) was designed to be a population-based survey that would track public health indicators for California, healthcare access, and health insurance coverage indicators. It is designed to support decision-making by decision makers at the State level and at the local level, in the public and private sectors, about how they make investment decisions in healthcare for California, and about how policy should be shaped to affect the care received.

CHIS is a collaborative project between UCLA, the Department of Health Services, and the Public Health Institute, comprising the Governing Board and make all of the key policy decisions on it.

CHIS was launched after a three-year planning project funded by the California Endowment Foundation. OSHPD data plays a large role in guiding policy, data collected in the process of treating patients in hospitals, clinics, emergency rooms, LTC facilities and other kinds of institutional reporting systems. CHIS goes out to the population to gather survey information. The CHIS survey is done biannually, and there is a questionnaire for adults, adolescents and children. The survey covers a wide range of topics, with extensive questions on health insurance coverage. There is a major focus on health behaviors. The 2005 survey will focus on diet and physical activity related to obesity. There are mental health measures, dental health measures and oral health measures, with age appropriate additional topics for adolescents and children. Questions are drawn from national surveys. The purpose is to enable comparability for estimating in order to compare estimates across the nation as a whole. The questions have been well used and well tested and validated in other ways. The CHIS sample reflects a very diverse population. Funders play a big role in deciding what topic areas to cover.

The survey was done in five languages in 2003. There are large samples of Latino ethnic groups, which have attracted a lot of federal money to support the survey. Dissemination of the data is through a wide variety of tools, such as publications, website, workshops, community briefings, etc.

Cal-Mortgage Loan Insurance Division: Dale Flournoy, Deputy Director

The Cal-Mortgage Loan Insurance program guarantees repayment of a loan. The borrower transfers his risk to this program, and enables the borrower to borrow at a lower interest rate. The lender is protected against the borrower's failure to perform over time. The program tends to deal with safety net providers and smaller entities. The large systems tend to have a credit rating equal or better than the State of California.

The total underwriting capacity remains at \$3 billion, and the program is entirely self-supporting, at no cost to the State's General Fund. The insurance reserve fund is constitutionally protected as a trust fund for the benefit of the program. Borrowers have to be non-profit, public entity, and have to be a health facility, licensed or certified.

The application process goes through about seven steps. CHPDAC has two roles. If loan staff and the Director deny a loan, the applicant has a right to a public hearing. There has been one appeal in about 36 years, with CHPDAC sustaining the staff and Director's recommendation. If the staff and loan committee recommend not to insure the project, but the Director finds a higher public benefit, he can appeal to the Health and Human Services Agency, which may request CHPDAC to conduct a hearing as to whether that is good public policy.

There have been some problem loans and bankruptcies. Several facilities have turned around under new management.

Adjournment: The meeting adjourned at 3:12 p.m.