DEPARTMENT OF HEALTH CARE SERVICES

Item 232 from the Health Care Deposit Fund — Budget p. L-35 — Program p. 809

Requested 1972–73	$22,364,614
Estimated 1971–72	21,449,143
Actual 1970–71	14,012,990
Requested increase $915,471 (4.3 percent)	
Total recommended reduction	Withhold

SUMMARY OF MAJOR ISSUES AND RECOMMENDATIONS — *Analysis page*

See discussion of this item under Item 233, California Medical Assistance Program. — 624

CALIFORNIA MEDICAL ASSISTANCE PROGRAM

Item 233 from the General Fund — Budget p. L-35 — Program p. 809

Requested 1972–73	$654,584,708
Estimated 1971–72	517,097,750
Actual 1970–71	484,497,959
Requested increase $137,486,958 (26.5 percent)	
Total recommended reduction	Withhold

SUMMARY OF MAJOR ISSUES AND RECOMMENDATIONS — *Analysis page*

1. Need for Most Recent Caseload Data. Withhold recommendation on the proposed appropriation pending: — 621
   (a) A review of the spring caseload and average cost estimates and,
   (b) Greater utilization experience of the new group of recipients brought into the Medi-Cal program effective October 1971.
2. Increased Administrative Cost. Also withhold any recommendation on the administrative budget pending more complete reports on the effect and necessity of prior authorization and the receipt of spring caseload reestimates. — 625
3. Bids to Potential Contractors. Recommend the Legislature be given the opportunity to evaluate the prototype operations prior to statewide implementation; and, should statewide operation of MMS be desired, we recommend a request for bids be made to potential contractors for operation of the system. — 634

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CALIFORNIA MEDICAL ASSISTANCE PROGRAM—Continued

GENERAL PROGRAM STATEMENT

The California Medical Assistance Program (Medi-Cal) began March 1, 1966 following enactment of Chapter 4, Statutes of 1965, Second Extraordinary Session. The Medi-Cal Reform Program was enacted by the 1971 Legislature which became effective October 1, 1971 following enactment of Chapter 577, Statutes of 1971 (AB 949).

The Medi-Cal Program

Medi-Cal is the state's medical assistance program to provide health care services to eligible people who cannot pay the full cost of medical care. It provides medical assistance to families with dependent children, and to those aged, blind and permanently and totally disabled individuals whose income and resources are either insufficient to meet the cost of medical services or are so limited that their application to the cost of such care would jeopardize the person or family's future minimum self-maintenance and security. Under the Medi-Cal Reform Program, eligibility has been broadened to cover some county medically needy children and adults, not linkable to categorical welfare programs.

Medi-Cal Reform Program

The Medi-Cal Reform Program (MRP) basically repealed, amended or added sections to the Welfare and Institutions Code pertaining to: (a) eligibility, (b) scope of benefits and prior authorization, and (c) co-payment for some services. Eligibility was expanded to cover county medically needy children and adults who are under 65 and not linkable to the categorical welfare programs. This group was previously referred to as county medically indigents and were covered under the County Option program which was repealed, or by individual county programs. All eligibles are entitled to receive Title XIX services provided by physicians, dentists, hospitals, nursing homes, etc. These benefits are divided into two parts: a uniform Basic Schedule of Benefits and a uniform Supplemental Schedule of Benefits. Basic benefits cover the full scope of benefits available to eligibles and are subject to specific allowances and limitations. Supplemental benefits require prior authorization and are available only after basic benefits have been exhausted. Copayment provisions require a small payment on the part of the beneficiaries for services received when such payment is not prevented by federal law. Copayment was initiated January 1, 1972 and is scheduled to cease June 30, 1973.

In addition, MRP has provided the Director of Health Care Services with greater administrative authority to control payment scheduling and modification. In developing and contracting prepaid health plans the consideration of customary and prevailing charges in determining reasonable charges for physician services is no longer required and the

department is granted flexibility with respect to duration and scope of services provided.

Eligibility

Under MRP there are now four groups of eligibles: (1) Public Assistance Recipients, which includes individuals who receive cash grant payments under the state's categorically needy welfare program; (2) Medically Needy Welfare-Linked Persons (MNO), which includes individuals who meet the requirements of one of the four welfare categories but have sufficient funds to meet daily needs and therefore do not receive cash grant payments; (3) Medically Indigent Children, which includes individuals under the age of 21 who reside with their families, who are medically needy on the basis of their income and resources; and (4) Medically Indigent Adults, which includes individuals from age 21 to 65 and those ceremonially married persons under 21 who are financially unable to purchase necessary health care.

Followup Legislation

After approximately two months of operation under MRP, it became necessary to make certain changes in the program. These changes were presented in a bill which was signed by the Governor and became effective immediately (Chapter 1685, Statutes of 1971). Changes, contained therein, affected: (1) the financial eligibility standard for noncategorically related needy persons; (2) certain benefits which were excluded from the basic schedule of benefits; (3) and the copayment provisions.

Originally the financial eligibility standard for noncategorically related needy persons living alone was $125. Under the new provisions, the minimun basic standard of adequate care for a single person living alone is 75 percent of the standard for a two-person family listed under Section 11452 of the Welfare and Institutions Code. The resultant basic need standard is $158.

Physical therapy services, occupational therapy services, speech therapy services, and audiology services, which were originally excluded from the basic schedule of benefits, have been added. These services are covered provided they are performed in rehabilitation centers approved by the department, and are subject to utilization controls and approval by the department of extended treatment plans.

Copayment is discussed under a separate section.

ANALYSIS AND RECOMMENDATIONS

We withhold recommendation pending: (1) a review of the spring caseload and average costs estimates, and (2) greater utilization experience of the new group of recipients brought into the Medi-Cal program effective October 1971.

The budget proposes a General Fund appropriation of $654,584,708 for the California Medical Assistance Program which is $137,486,958 or 26.5 percent more than is estimated to be expended during the cur-

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CALIFORNIA MEDICAL ASSISTANCE PROGRAM—Continued

rent fiscal year. The funds appropriated by this item represent the state's share of cost for the Medi-Cal Title XIX program. In addition to the state funds, the budget shows funds from other sources to bring the total program expenditure to $1,688,656,545, which is $190,122,387 or 12.6 percent more than is estimated to be expended during the current fiscal year. Table 1 shows the program expenditures by type of service and by type of administrative cost.

Table 1

Total Medi-Cal Costs

	Actual 1970–71	*Allocated 1971–72*	*Proposed 1972–73*
Professional services	$260,738,401	$395,460,900	$386,214,900
Prescription drugs	79,278,394	100,157,300	93,685,000
Dental care	46,934,885	56,114,900	55,475,200
Hospital inpatient	332,631,449	502,289,000	625,714,800
State hospitals	49,658,235	55,576,500	57,504,000
Nursing homes	219,164,784	251,297,500	255,132,800
Other services	43,618,268	51,916,300	74,701,700
Title XVIII B buy-in	24,142,254	29,740,800	29,137,200
Program savings	--	−80,000,000	--
Totals	$1,056,166,670	$1,362,553,200	$1,577,565,600
Administration:			
Fiscal intermediary	$28,289,197	$32,138,319	$40,606,735
County support	17,978,078	18,782,044	48,119,596
State administration	14,012,990	21,449,143	22,364,614
Totals, Expenditures	$1,257,996,423	$1,498,534,158	$1,688,656,545

Table 2 presents the source of funding for the program.

Table 2

Source of Funding for Medi-Cal Program

	1970–71	*1971–72*	*1972–73*
General Fund	$484,497,959	$517,097,750	$654,584,708
Federal funds	553,292,023	731,971,865	760,487,213
County funds	214,906,441	241,260,000	256,941,900
Transfer (from Item 245), Mental Hygiene	5,300,000	8,000,000	16,370,000
Board of Medical Examiners' Contingent Fund	--	204,543	272,724
Total Medi-Cal	$1,257,996,423	$1,498,534,158	$1,688,656,545

Current Year Budget

The budget shows a program savings of $80 million for the current year. The main reason given for this savings is the leveling of cash grant caseload compared to that which was estimated by the Department of Health Care Services last spring. There is no doubt that the cash grant caseload has leveled off and in the case of AFDC-U, the November 1971 caseload was 31.9 percent below the March 1971 caseload. The AFDC-FG caseload in November 1971 was only 106 higher

than March 1971. The total number of persons in the AFDC-FG caseload was down slightly due to less children in the families.

The OAS caseload was down 8,021, or 2.5 percent, from the March 1971 high of 323,612 and the ATD caseload was up 1,469, or 0.8 percent, from March 1971.

The $80 million savings is shown as a General Fund saving. We are not able to reconcile the contention that the savings results from a leveling of cash grant caseload, the funding of which is shared on a 50-percent basis by the federal government. If this were true, why is the federal funding for the current year up 32.3 percent ? The fact that the state has gone to a cash basis for the payment of bills during the current year rather than the modified accrual basis does not explain the difference.

Because the savings are all General Fund, one explanation may be that the savings will be in the nonfederally eligible group which came into the program October 1, 1971 under AB 949, the Medi-Cal Reform Program (MRP), (Chapter 577, Statutes of 1971).

If that conclusion is not correct then the budget document is in error and the program savings should be in the magnitude of $160 million rather than the $80 million as shown.

On page 812, line 47, of the program budget the following statement is made in regard to the program savings:

"At the time of printing a further decrease in 1971–72 welfare cash grant caseload is anticipated. It is estimated that this will result in a savings of $80,000,000 to the General Fund. The federal decreases have not been reflected due in part to the changes in federal law made in December 1971 and effective January 1, 1972, and the new and revised sharing programs they involve."

The reference to federal law has to do with the funding of the Intermediate Care Facilities (ICF) program. Prior to January 1, 1972 the Intermediate Care Facility program was funded out of Title XI of the Federal Social Security Act. Effective January 1, 1972, it will be funded out of Title XIX, the Medicaid (Medi-Cal) program. The net effect will be that counties will not have to participate in the funding of intermediate care facilities as has previously been the case, and Medical Needy Only (MNO) persons can now be moved from nursing homes to intermediate care facilities and federal funding will continue.

During the past year, the Department of Health Care Services through its Medical-Social Review teams has been moving patients from nursing homes to a lesser level of care if such care is appropriate. It has not been able to move MNO patients because there would be no federal funding for them in the intermediate care facilities. Now they can be moved to an appropriate lesser level of care and federal funding will be available.

This change in the method of ICF payments does not change the fact that the federal government will pay 50 percent of the cost of care.

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CALIFORNIA MEDICAL ASSISTANCE PROGRAM—Continued

If total costs are going to be less for the care of a given segment of patients, it would appear that the federal government would share in the savings.

1972–73 Fiscal Year

The proposed budget for 1972–73 shows an increase of $137,486,958 or 26.5 percent in General Fund expenditures over the current fiscal year. The considerable increase appears to result from the fact that $80 million has been shown as General Fund "savings" in the current year because of a leveling of the caseload but no adjustment has been made in the amount proposed for the budget year. Also, while the General Fund amount is projected to go up 26.5 percent, the federal funds are anticipated to increase only 3.9 percent.

On the basis of caseload projections shown in the budget (program budget page 812, line 14) it is reasonable to assume that the General Fund increase will be more than the federal increase because the largest projected caseload increase is in the nonfederally funded group of medical indigents. However, we are not able to reconcile the considerable difference in amounts and are therefore withholding any recommendation until the department's spring caseload estimates are complete. Of particular concern is the estimate of the medical indigent caseload which came into the program October 1, 1971. The department has admitted that there was little actual experience upon which to base estimates at the time the budget was prepared. Because the appropriation for this program is closed-ended it is imperative that the most recent and accurate estimates be used in determining the General Fund amount or the program could face cutbacks similar to those instituted in December 1970.

ADMINISTRATION OF THE MEDI-CAL PROGRAM

Under the supervision of the Secretary for Human Relations the State Department of Health Care Services is the single state agency responsible for administration of the Medi-Cal program. County welfare or public health departments acting as agents of county boards of supervisors subject to the supervision and regulations of the Department of Health Care Services are responsible for receiving and processing applications for Medi-Cal.

The fiscal intermediaries, Blue Cross North, Blue Cross South and Blue Shield, process and pay all the claims for payment submitted by providers of care after the eligibility has been determined by the counties. These fiscal intermediaries are under contract with the State Department of Health Care Services.

Administration consists of program control and coordination, eligibility determination and services payment, within the State Department of Health Care Services. Additional administrative services are provided through contracts with the Departments of Social Welfare,

Mental Hygiene and Public Health. The county organizations include either the county departments of welfare or public health.

Table 3 shows the total estimated cost incurred for administration in fiscal years 1970–71, 1971–72 and 1972–73.

Table 3

Estimated Medi-Cal Cost for Administration 1970–71 through 1972–73

Administrative category	*1970–71*	*1971–72*	*1972–73*
State administration	$14,012,990	$21,449,143	$22,364,614
Fiscal intermediary	28,289,197	32,138,319	40,606,735
County operations	17,978,078	18,782,044	48,119,596
Total	$60,280,265	$72,369,506	$111,090,945

Increased Administrative Cost

We withhold recommendation pending receipt of caseload reestimates to be made in the spring. We also withhold recommendation on the administrative budget until an evaluation can be made of the present prior authorization procedure and its effect upon the program.

The 1971–72 increase in state administration was mainly due to passage of MRP legislation. A Section 28 letter, which authorized the increased expenditure of $4.61 million from the Health Care Deposit fund, was required just prior to implementation of MRP largely to cover increases in personnel that were necessary because of prior authorization requirements.

The 26-percent increase in fiscal intermediary administration is also a result of MRP. The budget year figure is based on an estimated increase in claims volume due to the increase in the number of eligibles. Estimates for the Medi-Cal Management System are also included.

County administration has also increased on the basis of caseload changes. Eligibility determination costs are estimated to increase $24.8 million due to the caseload increase of 132 percent for medically needy and the medically indigent. According to the department, a lag exists in realizing these increased costs. Therefore, the increase is not reflected in the current year. An inflation factor and costs related to copayment are also contained in the estimate.

The department has conceded that it had very little actual experience upon which to base its medical indigent caseload for the budget year. Because the county administrative cost is estimated to increase so substantially (from $18.8 million to $48.1 million) on the basis of the new medical indigent caseload, we are withholding our recommendation pending receipt of more data based on actual experience.

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CALIFORNIA MEDICAL ASSISTANCE PROGRAM—Continued

Prior Authorization

Prior authorization is a control technique to keep overutilization and inappropriate utilization of Medi-Cal services to a minimum. Under this technique, Medi-Cal consultants review treatment authorization requests (TARs) and approve, modify, or deny them in accordance with regulations. Specified services under the basic schedule of benefits as well as all services (except emergencies) under the supplemental schedule require prior authorization.

Providers must submit TARs to department field offices for approval, await their return, and then attach them to claims requests, which in turn are submitted to the fiscal intermediaries for payment. Although this process has created a cumbersome and bureaucratic method of utilization control, the department states it is necessary since it feels there are no built-in incentives to hold down overutilization in the current Medi-Cal system.

Treatment Authorization Requests

During the first three months of operations following MRP, an average of 237,135 treatment authorization requests were processed each month. Of those requests, approximately 83 percent were approved. Table 4 contains excerpts from the department's monthly activity reports depicting requests for October, November and December 1971 and the action taken.

Table 4

Statewide Monthly Activity for Prior Authorizations

Month	*Requests remaining from prior month*	*Requests this month*	*Approved*	*Denied*	*Returned for information*
October	50,603	217,894	162,195	22,638	18,370
November	64,853	234,571	209,673	20,839	20,819
December	48,584	244,405	218,209	19,189	19,476
Average	54,680	232,290	196,692	20,888	19,555

Nature of Unapproved Requests

Requests denied or returned for information fall into one of three categories: (1) administrative, (2) medical judgments, or (3) nonprogram benefits. The administrative group consists mainly of incomplete or improperly prepared forms as well as those containing clerical errors. Requests in the medical judgments group may be returned for additional information regarding diagnosis or treatment plans if the information contained is considered to be inadequate, or they may be denied if the treatment does not correspond to the diagnosis or is in excess of that required by the diagnosis under usual circumstances. The nonprogram benefits group contains requests for benefits which were never in the program or are no longer in the program as a result of MRP. Most requests in this group are denied. However, suggestions

for substitute treatment plans which are covered in the program are offered when available.

During the first three months of operations under MRP there was a high volume of unapproved requests in the administrative and non-program benefits groups. As providers familiarize themselves with the basic and supplemental schedules and administrative procedures, a sharp decline in this volume will occur. A majority of the requests returned for information are resubmitted and approved.

Processing Costs

The Department of Health Care Services recently performed a study of the processing costs directly related to treatment authorization requests (TARs) of the major categories of service. Estimated salaries, general administration costs and overhead costs from the 1971–72 budget allocated to the Field Services Division and the actual number of TARs processed for November 1971 were utilized to determine the average cost of processing a TAR in each major category of service. Table 5 shows the results of that study and in addition, the approval rates for each category. Funding of the administrative costs is generally shared on a 50-percent state, 50-percent federal basis. Professional salaries are funded on a 25-percent state and 75-percent federal basis.

Table 5

Processing Costs Per Treatment Authorization Request (TAR) and Approval Rates by Category of Service[1]

Category of service	*Processing cost per TAR*	*Approval rate percent*
Drugs	$2.08	92.8
Dental	4.22	77.3
Medical	3.38	76.7
Visual	2.22	82.9
Nursing home (excluding medical social review)	2.21	90.0
Average	$2.95	83.3

[1] Statewide figures, based on current (1971–72) budget for prior authorization and November activity.

The department has recently contracted with a private firm to complete a study of pharmaceutical and dental claims. The purposes of the study are to investigate costs related to TAR processing and to establish an effective means of measuring utilization controls. It is hoped the results of this study will provide a basis for recommended reductions in the number of drug and dental TARs to be processed. The anticipated completion date is February 29, 1972.

Drug TARs

In an attempt to reduce the paperwork for providers of drugs, the largest single volume of TARs, the department introduced a new method for processing drug TARs on December 1, 1971. At that time, a few drug chain stores had refused to participate in the program because of administrative expenses related to the completion of drug

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CALIFORNIA MEDICAL ASSISTANCE PROGRAM—Continued

TARs. The new process enables the providers to phone in drug requests which are approved or denied concurrently. Those approved are placed on an appropriate form and sent directly to the provider, who attaches them to his claims request. The department is currently revising the form in order to accelerate the process.

This method has reduced the effectiveness of prior authorization controls for drugs since previous records are no longer used as a source of information affecting the approval or denial decision. In fact, records of phone-in requests are not being kept on file in some offices and only in bulk in the others.

Additional Controls with MMS

The Field Services Division and the Medi-Cal Management System Bureau of the Department of Health Care Services are in the process of organizing the most beneficial arrangement possible between the Medi-Cal Management System (MMS) and district offices in the two prototype counties (a discussion of MMS follows in this analysis). This arrangement will allow for MMS elements and district offices to be commonly located where possible. Complete beneficiary and provider profiles will then be available for Medi-Cal consultants to utilize in prior authorization and medical social review decisions. Under the current system, the only records available are previous treatment authorization requests and results of initial and annual patient reviews.

This relationship will allow a much stronger system of utilization controls within the new basic and supplemental schedules of benefits. Should MMS be adopted throughout the state, all efforts should be made to create similar relationships between the remainder of the field offices and other MMS elements.

Medical-Social Review Teams

The Social Security Act of 1967 requires periodic inspections to be made in all skilled nursing homes and mental institutions within the state by one or more medical review teams composed of physicians and other appropriate social service personnel. The aim of these inspections is threefold. First, the care being given to all eligible patients is to be generally inspected. Second, with respect to each of the patients receiving such care, the necessity and desirability of the continued placement in the facilities is to be evaluated. Third, the feasibility of meeting nursing home patient's health care needs through alternative institutional or noninstitutional service is to be evaluated.

The Department of Health Care Services established Medical-Social Review (MSR) teams during the 1970–71 fiscal year to satisfy the above requirement. These MSR teams review all prior authorization and reauthorization requests for nursing home and Intermediate Care

Facility (ICF) services. In addition, an individual on-site review of each patient is conducted to determine:

1. What level of care is needed?
2. Is this level of care being provided?
3. Does patient need skilled nursing care?
4. Is he in a facility to provide this care?

Nursing home patients are reviewed annually and ICF patients semiannually. All patients are reviewed at the time of their initial request for placement in either an ICF or nursing home.

Results of Reviews

The medical social review summaries prepared by the department for the months of September, October and November 1971 indicate that an average of 3,075 annual reviews have been conducted each month. The department is in the first cycle of annual reviews and as of December 1, 1971, 71 percent of the annual reviews were completed. The approximate percentages of patients currently residing in nursing homes recommended for each level of care were:

Nursing homes	85 percent
Intermediate care facilities	10 percent
Residential care or homes	5 percent

The percentages of those recommended for lower levels of care who actually relocate varies throughout the state. In some areas, approximately 6 percent of the patients who have been recommended for a lower level of care requested fair hearings. In other areas, ICF and/or residential care facility beds are not available. The department is currently assisting in the establishment of these facilities where possible. Overall, the percentage of patients being relocated has shown a steady increase.

Initial Requests

Prior to MRP, initial requests for nursing home care were not required at the time the patient was transferred. Retroactive approval was granted at a later date. With the requirement for immediate requests and reviews, a substantial savings has resulted. Patients who would later be identified for a lower level of care are now identified prior to or shortly after entering the nursing homes. During October and November 1971, there were 14,319 initial nursing home requests submitted and 1,149 were denied. Actual savings cannot be computed because data regarding the number of patients denied nursing home care who enterd ICF, residential care facilities, or returned home are not available.

Intermediate Care Becomes a Title XIX Benefit

House of Representatives Bill 10604 was signed by the President on December 28, 1971. A section of this bill adds intermediate care to the list of benefits covered under Title XIX of the Federal Social Security

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CALIFORNIA MEDICAL ASSISTANCE PROGRAM—Continued

Act. This change was effective January 1, 1972, and will require a transfer of funds and responsibilities related to intermediate care from the Department of Social Welfare to the Department of Health Care Services.

The transfer will result in an increase in General Fund expenditures by the amount of the county contribution to the current program. Thus, General Fund estimates must be increased by the amount of county contributions for the second half of the current year and the entire budget year. The estimates for each year are $429,950 and $881,900 respectively.

As indicated earlier, the cost and/or savings implication of this change in law are not known as of this writing. We will be prepared to discuss more fully the implications at the time of the budget hearings.

Copayment

The MRP contained a copayment requirement which was initiated on January 1, 1972. Beneficiaries required to copay are those whose income combined with their grants, if any, exceed the amounts to which they or their family would be entitled if they were solely dependent upon public assistance grants. Copayments of one dollar ($1) are paid to providers for each outpatient visit for services included under the basic schedule of benefits that do not require prior authorization. A copayment of fifty cents ($0.50) is also required for each prescribed drug listed under the basic schedule of benefits. This project will serve as a national test for determining the adequacy of overutilization and inappropriate utilization controls resulting from a copayment requirement for beneficiaries.

Since a copayment of this nature violates provisions of federal law, a federal waiver from the Department of Health, Education and Welfare was necessary prior to implementation. Under existing law, the project will terminate June 30, 1973. A continuation would require an extension of both the federal waiver and state law.

It was stated in the budget supplement that an estimated 50 percent of all Medi-Cal eligibles would be required to copay. More recent estimates derived during the first week of January indicate that actual figures will be between 35 and 45 percent. Sufficient data are not available at this time for a meaningful discussion of the copayment project. However, we are currently researching possible problem areas and anticipate that enough material will be available for presentation during the budget hearings.

MEDI-CAL MANAGEMENT SYSTEM

The 1968 Legislature authorized an amount of $250,000 for a study of the existing Medi-Cal eligibility process, claim payment process and management system. A private contractor conducted the study and

submitted a report with extensive recommendations in March 1969. The department adopted the report in the late summer of 1969 and asked for bids from potential contractors for the development and implementation of the system proposed on a prototype basis, that is, in two counties to test and perfect the procedures.

The report basically recommended the establishment of a single management claims processing control system to provide positive eligibility verification, and that local claims processing be linked to a centralized data processing unit. The present system was described as fragmented and totally unresponsive to the needs of the state, providers of care, and recipients of service.

In early 1970, the department executed a contract with a joint venture of insurance companies and a computer services corporation called Health Care Systems Administrators (HCSA) to implement a MMS on a prototype basis in two counties.

The project was originally to be implemented in three phases at a total cost of $5.578 million: design, scheduled to last seven months; development, scheduled to last 11 months; and implementation, scheduled to take six months. The department and the contractor initiated the design phase on July 1, 1970.

Just prior to completion of the design phase, HCSA requested that the original contract be amended, since justifiable delays and increased costs had been or would be incurred prior to the completion of the project.This request resulted in contract amendments that interpret the intent of the original contract with regards to implementation and prototype operation costs and compensate the contractor for those justifiable increased costs. The delays have postponed implementation of the prototype system in San Diego and Santa Clara Counties from January 1972 to August 1972. The request and contract changes are discussed in more detail below.

Delays and Increased Costs

The request contained extensive contract amendments that would be required to accommodate necessary changes in the prototype operational date and an associated rescheduling of certain deliverable items (deliverable items are specifically defined work products, each of which has its own scheduled date of delivery). Submission of the request was necessary because it was felt that the intent of the original contract was not clear, and justifiable increased costs were incurred or will be incurred during the remaining term of the contract. These increased costs were said to have resulted from a lack of timely response by the state, and changes in design which were necessitated by the changes which took place in the Medi-Cal program since the date the contract was written.

The state was 104 days late in supplying exact information on how provider claims were to be paid to the contractor. This caused a 104-day setback in all subsequent contract dates. Concurrently, four other

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delays in response by the state took place, resulting in further retardation of the schedule and increased costs to the data processing subcontractor.

The untimely responses by DHCS were due to problems concerning the complexity of the design, which made rapid decisions impossible, and difficulties in coordination with the federal government, other state departments, and county governments.

Additional costs were also incurred or projected for system design changes necessary to handle the increased caseloads and other modifications contained in the MRP.

Contract amendments incorporated costs for delays, adjustments for increased volume of claims and beneficiaries, and additional functional requirements for an estimated total of $1.041 million. The new schedule for receipt of deliverable items was also contained in the amendments.

Implementation and Prototype Operation Costs

The contract amendments interpret the intent of the original contract and clarify the costs which are included in the maximum price of $5.578 million. The contract covered design, development, testing, implementation, and prototype operations. However, it was neither clear as to how costs for implementation and prototype operations would be reimbursed, nor was it specific about defining implementation. Certain implementation costs will be incurred prior to prototype operations because the actual operation is scheduled to start on the day following the integrated system demonstration. It was not the intent of the original contract to include implementation and prototype operation costs in the maximum price. Therefore, the costs of deliverable items defined as the components of implementation were deleted from the contract. The estimated total cost of contract deletions is $1.141 million.

Net Effect of Contract Amendments

The net effect of the contract amendments was an estimated reduction in the maximum contract price of $100,000. This can be seen in Table 6 which shows estimates for the contract deletions and additions prepared by HCSA.

If the provisions of the amended contract are met, the maximum price of $5.578 million for design, development and testing will not be exceeded. It is also stated in the amendments that the "Items of Prototype Implementation and Operation Expense" shall not exceed $993,-571 plus any amount not expended under the "maximum price." This amount has been included in the budget year estimates for administration costs of the fiscal intermediaries.

Prototype Operation and Statewide Implementation

Estimates for operation of the prototype system and funds necessary to begin statewide implementation are also included in the budget

Table 6

HCSA Contract Estimates

Contract Deletions			
Deliverable No.			
10(b)	Operation and training manuals—printing only		$14,620
13	Provider and user forms and instructions—printing only for internal forms		18,960
15	Statewide Implementation Plan		28,515
16	Final system documentation		
	Development	$83,000	
	Printing	35,000	
			118,000
	Accounting and payroll system—software package		87,500
	Prototype implementation		873,601
	TOTAL CONTRACT DELETIONS		$1,141,196
Contract Additions			
1.	Date certain responses—104 days delay		597,064
2.	Lack of prototype funds F.Y. 1971–72 Budget adjustments for increased volume of claims and beneficiaries and additional functional requirements		444,132
	TOTAL CONTRACT ADDITIONS		$1,041,196
	Adjustment to Maximum Contract Price		−$100,000

under administration costs for the fiscal intermediaries (FI). The department has obtained the following estimates from HCSA:

Funds required to operate prototype system only $5,156,697
Additional funds to begin statewide implementation 2,452,686

Total estimated funds 1972–73 fiscal year $7,609,383

In developing these estimates, HCSA assumed that: (1) the prototype counties would be operational from August 1972 through June 1973; (2) Imperial County operation will begin in February 1973; (3) initial upgrading of equipment and facilities to statewide configuration will take place in April 1973; (4) operation will begin in Orange and Riverside Counties in May 1973; and (5) Los Angeles and San Bernardino Counties will begin operations in July 1973 (facilities and personnel expenses will incur in June 1973).

The estimates do not include any expenses chargeable under the recently amended MMS maximum contract. Prototype implementation costs, which were eliminated from the original contract, are included in the $5,156,697 for prototype operations. Peer review and forms and postage expenses are also excluded from the estimates.

It is estimated that MMS operations will offset FI costs by 6.6 percent. This is based on an estimated 9.4 percent reduction in claims volume at the FIs. However, certain fixed costs of the fiscal intermediaries cannot be reduced. Compensation was made for these by the amounts of the related fixed costs (2.8 percent). The net costs budgeted for 1972–73 for prototype implementation, prototype operation and the beginning of statewide implementation are:

164 12 7 145

CALIFORNIA MEDICAL ASSISTANCE PROGRAM—Continued

Total cost	$7,609,000
Less reduction in FI cost	2,292,000
Net MMS cost	$5,317,000

Statewide Implementation

We recommend that the Legislature be given the opportunity to evaluate the prototype operations prior to statewide implementation; and, should statewide operation of MMS be desired, we recommend that a request for bids be made to potential contractors for operation of the system.

It is our understanding that the prototype system will operate for a six-month period in San Diego and Santa Clara Counties. During that time, the system will be evaluated to determine if it accomplishes the established objectives. Then, providing the system is a success, the possibility of implementation on a statewide basis will be considered.

If the decision is made to adopt the system throughout the state, the department should then ask for bids from potential contractors for the operation of the statewide system. We have had no indication that statewide operations are included under the current contract, but we have received information denoting that actual plans exist.

As was previously pointed out, the department has included estimates for statewide implementation and operation of MMS in the amount of $2.45 million in the estimates of fiscal intermediary administrative costs for the 1972–73 fiscal year.

DEPARTMENT OF HUMAN RESOURCES DEVELOPMENT

Items 234, 235, 236, and 237, from the General Fund, Item 238 from the Department of Human Resources Development Contingent Fund and Items 239 and 240, from the Unemployment Fund and Unemployment Compensation Disability Fund, respectively. Budget p. 147 Program p. 821

Requested 1972–73	$27,417,929
Estimated 1971–72	24,175,551
Actual 1970–71	21,560,289
Requested increase $3,242,378 (13.4 percent)	
Total recommended reduction (Item 236, General Fund)	$26,608