

The Medi-Cal Program In Perspective

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|--|-----------|
| Introduction..... | 1 |
| Executive Summary..... | 2 |
| Chapter I..... | 4 |
| <i>Proposed 1987-88 Budget for Medi-Cal</i> | |
| Chapter II..... | 6 |
| <i>Medi-Cal Costs and Trends in Perspective</i> | |
| Medi-Cal Cost Increases Compared to Inflation in the Health Care Industry..... | 6 |
| Medi-Cal Costs Compared to Costs of Medicaid Programs in Other States..... | 8 |
| Medi-Cal Benefits Compared to Private Health Insurance Plans..... | 11 |
| Growth in Expenditures for Medi-Cal and Medically Indigent Services Compared to Growth in the General Fund Budget and the Appropriations Limit..... | 12 |
| Reasons for Medi-Cal Expenditures Growth Since 1983-84..... | 13 |
| Prospects for Future Increases in Medi-Cal Expenditures..... | 14 |
| Chapter III..... | 16 |
| <i>Major Options for Reducing Medi-Cal Costs</i> | |
| Optional Eligibility Categories..... | 16 |
| Optional Benefits..... | 17 |
| Cost-Saving Options That Do Not Involve Reducing Benefits or Eliminating Eligibility Categories..... | 19 |

Table of Contents

Introduction

This report is submitted in conjunction with our *Analysis of the 1987-88 Budget Bill*. The report is intended to provide the Legislature with background information needed to place in perspective the Governor's proposal to reduce Medi-Cal costs by \$250 million (\$125 million General Fund) through an as-yet-unspecified "program restructuring." The first chapter of the report provides an over-

view of the Medi-Cal budget proposal for 1987-88. The second chapter provides data intended to put Medi-Cal costs and trends into perspective. The third chapter identifies major options for reducing Medi-Cal costs.

The report was prepared by Michael C. Genest under the supervision of Carol Bingham. ♦

Executive Summary

The *Governor's Budget Summary* calls for the Legislature to work with the administration to formulate long-term reforms in the Medi-Cal program "to permit the state to provide necessary medical benefits to the needy while containing program costs at a level that is 5 to 10 percent less than current trends would indicate." The budget anticipates a \$125 million General Fund savings resulting from this restructuring effort. Neither the budget itself nor any of the supporting documentation submitted with it provide any specific proposals for program restructuring.

The proposed program restructuring would account for a 4.9 percent reduction in expenditures, compared to baseline estimates, in the first year of implementation. The long-term effect of the restructuring is likely to be substantially greater, however, since the proposed \$125 million General Fund reduction would translate into an ongoing reduction of at least \$150 to \$200 million, depending on the precise nature and timing of the changes that would make up the restructuring. This is because Medi-Cal payment lags would reduce the effect of any reform during the first fiscal year it takes effect.

In this report, we examine Medi-Cal expenditure trends to determine where the program stands relative to inflation in

the health care industry, other state Medicaid programs, private health insurance benefits, General Fund expenditures as a whole, and the state appropriations limit. The report also identifies major options for reducing Medi-Cal costs.

We conclude that:

- Medi-Cal costs are growing at a rate lower than inflation in the health care industry as a whole and lower than the rate of increase in the state's costs to purchase private health insurance for state employees.
- The program's costs per user are less than the costs of Medicaid programs in the nation's 12 largest states.
- The percentage of state population that uses the Medicaid program is higher in California than in other large states.
- California's taxpayers pay a somewhat smaller share of their incomes to finance the state's Medicaid program than do the taxpayers in the rest of the nation.
- The major differences between benefits provided by Medi-Cal and private insurance are inherent in the basic differences between the purpose of Medi-Cal and the purpose of private insurance.

- The program has reduced its share of the General Fund budget in recent years and has been growing at a rate that is lower than the rate of growth in the state's appropriations limit.
- The growth in program costs that has occurred since the enactment of the last major Medi-Cal reforms in 1982 has been due primarily to explicit decisions by the Legislature and the Governor.

We also note that the AIDS epidemic, the federal Immigration Reform and Control Act, and the aging of the state's population could have serious implications for Medi-Cal's future costs. We believe that there is too much uncertainty surrounding these recent developments, however, to warrant basing a major reform solely on their potential effects.

Finally, we recognize the possibility that the Legislature may desire to implement a major reform of the Medi-Cal program in response to the state's overall fiscal condition and as a way of funding the Legislature's priorities in other program areas. In order to accommodate a Medi-Cal savings of the magnitude proposed in the budget, the Legislature probably would have to (1) eliminate some benefits or eligibility categories that are optional under federal law (the annual General Fund costs of federally authorized optional *benefits* is approximately \$500 million, while the costs of services to individuals in optional *eligibility* categories totals \$860 million annually), (2) pursue various cost avoidance and recovery enhancements, (3) implement changes in purchasing practices, (4) improve utilization review, and/or (5) develop alternatives to long-term care. ♦

Chapter I

Proposed 1987-88 Budget for Medi-Cal

The California Medical Assistance program (Medi-Cal) is a joint federal-state program initially authorized in 1966 under Title XIX of the federal Social Security Act. This program is intended to assure the provision of necessary health care services to public assistance recipients and to other individuals who cannot afford to pay for these services themselves.

The budget proposes expenditures of \$5.2 billion (\$2.5 billion General Fund) for Medi-Cal in 1987-88. These funds consist of:

- \$116 million (\$42.2 million General Fund) for state administration.
- \$148.3 million (\$71.5 million General Fund) for county administration.
- \$37.7 million (\$11.1 million General Fund) for claims processing.
- \$4.9 billion (\$2.4 billion General Fund) for reimbursements to providers for health care services.

The level of General Fund expenditures proposed for Medi-Cal health care services in the budget year represents a reduction of \$7.4 million, or 0.3 percent, compared with estimated expenditures in the current year. It is a reduction of \$168.6 million, or 7.1 percent, compared to "baseline" expenditure estimates for 1987-88 prepared by the Department of Health Services.

The major reason for the reduction in health care services costs below baseline estimates is a \$125 million General Fund savings anticipated as a result of "program restructuring." Neither the budget itself nor any supporting documentation provide any specific proposals for program restructuring. The 1987-88 *Governor's Budget Summary* calls for the Legislature to work with the administration to formulate long-term reforms in the Medi-Cal program "to permit the state to provide necessary medical benefits to the needy while containing program costs at a level which is 5 to 10 percent less than current trends would indicate."

The \$125 million restructuring represents a 4.9 percent reduction in expenditures, compared to baseline estimates for Medi-Cal health care services, in the first year of implementation. The long-term effect of the restructuring is likely to be substantially greater, however, since the proposed \$125 million General Fund reduction would translate into an ongoing reduction of at least \$150 to \$200 million, depending on the precise nature and timing of the changes that would comprise the restructuring. This is because Medi-Cal payment lags would reduce the effect of any reform during the first fiscal year it takes effect. Thus, the budget summary is probably reasonably

accurate in characterizing the proposed restructuring as reducing costs in the long run by 5 to 10 percent.

In the second chapter of this report, we examine Medi-Cal expenditure trends to determine where the program stands relative to other state Medicaid programs, General Fund expenditures as a whole, the state appropriations limit, and private

health insurance costs and covered benefits. In the third chapter, we identify major options for reducing Medi-Cal costs. This is in recognition of the possibility that the Legislature may choose to impose a Medi-Cal reduction as a means of addressing the state's overall fiscal condition and as a way of funding legislative priorities in other program areas. ♦

Chapter II

Medi-Cal Costs and Trends in Perspective

Medi-Cal Cost Increases Compared to Inflation in the Health Care Industry

One way to assess whether the Medi-Cal program costs more than is warranted is to compare the rate of increase in Medi-Cal prices with price inflation in California's health care industry as a whole. In order to do this, we used data provided by the federal Bureau of Labor Statistics to estimate price increases in the state's health care industry. Chart 1 displays our estimate of overall health care inflation and compares it to the increases in the

state's costs per fee-for-service eligible person under Medi-Cal. As the chart shows, between 1978-79 and 1986-87 the cumulative increase in Medi-Cal's costs per eligible has been about one-half of the increase in private-sector prices. Even in the years following enactment of AB 799 in 1982--the last major Medi-Cal reform legislation--Medi-Cal cost increases have been below the level of overall inflation in the health care sector.

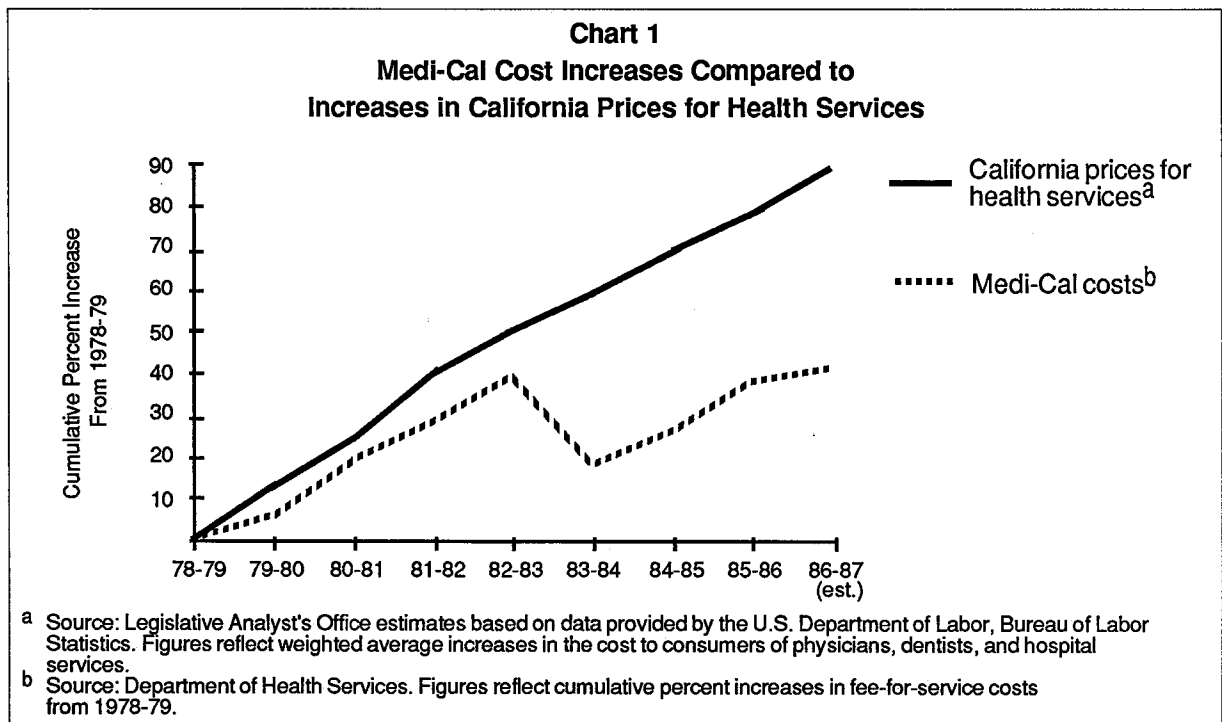
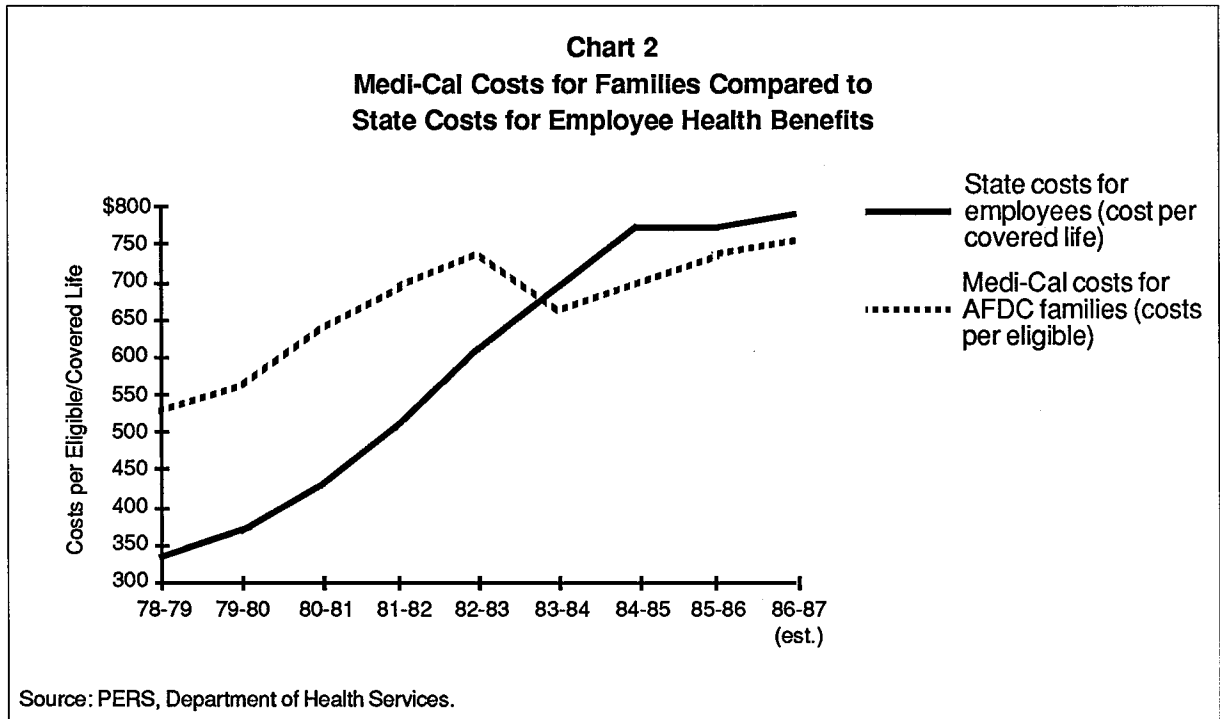


Chart 2 provides another indicator of how Medi-Cal costs compare with private-sector costs. The chart compares the cost to the state of insuring the average individual in an AFDC family under the Medi-Cal program with the state's cost to insure the average individual in the family of a state employee. The chart should be interpreted cautiously. This is

because the amount and kind of medical care needed by these two groups may vary greatly. What the chart clearly shows, however, is that in recent years, the costs of Medi-Cal have been growing at a substantially lower rate than have the costs of the private insurance that the state purchases for its own employees.



Medi-Cal Costs Compared to Medicaid Program Costs in Other States

Chart 3 compares the costs per Medicaid user for the nation's 12 largest states and for the average of all states. As the chart shows, California's cost per user is the

lowest of any of the 12 largest states and significantly lower than the national average.

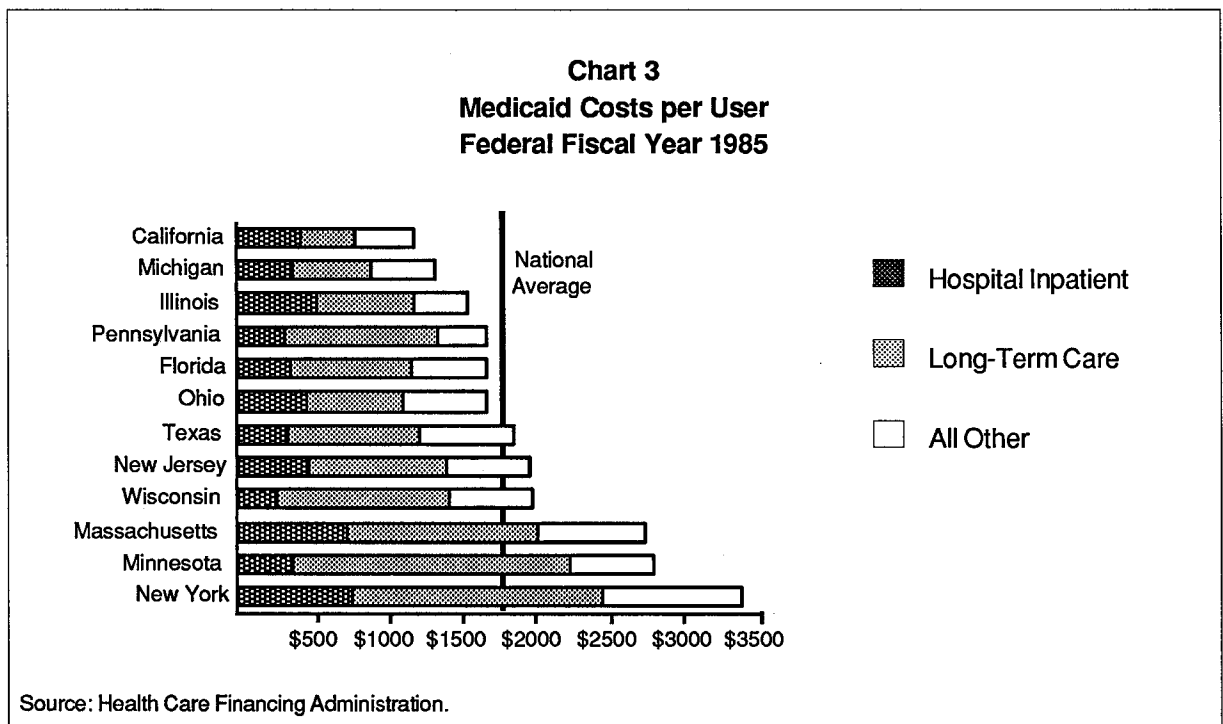


Chart 4 provides another perspective on how Medi-Cal compares with other states' Medicaid programs. Specifically, the chart displays Medi-Cal "users" as a percent of California's overall population and shows comparable figures for the other 11 largest states. As the chart shows, more of California's population received Medicaid

services than did the populations of any of the other largest states. Taken together, Charts 3 and 4 seem to indicate that California has a very "broad" Medicaid program, in the sense that it serves a relatively large part of the state's population at a relatively low cost per individual served.

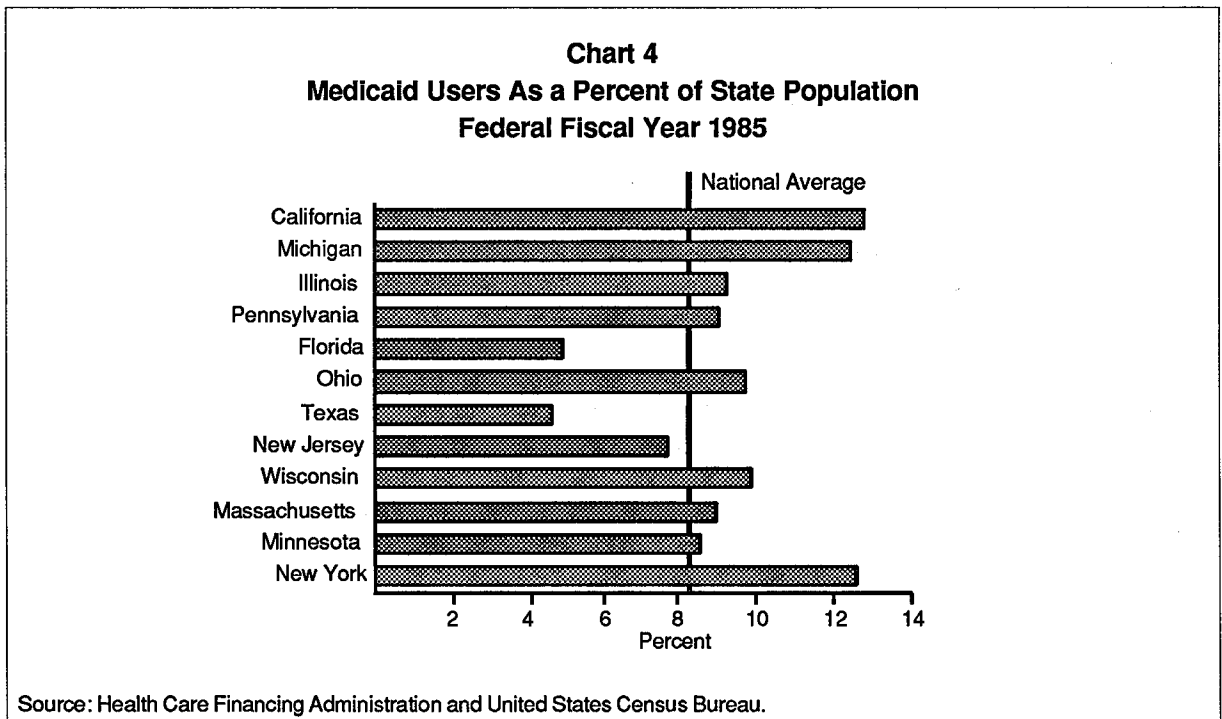
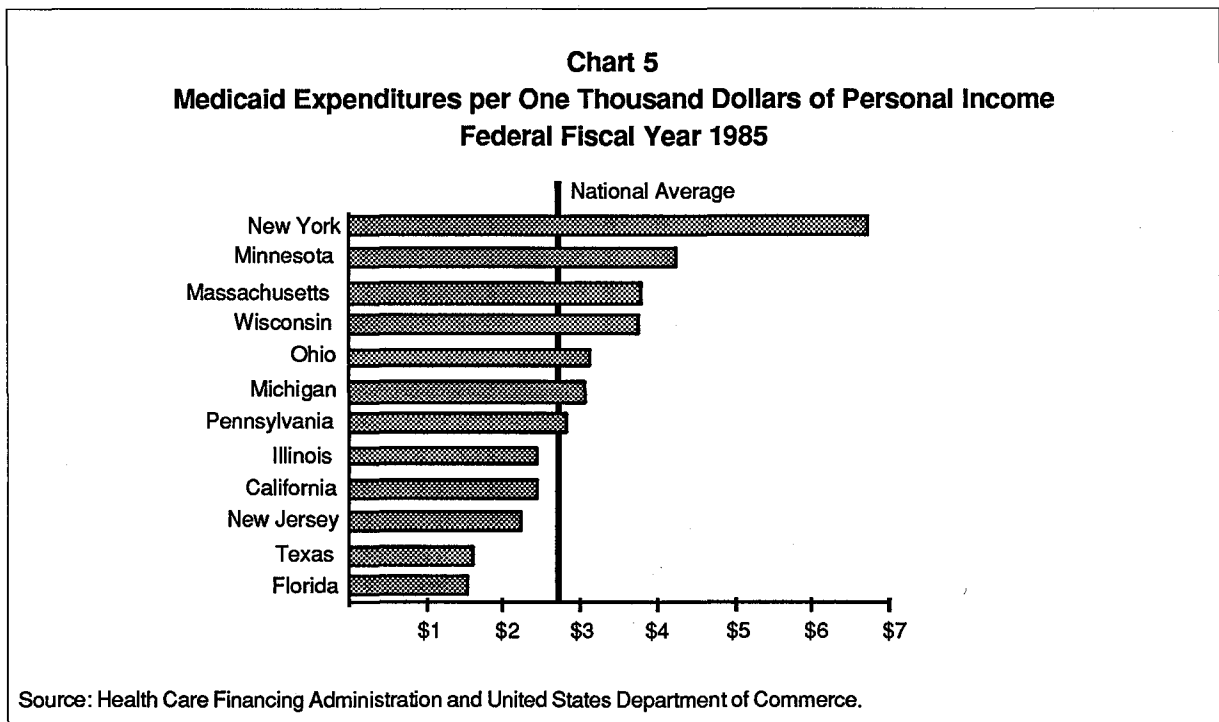


Chart 5 displays Medicaid expenditures per \$1,000 of state personal income. State personal income represents the total annual pre-tax income of individuals (not including corporations) in the state. Thus, the chart can be viewed as depicting the relative burden on individual taxpayers of

each state's Medicaid program. As the chart shows, California's taxpayers pay a somewhat smaller share of their personal incomes to finance the state's Medicaid program than do the taxpayers in the rest of the nation.



Medi-Cal Benefits Compared to Private Health Insurance Plans

The budget states that the proposed program restructuring "will strike a balance between providing a wide range of basic benefits and ensuring that taxpayers are not asked to fund a program which provides more benefits than would typically be provided as part of an employee benefit package."

The budget does not provide a comparison of typical employee benefit packages with the benefits available through Medi-Cal. Such a comparison is difficult to make because of two unique characteristics of the Medi-Cal program:

- ***Medi-Cal Covers Long-Term Care.*** Long-term care accounts for approximately 25 percent of Medi-Cal fee-for-service expenditures. Neither private insurance nor the federal Medicare program covers long-term care. In fact, many individuals become eligible for Medi-Cal long-term care services only after they have exhausted all other resources and all of their own funds. Private coverage is simply not designed to take care of individuals who find themselves in these circumstances.
- ***Medi-Cal Covers Poor People.*** Like Medi-Cal, most private insurance plans cover an assortment of routine services, such as doctor office visits. Many insurance plans, however, require the beneficiary to pay either a

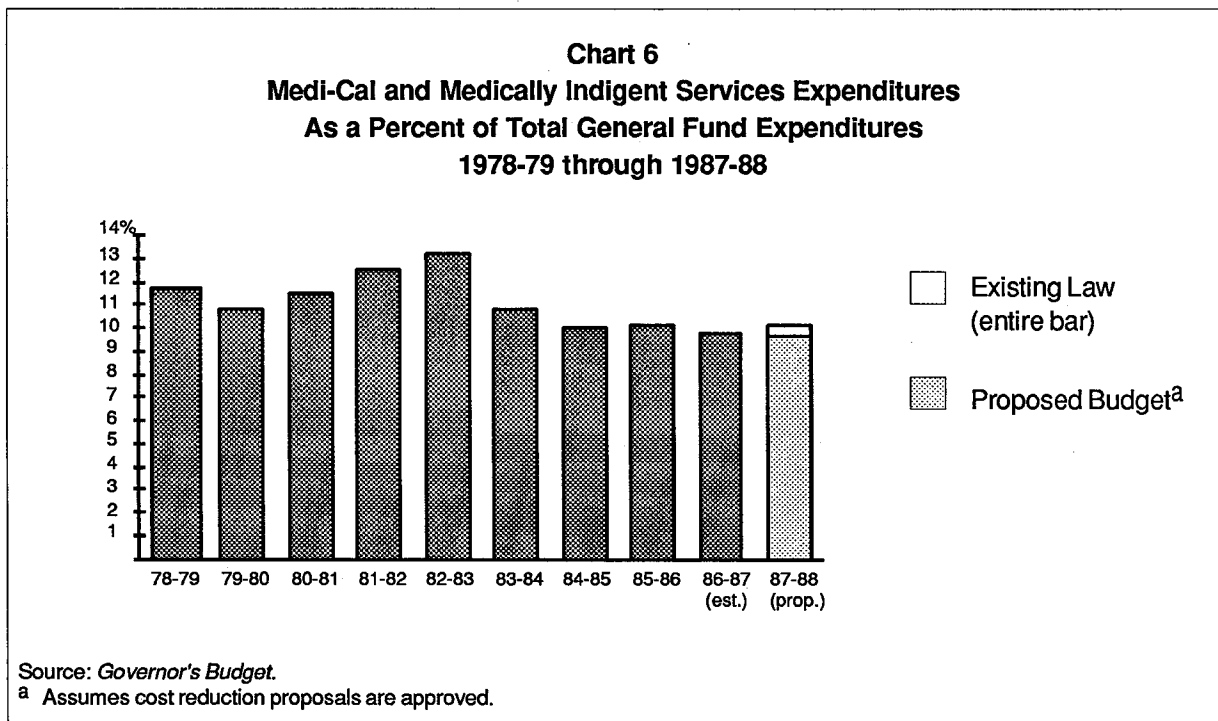
set fee or a fixed percentage of the cost of the visit. Because Medi-Cal covers people whose incomes are very low, it does not require beneficiaries to pay a fee or a portion of the cost. Medically needy beneficiaries must "spend down" their income to specified levels before they can qualify for Medi-Cal.

We compared Medi-Cal benefits to benefits under one major private plan--Kaiser Health Foundation-North. Our comparison indicates that with the exceptions of long-term care coverage and beneficiary copayments, Kaiser's coverage generally is comparable to Medi-Cal's. Kaiser does not, however, cover dental, chiropractic, or podiatry services; and less than 20 percent of its enrollees are covered for optometric services. (Some of the individuals covered by Kaiser, however, could be separately covered for some of these services under their employee benefit plans. For example, state employees have separate dental and optometric coverage.) These services are excluded from private insurance coverage, in part, because they represent relatively small expenditures that non-welfare-eligible families can generally accommodate within their family budgets. To Medi-Cal beneficiaries, however, the costs of these services could be more than they can accommodate within their limited budgets.

Growth in Expenditures for Medi-Cal and Medically Indigent Services Compared to Growth in the General Fund Budget and the Appropriations Limit

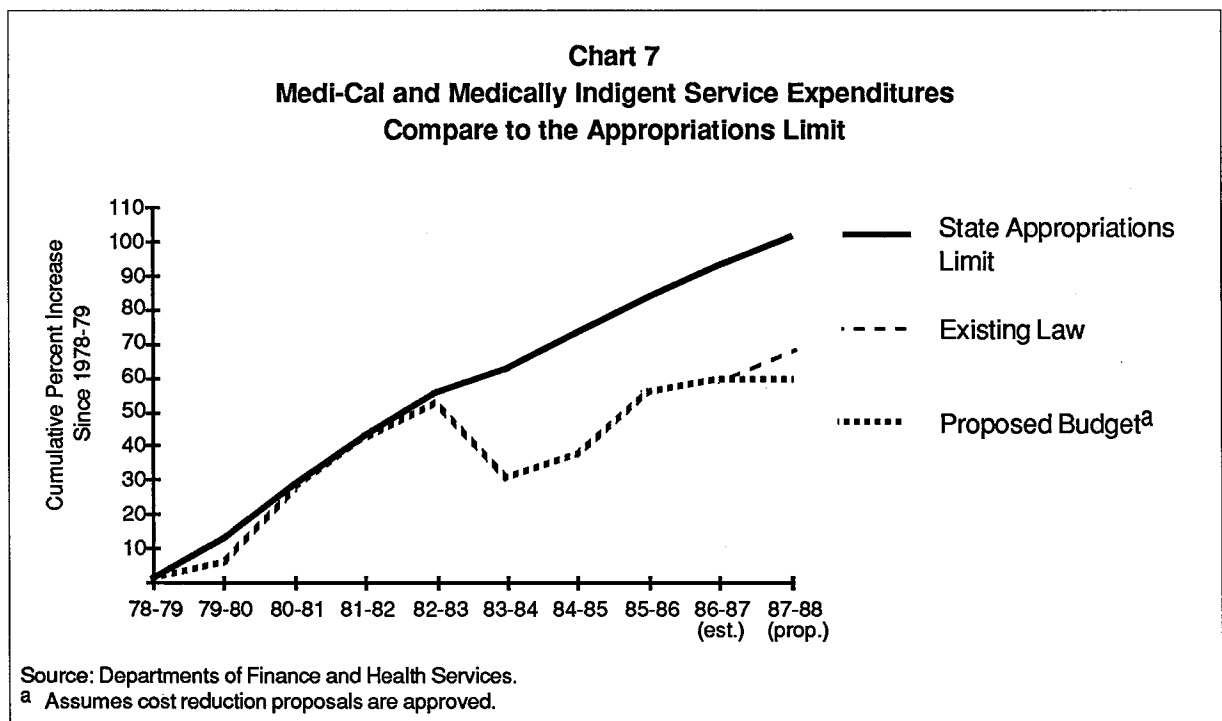
Medi-Cal and Medically Indigent Services as a Percent of the General Fund Budget. Chart 6 displays General Fund expenditures for the Medi-Cal and Medically Indigent Services programs as a percent of total General Fund expenditures. We combined the state's costs for these programs for the purposes of this display because there is no other basis for comparing current costs to costs before the Medi-Cal reforms in 1982, which eliminated Medi-Cal financing for most medically indigent adults. As the

chart shows, the programs' share of General Fund expenditures has declined since 1978-79. If the proposed program restructuring and other specific cost control measures proposed in the budget are not approved, however, the chart shows that these programs' share of total General Fund expenditures would increase from a nine-year low of 9.6 percent in 1986-87 to 10.1 percent in 1987-88. This 10.1 percent share is still lower than the programs' share of these expenditures in 1978-79.



Medi-Cal and Medically Indigent Services Compared to the Appropriations Limit. Another way to assess the state's continuing ability to pay for the current Medi-Cal program is to consider the relationship between program growth and the state's constitutional appropriations limit. As Chart 7 shows, the growth in expenditures for Medi-Cal and medically

indigent services has been substantially less than the growth in the appropriations limit over the period 1978-79 through 1987-88. The chart also shows, however, that if the proposed program restructuring and other cost control measures are *not* approved, costs of the programs will grow slightly faster than the appropriations limit in 1987-88.



Reasons for Medi-Cal Expenditures Growth Since 1983-84

Chart 7 shows the effect of the last major Medi-Cal reforms, which were enacted in 1982 (Ch 328/82--AB 799, Ch 329/82--AB 3480, and Ch 1594/82--SB 2012). Specifically, the chart shows a dramatic downturn in costs in the first full fiscal year in which the reforms were in effect--1983-84. The chart also shows, however, that costs

have increased steadily since 1983-84. The 1987-88 baseline cost of the program (that is, the cost without the proposed program reductions) represents an increase of \$591.4 million over the General Fund costs in 1983-84. This represents a 30 percent increase in four years, or an average annual increase of 6.8 percent.

Table 1 summarizes the decisions that led to these increases. As the table shows, the bulk of the increase in program costs since the last major reform is attributable to budgetary (cost-of-living adjustments) and statutory decisions enacted by the

Legislature and signed by the Governor. Other factors, including court orders, have resulted in growth of \$177 million, or 9 percent, in General Fund spending since 1983-84.

Table 1
Increases in the General Fund Costs of the Medi-Cal Program
Assuming Existing Law
1983-84 through 1987-88
(dollars in millions)

| <i>Reason for Increase</i> | <i>Amount</i> | <i>Percent Increase Since 1983-84</i> |
|----------------------------|----------------|---------------------------------------|
| Cost-of-living increases | \$343.4 | 17.6% |
| Legislation | 70.9 | 3.6 |
| Court orders | 80.4 | 4.1 |
| All other | <u>96.7</u> | <u>5.0</u> |
| Totals | \$591.4 | 30.3% |

Prospects for Future Increases in Medi-Cal Expenditures

While recent trends in Medi-Cal costs do *not* indicate that the program's costs are growing out of control, there have been several developments that *could* accelerate the growth in program costs in the near future to levels beyond those indicated by recent trends. Specifically, expenditures related to three audit issues-- (1) the Los Angeles County settlement, (2) the institutions for mental disease audit, and (3) the new requirement for accelerated payment of a variety of outstanding federal audits--could increase the General Fund costs of the program in the current year by an additional \$198.5 million. While an increase of this magnitude could have serious fiscal implications

for the state, the one-time nature of the payments involved argues against instituting permanent program changes simply to accommodate these costs.

Three relatively recent developments, however, may result in long-term changes that *could* accelerate the rate of growth in Medi-Cal costs beyond what recent trends would indicate. These are the Acquired Immune Deficiency Syndrome (AIDS) epidemic, the federal Immigration Reform and Control Act (IRCA) of 1986, and the aging of the state's population. We discuss each of these issues in detail in *The 1987-88 Budget: Perspectives and Issues*. The potential for each of these issues to

increase Medi-Cal costs is as follows:

- ***The AIDS Epidemic.*** The department estimates that in 1984-85 the total costs of care for Medi-Cal AIDS patients totaled \$55 million. We estimate that these costs could increase by as much as four-fold by 1990-91. The DHS is currently updating its estimate of the effect of the AIDS epidemic on Medi-Cal costs. The new estimates should be available by the time the Department of Finance submits the May revision of the budget to the Legislature.
- ***The Immigration Reform and Control Act (IRCA) of 1986.*** The IRCA established a program by which undocumented aliens meeting specific requirements may become temporary and then permanent legal residents. The act also allows some Medicaid coverage for those persons with legal resident status. While the extent of the increase in the Medi-Cal eligible population as a result of this act is unknown at this time, it could be substantial. The department advises that the data required to estimate the effect of the IRCA on Medi-Cal costs

will be available at the time of the May revision.

- ***The Aging of the State's Population.*** The state's population over the age of 65 is growing at a much higher rate than is the population as a whole. Because this is the age group that is most apt to need two of the most costly Medi-Cal benefits--long-term care and inpatient hospital care--the aging of the state's population could increase Medi-Cal costs substantially in the future. The effect of the aging of the population would be more gradual than the effect of the AIDS epidemic and the IRCA, which could result in significant cost increases over the next five years.

These issues have two things in common: they could all increase Medi-Cal costs significantly beyond the rates of increase that have occurred in recent years; and the timing, and even the magnitude, of their effects on the Medi-Cal program are unknown. Given this amount of uncertainty, we cannot advise the Legislature to undertake a major restructuring of the Medi-Cal program *solely* on the basis of these potential costs. ♦

Chapter III

Major Options for Reducing Medi-Cal Costs

To the extent that the state's overall fiscal condition or the Legislature's priorities in other program areas require a reduction in the costs of the Medi-Cal program of a magnitude comparable to what the budget proposes, major changes in the program would probably be necessary. In designing such a reform, the

Legislature would need answers to two questions: (1) what are the options available under federal law to reduce benefits or eliminate eligibility categories? and (2) what savings options does the Legislature have that do not involve reducing benefits or eliminating eligibility categories?

Optional Eligibility Categories

The state provides Medi-Cal benefits to several groups of individuals that the federal government does not require the state to cover. Table 2 displays the various

"optional categories," the numbers of individuals currently covered in each category, and the costs of benefits provided to these individuals.

Table 2
Medi-Cal Program
Optional Eligibility Categories Under Federal Law
1986-87
(dollars in millions)

| Category | Average Monthly Eligibles | Cost | |
|--|---------------------------|------------------|----------------|
| | | All Funds | General Fund |
| AFDC and SSI/SSP "refused-grant" cases | 108,900 | \$296.3 | \$148.2 |
| Medically needy | 148,000 | 290.1 | 145.1 |
| Long-term care | 66,800 | 949.3 | 474.7 |
| Medically indigent children (between 5 and 21 years of age) | 83,400 | 158.5 | 79.3 |
| Medically indigent adults | 3,400 | 25.5 | 12.8 |
| Totals | 410,500 | \$1,719.7 | \$859.9 |

As the table shows, about 25 percent of the individuals who receive Medi-Cal benefits under "optional" categories are individuals who qualify for assistance under one of the two major welfare programs but for various reasons refuse to accept the cash grants. If coverage for these cases were eliminated, it is likely that some of the recipients would accept the cash assistance to which they are already entitled as a way of continuing to receive Medi-Cal benefits. It is therefore possible that any Medi-Cal savings which resulted from the elimination of this category would be partially or fully offset by (1) increases in the numbers of categorically eligible beneficiaries and (2) increased welfare payments to persons who currently refuse welfare.

The largest "optional" category is the medically needy. These are individuals who would qualify for AFDC or SSI/SSP, except that their income is too high. These individuals are required to spend their income down to 133 1/3 percent of the AFDC grant level before the Medi-Cal program covers the remainder of their medical costs. Federal law allows states the option of either not covering these individuals at all or setting the maintenance need level--the level to which they must spend down their own income--as low as 100 percent of the AFDC grant level.

The "optional" category for which the

Optional Benefits

In addition to optional eligibility categories, the state provides a variety of *benefits* under the Medi-Cal program that are not required under federal law. Table 3 displays the various optional benefits and the department's estimate of the 1986-87 expenditures for each benefit.

It is important to note that the long-term savings which would result from eliminating some of the benefits displayed in

state spends the most money is long-term care cases. These are individuals who reside in long-term care facilities (nursing homes) and who have incomes of more than \$35 per month, but less than the full cost of their care (the average cost of care for these individuals is \$1,200 per month; thus, the individuals in this group may have incomes up to \$1,200 per month and still have some of their care paid through the Medi-Cal program). Federal law allows states to cover all of these individuals, none of them, or the portion of the group whose income is less than 300 percent of the SSI grant level (currently, 300 percent of the SSI grant level is equal to \$1,020 per month). All but about 4,000 of these individuals have income of less than 300 percent of the SSI grant level.

The final optional eligibility category is the medically indigent. These are individuals whose families or personal situations make them ineligible for AFDC or SSI/SSP (that is, they live in intact families in which one parent works and they are neither aged, blind, nor disabled) but whose income and resources are less than the maximum allowed for AFDC eligibility. Federal law requires states to cover medically indigent children five years of age or younger, as well as medically indigent pregnant women. As Table 2 indicates, coverage of children over the age of five and certain medically indigent adults is optional under federal law.

Table 3 would not fully offset the costs displayed in the table. This is because (1) beneficiaries and providers could substitute mandatory benefits for some of the optional benefits--for example, some intermediate care facility residents could be moved to skilled nursing facilities if intermediate care were eliminated as a Medi-Cal benefit--and (2) depriving beneficiaries of certain optional benefits could lead to

Table 3
Medi-Cal Program
Cost of Optional Services
1986-87
(dollars in millions)

| <i>Services</i> | <i>All Funds</i> | <i>General Fund</i> |
|--|------------------|---------------------|
| Outpatient drugs | \$357.9 | \$176.3 |
| Adult dental | 62.0 | 31.3 |
| Intermediate care facilities | 360.3 | 180.7 |
| Medical transportation | 37.2 | 18.6 |
| Miscellaneous services ^a | 74.2 | 19.0 |
| Other medical | | |
| Psychology | 12.0 | 6.1 |
| Chiropractic | 0.6 | 0.3 |
| Adult optometry, optician ^b | 32.3 | 16.2 |
| Podiatry | 4.4 | 2.2 |
| Prosthetic | 2.3 | 1.2 |
| Orthotic | 3.2 | 1.6 |
| Outpatient clinic | 21.7 | 10.9 |
| Surgicenter | 3.0 | 1.5 |
| Heroin detoxification center | 1.6 | 0.8 |
| Independent rehabilitation center | 0.3 | 0.1 |
| Nurse anesthetist | 0.5 | 0.2 |
| Occupational therapy | 0.1 | -- |
| Adult speech therapy, audiology ^b | 5.4 | 2.7 |
| Physical therapy | 0.2 | 0.1 |
| Hemodialysis | 19.2 | 9.6 |
| Acupuncture | 2.6 | 1.3 |
| Other services | | |
| Durable medical equipment | 17.4 | 8.7 |
| Adult hearing aids ^b | 5.2 | 2.6 |
| Blood bank | 0.7 | 0.4 |
| Totals | \$1,024.3 | \$492.5 |

^a Includes expenditures for home- and community-based services provided through the Department of Developmental Services, the Multi-Purpose Senior Services project, adult day health care, in-home medical care, senior health services, primary care case management, the senior action network, and the Los Angeles County health plan.

^b The amounts shown in the table include optional spending for adults and required spending for children.

higher costs in the long run—for example, the elimination of drugs as a covered benefit could, in some cases, result in the need to hospitalize patients whose conditions worsened as a result of the loss

of their medication. In addition, deleting intermediate care facility services as a benefit would result in major revenue reductions at state developmental centers and hospitals.

Cost-Savings Options That Do Not Involve Reducing Benefits or Eliminating Eligibility Categories

Short of eliminating benefits or restricting eligibility, there are four major options for reducing Medi-Cal costs: (1) cost avoidance and recovery enhancements, (2) changes in purchasing practices, (3) improvements in utilization review, and (4) development of alternatives to institutional long-term care. We discuss each of these options below.

Cost Avoidance and Recovery Enhancements. The budget proposes two initiatives to avoid costs and increase recoveries in the Medi-Cal program. One of these proposals would improve the department's efforts to identify Medi-Cal patients who are also covered by private insurance. The other would improve the recovery of funds owed to the Medi-Cal program by the estates of deceased beneficiaries. According to the department's estimates, these proposals would reduce costs by \$3.5 million (\$1.7 million General Fund) in 1987-88 and by \$13.2 million (\$6.6 million General Fund) annually thereafter.

Changes in Purchasing Practices. The budget proposes to implement negotiated purchasing of certain durable medical equipment (hospital beds, for example) and to enhance the department's ability to limit the prices Medi-Cal pays for drugs. According to the department's estimates, these changes would reduce Medi-Cal costs by \$452,000 (\$225,000 General Fund) in 1987-88 and by \$3.4 million (\$1.7 million General Fund) in future years. While the savings associated with these

proposals is relatively small compared to the total amount of Medi-Cal savings called for in the budget, our analysis indicates that it would be possible to achieve substantial savings through the use of volume purchasing of other items. For example, a 10 percent reduction in the purchase price of drugs, durable medical equipment, medical transportation, and laboratory services, which are all items that *could* be purchased on a negotiated basis, would result in annual savings of \$62 million (\$31 million General Fund).

Improvements in Utilization Review. The budget proposes several initiatives to improve the techniques the department uses to review Medi-Cal utilization, both before a particular service is provided (many Medi-Cal benefits are subject to prior authorization by the department) and after the fact. According to the department's estimates, these proposals would reduce Medi-Cal costs by \$53.7 million (\$26.9 million General Fund) in 1987-88 and by \$58.7 million (\$29.3 million General Fund) in future years. Our review of the documents submitted in support of the budget indicates that the department has identified a variety of additional options for improving utilization review that are not included in the budget. Moreover, the draft request for proposals, issued by the department as part of its fiscal intermediary contract procurement project, indicates that there may be significant opportunities to

improve the department's utilization review techniques and thereby achieve substantial Medi-Cal savings in the long run.

Development of Alternatives to Institutional Long-Term Care. Approximately 20 percent of Medi-Cal costs are for long-term care. As noted in our discussion of options for funding long-term care (please see *The 1987-88 Budget: Perspectives and Issues*), the disproportionate increase in the state's aged population makes it likely that unless less expensive alternatives are developed, long-term care costs could grow dramatically. It may not, therefore, be realistic to think in terms of reducing Medi-Cal's long-term care costs. Any major reform of the Medi-Cal program, however, probably should include some

mechanism for containing the growth of these costs.

The budget includes funds for several ongoing projects that provide alternatives to long-term institutional care. For example, the department operates a "gatekeeper" program in which Medi-Cal field office staff divert individuals from institutional placements whenever community-based alternatives are feasible. The department also jointly administers several community-based care programs in conjunction with the Departments of Aging and Developmental Services. In our discussion of funding options for long-term care, we note that there are several strategies the Legislature could employ to contain the costs of long-term care. ♦