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The San Diego County Medical Services Program

Ron Threatt, MPH, MA*

Then: In the early 1980s we attempted to find solutions to the problem of lack of access for the Medicaid population in California's Monterey County. There had been an erosion of the number of providers who were providing care to this population. For the 27,000 Medicaid recipients, there were only four obstetricians and gynecologists providing care and only one of these was available to provide care to new patients. Although the average turnover rate in the Medicaid population was about 40% to 50% at that time, Monterey County had nearly a 100% recidivism rate. Because the area is basically an agricultural region, there was a large population of people entering and leaving the program due to employment spikes. As we attempted to resolve this problem of access, we faced at that time an increasing inflation rate in health care and resistance by local providers to provide care to this population.

Now: That was ten years ago. Unfortunately, not much has changed in California or nationally. As we look at the Medicaid program today, we are still faced with the same types of problems, although they may be a bit worse now than they were a decade ago. Recent statistics indicate that from 33 million to 37 million people have no access to medical insurance in this country. Most experts agree that we need to develop an efficient and cost-effective health care delivery system in order to solve this chronic problem.

Basic System Constructs

San Diego County's managed care program, which was started in 1983, includes elements that, I feel, are basic to the success of any indigent care or urban medical delivery process. First, given the demand for care and the level of medical resources needed by an indigent population, the managed care system is the only accessible vehicle for the provision of care. Moreover, the managed care process cannot be simply an overlay for an existing process that was specifically designed to provide care to an employed and incentive population. What is appropriate for a family of four with an income of \$40,000 may not work for a single parent with three children, limited or no income, and multiple medical and social problems.

Second, the program needs to have linkages that manage and connect the different components of a delivery system into a sin-

gle continuous process. The crucial continuity factor is missing in most Medicaid or uninsured programs.

Third, all the participants (payers and providers) in the program must have a common interest or incentive to join.

Finally, and most importantly, a prototype delivery system must be able to differentiate between types of consumer conditions in order to manage their health care allocated resources effectively and appropriately.

San Diego County Medical Services Program

Why is the San Diego County Medical Services (CMS) program a viable model of health care delivery for an urban population? The CMS program has been designed to serve a specific population of people who are classified as medically needy, i.e., they are not categorically linked to any of the four classifications of Medicaid. Michigan's Wayne County has a similar type of program, which is known as CountyCare.

Prior to 1982, the San Diego population had been the responsibility of California's Medicaid program, MediCal. The Medical Reform Act of 1982 essentially has allowed the state to mandate the responsibility of health care for this population to the counties. Thus, to receive health and medical care under the CMS program in San Diego, individuals must be 21 to 64 years old, legal residents of the county, have no MediCal linkage, meet the financial requirements for the program, and have either a chronic or symptomatic condition at the time of presentation to the system.

Since San Diego did not have a county hospital, in 1983 the County of San Diego decided that the most appropriate way to provide care to this population would be through a managed care process. Consequently, the County developed and let a full-risk contract for the care of this population to four organizations which had the responsibility for certain geographical areas of the county. In addition, the County decided to let a contract for

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an administrative contractor to oversee the program. Medicus Systems has been the administrative contractor since that time.

The principal functions of the administrative contractor have been to institute a quality assurance program throughout the county, to be responsible for retrieval, analysis, and reporting of utilization and financial information for the program, and to establish the county program policies and procedures.

Patient Characteristics

During the first five years of running the program, we learned that management of this patient population in a manner similar to the normal health maintenance organization population was not possible. The client profiles were atypical of other populations. In 1982, when the medically indigent adults were about to be transferred to the County, this population was described as being recently or temporarily unemployed. We found that this was not the case. In general, this patient population included either the long-term unemployed or the casual labor person rather than the full-time, regularly employed person. The population was bimodal, consisting of young men, aged 21 to 39 years, and older women, aged 40 to 64 years.

The younger men usually fall into one of two categories. The first group includes those who are regularly or permanently homeless, with chronic mental or physical problems. They also tend to be substance and/or chemical abusers. The second group includes those who are unemployed or underemployed and have been involved in trauma, particularly motor vehicle accidents. The older women are usually unemployed and may be widowed, divorced, or have spouses who are on disability or have Medicare coverage. These women typically have chronic cardiovascular, respiratory, and metabolic diseases.

Many of the CMS patients do not fit into any of these categories. There are individuals who find themselves temporarily jobless and without health insurance, have illnesses not covered by their health insurance, have exhausted all their health insurance benefits through their employers, and chose not to obtain health insurance.

In 1986 the Employee Benefit Research Institute (1) conducted a population survey aimed at characterizing those populations which had problems accessing the health care system. The Institute divided the populations into two groups: the insured, and the uninsured. The highest risk insured populations were the low-income groups whose medical services were covered by Medicaid and Medicare. The uninsured group consisted of three populations: 1) those employed in low-income jobs and their dependents, 2) the self-employed, and 3) the chronic or transient nonworkers. The two access issues illustrated by the Institute's survey for each subgrouping were similar to the issues and problems faced in planning and designing a delivery system to manage.

Social Case Management

The analysis of patterns of utilization allowed the program case managers to isolate service demands by more discrete subgroupings. The analysis showed that individuals with certain socioeconomic characteristics tended to utilize a distinct set of

services in a certain manner which required a discrete level of services and resources. As a result, the San Diego CMS program developed a classification system to determine the extent to which case management resources could be committed.

We identified four groupings by which we managed the indigent medical delivery process. The first group included those who had access to a private source of care outside the publicly funded program. These were persons who paid out-of-pocket expenses for care, i.e., students with some form of health insurance or working individuals with employee health insurance. These individuals were generally healthy people who accessed the system sporadically for episodic treatment or relatively minor accidents or illnesses. In most instances, these people generally accessed the publicly funded programs only when they required extensive services such as hospitalization, outpatient surgery, or high-technology diagnostic studies. Many of these individuals also received care inappropriately through hospital emergency departments. It was not feasible to case manage these individuals because either their care-seeking behaviors were unlikely to change or the extent and/or scope of their illnesses would not warrant the management process.

The second group represents the first category of patients for whom it was appropriate to institute aggressive coordination and follow-up. This group included patients who were suffering from social problems severe enough to impede or thwart typical delivery of health care services. These patients had multiple sporadic encounters with the system, often for very serious injuries or illnesses, many of which could have been prevented or treated at an earlier stage. This group included the homeless, the chronically mentally ill, and substance and chemical abusers. For these patients, the key to case management was early recognition of their needs and the ability to track them throughout the system from the beginning.

The third group included those who entered the system as the result of a catastrophic event such as trauma or a life-threatening illness. The 1988 CMS trauma case study (unpublished data, Medicus Systems Corp) indicated that 25% of all admissions were a result of trauma and that approximately 5% of all admissions originated from the county's trauma system. These problems required full case management, and almost 100% of these patients needed such case management resources.

The fourth group included patients who had chronic illnesses which may be characterized by acute flare-ups followed by periods of remission. This was a group of patients for whom primary case management was the most effective and desirable approach because it not only controlled costs but also offered the best chance of optimal health care outcomes. The key for successful case management of this group, which to some extent was appropriate for all of these groups, was early identification and intervention of patients who had benefited from primary case intervention, as well as continual problem-solving and evaluation.

Since 1984, utilization of the CMS program has progressively increased, with the exception of 1988. Because this is not a capitated system but rather a fee-for-service reimbursement system, we count utilization in terms of users. In 1988, 20,000 people in the program accessed the system at least once. Our monthly case volume averages about 4,400 people who account

for 66,000 outpatient encounters, 7,263 emergency room treatment/release episodes, and about 4,615 hospital admissions. Between 1984 and 1989, the average length of inpatient stay has remained fairly stable at around six days, which is significantly below the state average of 8.51 days for this population. For outpatient visits, the leading diagnoses for primary and specialty care encounters have been hypertension, diabetes, orthopedic care, and respiratory and abdominal pain. The leading treatment has been follow-up for orthopedic care, surgery, diabetes, and diabetes complications.

There were several operational and organizational deficits associated with regional and decentralized management processes. The most serious problem was access. Because the regional contractors were at risk for all services, there may have been some inadvertent efforts to limit access in order to maintain profitability. Utilization increased 41% in five years. However, appropriations increased incrementally. Arguably, in order to maintain profitability, access must be denied.

Another problem was the cost-shifting to hospitals. Since entry to the system was either through a clinic or an emergency room, many patients who entered the emergency room were not appropriately followed up on their eligibility determination. Of course, being at full risk for payment of services, the regional contractors did not provide much assistance to the hospitals in qualifying these individuals. The end result was ill will and bad debts for both hospitals and attending providers. There was also a lack of control over provider payments. The four regional contractors had the option of contracting for different rates or, in some cases, the same providers. This lack of uniformity caused confusion among providers as well as disenchantment with the payment process because each contractor had different policies on reimbursement for services. Although other issues were involved, the final key deficit of the program was the lack of uniform management of the delivery process. Each regional contractor regulated the health care process to its indigent population in a manner that suited its management style. Consequently, the regional contractor CMS program was similar to the national Medicaid program in that payment and policies were centralized, but the execution of policies and operational system parameters was at the discretion of the individual states.

To resolve these problems, we launched a two-year planning process in which there was a community discussion on most of the appropriate methodology for providing care to the indigent population. The result of this process was a restructured system which San Diego County believes will carry through the 1990s.

The major characteristics of the restructured program are as follows. First, the four regional contractors have been replaced by one administrative contractor in an effort to avoid duplication of services and resources. The principal role of the administrative contractor is to manage the treatment process, which includes treatment authorization for admissions and access to specialty services, development of discharge planning and utilization review, and responsibility for maintaining the provider network. The administrative contractor is also responsible for the

provider reimbursement system, dissemination of information to both the general public and potential patients, and reporting financial utilization data to the county and other interested parties.

Second, because of the problems associated with managed care to indigent populations, such as low reimbursement levels, differential levels of reimbursement among service providers, and disproportionate service demands, Medicus Systems developed a prospective reimbursement system in which resources are paid via three risk pools for hospitals. In effect, we have developed a single payer rate for the county. The first pool is basically primary care. This is the amount of money allocated to a network of primary care clinics throughout the county which coordinates care at that level. The second pool is for specialty and diagnostic services, funded with a finite amount of dollars, and utilization on a monthly or quarterly basis determines the value of reimbursement. For example, in a hospital pool, the hospital utilization is funded with a set amount of dollars for that month. All hospitals are reimbursed at the same rate and are paid proportionately for their share of utilization for that period. The result is an equitable hospital payment process with no hospital suffering disproportionately because of adverse utilization for any time period.

Management Objectives

The highlight of this program is the case management system which coordinates services for the patients from primary care through postdischarge care. There are two important elements of this system. The centralized patient management process allows us to create consistency among providers in coordinating the needs of the patients through all levels of care and to micro-manage individual patients who present with characteristics and problems of a defined group treatment process.

The administrative contractor's responsibilities, therefore, include prior authorization for all admissions and entry into specialist services, as well as discharge planning for difficult patients in the system. In addition, within discharge planning, we have social workers who take responsibility for coordinating and monitoring care in subacute facilities. A major activity includes the follow-up of and assistance to patients in qualifying for other payment sources such as Social Security income, Medicaid, and private insurance.

Given the demands of the 1990s in terms of expected increases in both health care costs and the problems of people who will not be able to afford adequate health insurance, as well as the rapidly increasing number of individuals who will continue to lack access to adequate health care, we feel it is incumbent upon all health care professionals to develop different types of strategies to insure that all Americans have access to care.

Reference

1. Assessing the access problems. Washington, DC: Employee Benefit Research Institute, 1986.