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Oversight Hearing on Patient Dumping of the Medically Indigent - Transcript

Special Committee on Medi-Cal Oversight

COMMITTEE MEMBERS
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ASSEMBLYMAN BURT MARGOLIN
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CHAIRMAN MARGOLIN: Since it's 10 after 10, we'll try to start right now. We have a large number of witnesses who want to testify and we want to try to get you all in in the allotted time.

I'd like to welcome you to the Medi-Cal Oversight Committee's hearing on the problem of patient dumping . We have with us here today Senator Herschel Rosenthal who is a member of the Senate Health Committee and very actively involved in this issue during the last session of the legislature. We also have with us on my right, Lucien Wulsin, who is the Chief Consultant of the Committee.

In today's hearing, we are going to examine the problem of patient dumping, the term commonly applied to the situation where a hospital emergency room denies its care to a critically injured patient because they are more concerned about who is going to pay the bill than the patient's medical emergency.

Patient dumping of indigents and others who lack proof of insurance has been on the increase in recent years. There has been a growing number of documented cases of lost lives, stillborn babies and permanent disfigurements. While the vast

majority of physicians in emergency rooms, and I want to emphasize this point again, the vast majority of physicians in emergency rooms are not guilty of this practice and hold to the highest ethical standards, those that don't represent a serious and growing health hazard.

Patient dumping not only offends and shocks society's sensibility but it also violates existing law. Unfortunately, under existing state law we have no effective means of enforcement. We can only impose one of two penalties. A meaningless paper citation on the one hand or we can impose a massive and counter productive overaction which would be the shutting down of the emergency room which would thereby deny emergency care to the entire community.

Last year I authored AB 3403, a bill that I believe would have addressed the enforcement issue in a simple way. It would have created an intermediate, realistic and therefore, usable range of civil fines directed at the hospital or the emergency room doctor or the on-call physician who denied care. In unusual cases of willful acts that cause injury, criminal penalties could have been applied.

After months of talks and negotiations we resolved all of our differences with the hospitals and emergency room doctors so they

no longer opposed the bill. However, from day one of its introduction and through the end of session, the California Medical Association fought against this bill with the full resources at its disposal. Their principal criticism was that we weren't addressing the larger problem of uncompensated care and they specifically wanted the counties to be the "deep pockets" for privately provided emergency care. In the end, both my bill and a companion measure with the same intent authored by Senator Ken Maddy failed.

There will certainly be new efforts this coming session to address the issue of patient dumping. We scheduled this meeting during the interim to look at several issues that will be key to next year's debate. We specifically wanted to look at patient dumping in Southern California. Most of our testimony last year concerned Contra Costa County, Alameda County, Fresno County, northern and central valley counties. We need to fill the information gap we now have about Southern California.

We also want to look at the relationship between uncompensated care and patient dumping. Is it the principal motivating cause of patient dumping? Has uncompensated care been increasing in drastic fashion in the private sector? And if it has been, where do we get the dollars to pay for it, and most importantly, this is the key issue I think for today, how do we

get chief antagonists on the patient dumping issues, the counties and the California Medical Association to cooperate in the search for a solution?

Let me also welcome to our hearing today, Assemblywoman Theresa Hughes, in whose district we are this morning, and Terry Friedman, on the far left here, who is the member elect from the 43rd Assembly District, not yet sworn in but soon to be sworn as a member of the Assembly representing that district. I'd like to next turn, and we also have Assemblyman Bill Leonard who has just arrived. Good morning, I am glad you could make it. Assemblyman Leonard is a member of the Medi-Cal Oversight Committee. He represents the San Bernardino area of Southern California.

Let me turn now to any members of the committee who might have any comments they'd like to make at the offset. If not, then we'll go to our first witness. We're going to, in the interest of accommodating a scheduling problem that he has, slightly reverse the order on your schedule and go with Dr. Gayle Anderson, Chief of Emergency Medicine at U.S.C. Medical Center L.A. County to be our first witness. Dr. Anderson, could you please come forward? You can slip through here.

DR. GAIL ANDERSON: What I would like to do, if you don't mind is since I have thought about this a fair amount since my

initial approach by Mr. Wulsin. And so I have jotted down some thoughts - they are not very long so I'd like to read those and then throw it open to questions from you.

My name is Gail V. Anderson, M.D. I work for the county of Los Angeles as Director of the Department of Emergency Medicine at Los Angeles County/University of Southern California Medical Center. I have functioned in this capacity for the past 15 years.

In addition to "day to day", "moment-by-moment basis, I am responsible for the operations of the Medical Alert Center for the Department of Health Services of Los Angeles County. It is this "Medical Alert Center" that coordinates the transfer of patients from community emergency departments and hospital beds to the hospitals (LAC/USC Medical Center, Harbor UCLA, Martin Luther King, Olive View County Hospital, etc.) under the jurisdiction of the Department of Health Services. The acronym "MAC" thought the years has come to mean many things to many people. Some praise it highly, others feel it is the main impediment to "quick and easy" transfer of patients without insurance or other resources to pay for medical care.

While the Medical Alert Center also coordinates the medical response to disasters (Triage Team dispatch which is done through

UCLA, Harbor and our institutions), diving accidents, its principal function is the coordination of appropriate and safe transfer of patients from community (private) hospitals to those operated by the Department of Health Services. However, the problem of obstetrical overload (some 7,000 patients last year) and other special situations, may require the MAC's assistance in arranging for safe and appropriate transfer to hospitals outside the Department of Health Services' hospitals.

LAC/USC Medical Center is the designated catchment transfer DHS hospital for some seventy (70) community (private) hospitals. Harbor/UCLA and Olive View are the designated catchment DHS hospitals for some twenty (20) hospitals each, and Martin Luther King is the designated hospital for three (3). While the daily census at LAC/USC Medical Center exceeds 1,500 patients daily, the daily birth rate exceeds 50 and the combined emergency patients seen in the emergency sections which are the main Hospital, Women's Hospital, Psychiatric Hospital and Pediatric Facility, exceed 1,000 patients per day. All hospitals in the Department of Health Services operate at a "capacity level".

While the Department of Mental Health is said to operate as an independent branch of health care, the daily problems associated with transfer of mentally ill patients indicate considerable dependency on the Medical Alert Center and the Department of Health Services.

The patient transfer guidelines, procedures and surveillance of these transfers between hospital facilities (both private and public) are necessarily evolutionary in nature and design.

While a given impetus for definition of reasonable and acceptable standard for safe transfer of patients between hospitals may derive from being a receiver of transferred patients at the DHS hospitals, the actual definition of standards and their implementation are a required action by the Joint Commission of Hospitals, the Department of Health Services, as well as the California Legislature. In addition to these, on the local level, Los Angeles County has been fortunate to have had active and direct participation by the Hospital Council of Southern California, the Los Angeles County Medical Association, Emergency Medical Services Commission and the Emergency Care Advisory Committee.

The enclosed documents which I gave you details the procedures for a transfer of patients: what is considered appropriate; what is inappropriate; and what are unacceptable transfers. This list includes psychiatric, as well as medically ill and injured patients. In addition, the special situation of burns, special care transfer, obstetrical, and decompression emergency which is the diving accident. Transfer requirements are included as well.

Finally, the surveillance requirements and procedures are included in this packet. The Department of Health Services' Problem Transfer Reporting Procedure provides for written notification of the referring community hospital when a Problem Transfer Report has been filed by the receiving County Hospital. However, prior to this submission, all reports are reviewed by staff of the Emergency Department as a "second opinion" or monitoring aspect to rule out "emotional" or "judgment calls" that might not be agreed upon by a more senior and experienced professional staff.

Cases judged to be neglect and abuse are referred directly to Health Facilities for investigation.

In summary, the evolution of the above system has resulted in a marked reduction in the number of "inappropriate" and "neglect and abuse" transfer of patients to Department of Health Services hospitals during the past 10 years. At LAC/USC Medical Center, senior staff are on continuous call for the Medical Alert Center to review the problem of transfer reports and review the problem of transfer reports on a weekly basis. We urge direct telephone contact, as well as written contact with the referring hospital regarding a problem patient transfer. However, our objective has been more to "inform" and "educate" rather than to be punitive and threatening. During the past 10 years we have seen a

reduction of some 20 cases per week, to 3 to 4 per week with a significant reduction in the more flagrant, inappropriate and neglect and abuse cases in recommendations.

In the immediate past and for the present, State Legislation, and regulations of Department of Health Services and Joint Commission of Hospitals, as well as support from local organizations have been sufficient.

Change in both reimbursement as well as responsibilities for the health care of the indigent (and Medically Indigent Adults) may make more legal constraints necessary. However, additional laws and penalties will only encourage more suits, make more work for lawyers, tie up more court time and create unnecessary conflicts between physicians, nurses, and other health care professionals.

This is now strictly my own philosophic needle I guess, eliminate the term "dumping". Patients are not dirt or cement. They deserve a more appropriate term such as "inappropriate" transfer. Thank you very much for your indulgence and now I am open for questions.

CHAIRMAN MARGOLIN: Dr. Anderson, you've done in many respects done an excellent job with the program. You have

pioneered in reducing the number of inappropriate transfers, if you prefer that term to patient dumping, which is the term more commonly used to refer to this practice. And, again, it is not meant to reflect negatively on the patient, but to reflect on the practice itself which is so disgraceful and insidious, and unacceptable. Tell me about what reduced the number of dangerous transfers through these protocols, protocols, which by the way are largely incorporated in AB 3403, a bill which we tried to move through the legislature. Protocols which would for the first time if we applied them statewide, require that the hospital doing the transferring communicate with the hospital that is going to be the recipient and work out an orderly transition.

While you've made major strides in reducing the number of transfers, you still do have here in L.A. County dangerous transfers, transfers made of unstabilized patients. And could you tell us a bit about the kinds of circumstances that to this very day still create those kinds of transfers and the kinds of cases you still have to deal with.

DR. GAIL ANDERSON: Yes. As I tried to imply, and your statement is certainly correct, these evolved out of legislative action as well as Hospital Council action and Health Services. So they are really are no creation of one individual. Now, your

point about problems continue to exist. Yes, they do and since I am this week and every third week the continuously "on-call" person for the Medical Alert Center, I can assure you that this week I will be involved in some discussion about inappropriate transfers of patients into our hospitals. But, these strong concerns and feelings that I had some fifteen years ago when I took over Emergency Medicine have been assuaged considerably because of what I view as an attempt and concern of community hospitals to not be caught in a situation of inappropriate transfers. But, I would have to be honest with you to say that this week I am sure there will be a situation arise in which an indigent person is at a local hospital and they would like to transfer the patient.

CHAIRMAN MARGOLIN: An indigent person would be in unstabilized condition suffering from a potentially life-threatening or disfiguring injury and would be transferred to the county hospital without treatment.

DR. GAIL ANDERSON: The sending hospital is not likely to do that today because they are aware of the fact that I will be on the phone or someone who represents me, and they would have to get approval to transfer the patient and in the event that they would transfer that patient without approval they will be cited and written up, as you will see in the documents. And we are required by mandation to do that. We have no choice.

CHAIRMAN MARGOLIN: I understand that. But I guess the point I am making, Doctor, is that the data that we received from your office and the information we have gathered indicates to us clearly that while you have reduced the scope of the problem here in L.A. county because you have a program that far exceeds in its thoroughness and professionalism, the programs that other counties have in this area, the protocols for transfers.

DR. GAIL ANDERSON: I didn't make that claim. You know that I don't.

CHAIRMAN BURT MARGOLIN: I'll make that claim on your behalf. It is an excellent program. But while it exceeds what other counties are doing in most respects you still do have these dangerous transfers occurring. And I'd like to get these, since you are in the front line, in this battle to stop patient transfers, your explanation as to what goes on when a dangerous transfer occurs. What is going through the mind of that emergency doctor or that emergency room administrator which motivates them to send that patient to the county?

DR. GAIL ANDERSON: It is strictly money as you said earlier.

CHAIRMAN BURT MARGOLIN: Strictly money.

DR. GAIL ANDERSON: It is non-paying patients and hospitals can't, you know, go broke. There are low occupancy rates now in Los Angeles County and it is a business operation for them.

CHAIRMAN BURT MARGOLIN: Although under the terms of state licensure, the emergency rooms are obligated if they want to be licensed emergency rooms, to provide care to anyone who comes in those doors with an injury and certainly to deal with the life-threatening kinds of injuries that this legislation is most concerned about.

DR. GAIL ANDERSON: Well, unfortunately right at this moment I don't have a "horrendo" to tell you a story about but I do from time to time see some. But, as I say, the incidence is so different than it was 10 years ago that I am less inclined to get up on a soap box and preach about it. I am not trying to play down anything. I think we are facing some big problems in terms of financing health care in this country and that's one reason why the Rand Corporation right now is setting health policy development on a national basis because I am deeply concerned about the future and I don't think that's too far down the road because there is a large number of patients not able to pay for their care. And I think we are just beginning to see the tip of the iceberg myself. And I think that it is money for health care.

CHAIRMAN MARGOLIN: And the money trend as you suggest is money in a negative direction. There is less and less money available for a range of reasons from public agencies.

DR. GAIL ANDERSON: Unless you got a rocket that you can send up in the air.

CHAIRMAN MARGOLIN: It is just not available for public health purposes.

DR. GAIL ANDERSON: It is dead. I can live with the seasons. It is hard for me to accept the idea that we can spend so much money on defense and not take care of poor people.

CHAIRMAN MARGOLIN: Right, and I agree with that. But if I can the audience not to express your political....

DR. GAIL ANDERSON: I am not running for a political office.

CHAIRMAN MARGOLIN. Right. We appreciate that. But you never know.

DR. GAIL ANDERSON: You are very cautious of this...

CHAIRMAN MARGOLIN: Dr. Anderson, since money is drying up right now there is less and less money being made available at the federal level, fewer and fewer dollars coming from the state for the provision of health care for the poor people, aren't you worried that this money motivation you have already described is the principal motivation behind certain emergency rooms right now using very poor judgment here in L.A. County, aren't you worried that that motivation will grow stronger and that the steps that are working for you today won't be working for you six months from now or a year from now.

DR. GAIL ANDERSON: I think the urgency to transfer patients that can't pay is certainly going to get more urgent and not less urgent, but I must say that being philosophically an optimist and also a believer in human beings, I don't sense a lot of fear that we are suddenly going to see a big increase in this. I think that the intent is to avoid this. I really don't know what legislation with a $25,000 penalty, or whatever would do. I am a bit skeptical about the implementation of laws because I have been around a long time in terms of trying to help legislation for physician assistance through Senator Whitworth and Assemblyman Duffy of years back. But, legislation does not mean implementation.

CHAIRMAN MARGOLIN: That's true.

DR. GAIL ANDERSON: That's what I'm concerned about. Hopefully, we would not create an atmosphere that would result in more problems because of hostility that develops there is more likely to be a patient dropping through the slot so to speak and that's my concern.

CHAIRMAN MARGOLIN: Yes. I wouldn't be worried about the hostility because in the end what we are dealing with here doctor, are again fairly small number of people.

DR. GAIL ANDERSON: You're right. It is a very small number.

CHAIRMAN MARGOLIN: But still, if you are the patient, you are the indigent, who is being turned away from that emergency room door. As you well know, it doesn't matter whether you are a part of a group of 5 or a group of 500, you don't want to see that practice go on. And, the situation that we have right now is that there is no effective penalty at all and if an emergency doctor exercises the incredibly poor judgment involved in turning away someone with a severed artery or some other life threatening condition because they don't have proof of insurance and they don't want to run the risk of having to give the care for free, then I think having the prospect out there of a modest civil penalty is the minimum the state should be doing. Doctor, let me turn now to members of the committee who might have questions if there are any. Senator Rosenthal.

SENATOR HERSCHEL ROSENTHAL: I also am convinced that probably you do a better job in L.A. County than is being done in other parts of the state. Do you think that there is any responsibility for the legislature to try to do something to at least get the same kind of treatment in other counties and how do we do that?

In other words, shouldn't there be some sort of a state standard and then possibly something more than just a slap on the wrist for those who violate what you would consider to be the basic attempt to solve the problem?

DR. GAIL ANDERSON: Yeah. I guess I would have to agree with you that you look at the picture or problem from a state point of view, statewide and you probably are more likely to get a generalized compliance with some type of legislation. I think that's true and every county is different like every big city is different. I don't think New York or Chicago for that matter have a similar system as we have in Los Angeles County.

Again, I am not trying to play up our own program but it has grown up because I sort of grew up with emergency medicine. And I grew up with a lot of those doctors that are out there. And many of them trained in my institution. And so I think that that is different. That makes it different. It makes the compliance

different. It makes a whole different picture. And I would have to agree with you that it may be necessary to get that kind of compliance to have some legislation.

SENATOR HERSCHEL ROSENTHAL: I think that the Committee and certainly the Assemblyman would appreciate your thoughts on what should at least be a minimum basis for compliance so that maybe.

DR. GAIL ANDERSON: A minimum in terms of something like a Kennedy bill.

SENATOR HERSCHEL ROSENTHAL: Well, I really.

DR. GAIL ANDERSON: You are really searching, like I am, for what it would take to achieve the problem of protecting the patient. And unfortunately, I guess legislation is probably more effective on a wider basis. Local situations do not prevail everywhere.

SENATOR HERSCHEL ROSENTHAL. See, I really believe that people will follow the law. I not even sure that the penalty is....

DR. GAIL ANDERSON: At least you and I will. I am not sure about some of the others.

SENATOR HERSCHEL ROSENTHAL: But it seems to me that at least we need some minimum, some bottom line approach with certain kind of penalties and I am convinced that if one or two penalties were applied, we probably would begin to see the ending of the practice.

DR. GAIL ANDERSON: I think that's true. Certainly the examples that were given and I would have to say that those kinds of things have happened and to prevent that sort of thing. I think that legislation would do that.

SENATOR HERSCHEL ROSENTHAL: I have no further comments.

ASSEMBLYMAN BILL LEONARD: I have a question. I am one of those who opposes the penalty concept along the lines of what you have been discussing. I am not sure that it gets the action that we want. Let me ask the other side of the economics. Say there is a patient who is not suitable for transfer but not at L.A. County hospital, but the facts of their situation as mentioned are that they would otherwise be coming to the county program. What is your practice in compensating the private or the non county hospitals for that patient?.

DR. GAIL ANDERSON: I can't really speak with great authority in that area of financing but it is supposed to be in fact

occurring that the hospitals that have to keep the patient are, in fact, reimbursed. They are not reimbursed the full amount I don't think and they have delay in paying the bills as I understand it from other doctors that I know in the communities. So, yes for example, the obstetrical patients, those 7,000 patients, who were delivered in private hospitals last year, they were paid for those deliveries. And if they have to keep a patient an extra day, they are paid for that. So, there are ways in which hospitals can be reimbursed. I think the amount and the payment procedures probably need to be cleaned up.

ASSEMBLYMAN BILL LEONARD: You don't have suggestions on that side. I'd like to hear them if you do.

DR. GAIL ANDERSON: You mean in terms of administrative and management programs. Well, I don't have this moment. That could be corrected with the proper people in the right positions.

ASSEMBLYMAN BILL LEONARD: You pointed out accurately that the problem is one of economics assuming that the first receiving hospital has the physical ability to deliver the service or whatever the degree of medical need is. And at that point we should concentrate on the economics portion of it, whether it is an administrative problem of delivering the reimbursement properly or whether it is that or a combination of the fact that

the reimbursement falls way too short of comparable reimbursements for other Medi-Cal or private pay contracts.

DR. GAIL ANDERSON: Well, I believe that money would fix it, frankly. Because without money and reimbursement for those successful deliveries, that would not have occurred. Now, those hospitals don't even want to give up those deliveries because its a significant fiscal factor in their staying even with the board. And, I think that the same thing would happen, at least I believe it would happen, if you would adequately reimburse those hospitals for caring for the patients we are talking about. Again, I may be too optimistic.

ASSEMBLYMAN BILL LEONARD: But there would not be a problem.

DR. GAIL ANDERSON: I think if money was there I don't believe that there would be a problem. I may be wrong but then again, maybe I'm too cynical or maybe I am more trustful.

CHAIRMAN MARGOLIN: Just one follow-up comment on your point Mr. Leonard. While money would, I think go a long way towards dealing with the situation with which we have evidence from the testimony on AB 3403 last year, that the amount of money it would take to totally fund emergency care throughout the state would be upwards of $200 million dollars, conceivably, a sum of money that

neither this Governor nor would it be likely any other Governor under this current physical circumstances would be able to appropriate. So, while we all struggle with ways of bringing up new dollars in trying to find new sources of revenue for the health care system, we have an existing problem with an existing law that says that if you're injured and you come to an emergency room, under the terms of that license you have to be cared for.

DR. GAIL ANDERSON: That is it.

CHAIRMAN MARGOLIN: So while we have to deal with the money issue I want to keep the attention of the committee focused on the fact that its a long-term problem that won't be easily solved. And, in the meantime, in my view, no one should be put in a position of going to an emergency room and being in a terribly serious condition and be turned away for lack of money in the meantime. Any other questions. If not, Dr. Anderson, thank you very much for being here with us. We understand you're under time constraints, and we appreciate your cooperation.

CHAIRMAN MARGOLIN: Our next witness is Dr. Max Lebow, the Director of Clinical Services in San Bernardino County Medical Center.

DR. MAX LEBOW: My name is Dr. Max Lebow. I am Clinical Director of Emergency Services in San Bernardino County Medical Center. I have been asked to come before the committee and to discuss some of the experiences of San Bernardino County Medical Center with the inappropriate patient transfers, sometimes referred to as dumping.

Our intense involvement in this issue began about a year and a half ago and it was a series of events and I'd like to discuss one of them with you as a way of an example and to give you an idea of how unstable patients sometimes have this patient dumping occur.

About a year and a-half-ago I reported to duty in the Emergency Room on a Saturday morning and I got a call from one of the local hospitals across town that said that they had a 15 year old that had been stabbed in the chest three times. He didn't have any apparent means of support and they wanted to transfer the patient to the county hospital. This is, by the way, this hospital has a full operating facility and would have otherwise been able to treat this patient with no difficulty. Well, this represented to me a grossly unstable patient and as the E.R. doctors here today can tell you, this is far below the standard care. I refused the transfer and I told him that what this patient needed was to be operated on where he was at and I wouldn't be involved with the transfer.

Well, about an hour later I got a call back and said he had talked with his thoracic surgeon. The thoracic surgeon said this patient was stable enough to come to the county hospital and they were going to send him. I, again refused emphatically. I told him that no, that while I didn't have the patient in front of me, anyone who was stabbed in the chest 3 times, by my standards, is unstable. Well, I got a call, another call, an hour later. The patient still was just lying in the emergency room at this other hospital. He had not been treated yet and I was getting pretty nervous. So, I said well, look if you're not going to do anything for this kid send him over. When the patient got to our emergency room it was now about 10:30 in the morning. He was very pale with barely palpable blood pressure. Although he was still alert and talking to us he also had some signs that were very disturbing to any ER doctor. He had engorged neck veins, which would indicate that one of his stab wounds had entered his heart. We, I had the ward-clerk call the operating room and call the surgeons and we had the patient in the operating room within about 5 minutes. Unfortunately, I got a call back about 20 minutes afterwards from the surgeon. He told me that the patient was dead.

A similar situation happened about two weeks later and I was just totally disgusted with the whole situation. I was prepared to leave County Hospital. I was not willing to practice medicine

in an environment where the standard of care would allow this sort of thing to happen.

In my conversations with my hospital administrator, he indicated that he would be cooperative in an attempt to do something about this problem in our county and had asked me if I wouldn't stay and see if we both could do something. I thought if I could get the backing of the administration of my hospital, o.k. we'd give it a shot. What we did was, and you will find it in the packet in front of you, is a study of the transfers of San Bernardino County over a three month period: September, October, November of 1985. You find there, that there were over this three month period, there were 423 patient transfers. This is just an incredible number of patients for a hospital our size, 150-160 bed hospital. We were getting a transfer every five hours or so, day in day out, seven days a week and it was just quite a large amount of traffic coming to us. Now not all these transfers are inappropriate. We, at county hospital, recognize two kinds of transfers that are appropriate. Number one is if a county hospital represents a higher level of medical care then the hospital gets the patients in. In other words, San Bernardino County is a very large county, the largest in the country. We have several rural hospitals, especially up in the mountains and there are certain facilities that they don't have that we offer, and in addition, there's our burn care and our

neonatal ICU. These are considered appropriate transfers. In addition, we have a sanction by Title XXII and several other state regulations. We have our medically indigent adult program that we have prior contracts with hospital that if the patient comes in and is an MIA Patient we will accept the transfer. Unfortunately, of these 423 transfers, only 9% were cases were county hospital represented a higher level of care and only 11% were MIAs. So, about 20% were appropriate. 80% were inappropriate.

What I would like to discuss now, I sort of divide the transfer issue into two parts. The first part is those patients who are unstable, unstable patient transfers. This is the most onerous and the most disturbing part of this whole issue and the other is the economic issue. I'd like to speak first toward this stability issue. You also find in your packet a separate page listing during a three month study period a list of the unstable patients that we received in county hospital. As you can see, these patients represent stab wounds in the chest, of the abdomen, multiple trauma, cardiac arrhythmias, respiratory arrest and near drowning, gunshot wounds to every part of the body.

During our three month period we also had one person die en route. Now, I can't say for sure that this patient would be alive if he had stayed at the hospital he was at, but he

certainly would have had a better chance, I believe, if he would be in a hospital rather than he was actually in the air in a helicopter when this happened. I'd like to now say some of the steps that we have taken to try to combat this and and how we have approached the problem.

After this study came out, there was quite a big flap in the county. The Los Angeles Times did a story about it and every local paper from every community in San Bernardino County had an article on the study. So, it got quite a bit of press and it caused quite a stir in the emergency medical as well as the entire medical community in the county.

In addition, just to keep it topical, what we began to do was when an inappropriate transfer would come in, I would make a written report to the state hospital licensing board and they started paying some visits to some of the local hospital administrators and so pretty soon I had a lot of people in my county just as interested in this issue as I was. What we did was, I met with my hospital administrators, the emergency room staff medical director and what we did was we drew up a transfer protocol which you also will find in your packet. It is my contribution, this part of patient stability. What we felt that we needed to define what a stable patient was. What is stable in one person's eye may not be stable to another and there was quite

a bit of problems of how to define stability. You will find that on pg. 3 of the San Bernardino County Medical Center Hospital transfer policy and protocol.

What we did with this in its initial draft is we took it to the county medical society as well as the, we had the committee of all the emergency directors and we threw it out to them for their comments, questions, and additions. They initially , they were very, especially the E.R. directors, were very hostile toward any list of stability. They said we know what stable is and stable is stable. Well, my point as you can see by the list of unstable transfers that we got, they may know what stable is, but we were still receiving them. So, we got their input and this has now gone before the Boards of Supervisors of San Bernardino County, which is our governing board, and it has been approved. And although its not been endorsed by the other E.R. directors, they're living by it anyway because it's what we are using as our guidelines for accepting or denying stable transfers. We were getting, before we started this work, we were getting about an unstable transfer every 72 hours or so. We have decreased this to maybe 1 every 3 or 4 weeks, and we have made good progress that's taken a lot of work but we're happy. We still have a long way to go, but we seem to have made progress on this issue.

The, I'd like to just speak very briefly about the, some of the economic issues, just specifically since this is a Medi-Cal Oversight Committee about Medi-Cal transfers. I had the secretary type up some figures for the committee today. It is the memo to Mr. Wulsin that you find in your packet. Now, one of the arguments with the whole transfer issue is that money equals end of dumping and my reply to that would be look at this memo of November 18th to Lucien Wulsin. These are three pages of Medi-Cal transfers that occurred over a six-month period. These patients all had, state financed care, but they were transferred anyway. So, there is more to the issue than simply a dollar sign. That really is the end of my prepared statement this morning if there is any questions.

CHAIRMAN MARGOLIN: Dr. Lebow, to follow up on the last point you were making that there is more to the issue than simply a dollar sign, what in your judgment is that additional factor. What is going on in the minds of these medical professionals who make these inappropriate transfers?

DR. MAX LEBOW: O.k., now, there are several different players in the transfer ballgame here. There is first of all, hospital administrators. There are a few cases where I have been called by the E.R. doctor or the doctor who is on call, who at least tell me that they would be willing to treat this patient

but their hospital policies or their hospital administrators says that we do not accept these kinds of patients. So, they are barred from admitting this kind of patient.

Sometimes I get a call - I've known this patient, he's been a private patient of mine for 10 years, he's out of work, I can't treat him anymore. The hospital won't allow me to admit him. I am going to have to send him over to you. So, this is one the players, the hospital administrator's hospital policy.

The second player is the physician on call. I believe that if, and I understand that it is state mandated as well, if a hospital puts out a sign that says emergency medicine, we provide emergency care than they have the obligation to do this. Regardless of the ability to pay, they have the obligation to provide acute medical services. What happens is sometimes there will be, the hospital will have, a physician on call who won't take Medi-Cal for instance, a lot of these patients you see on your Medi-Cal list have orthopedic problems. We have a couple of orthopedic surgeons who take call at some of the local hospitals that don't take Medi-Cal yet they are still "on call" for the non Medi-Cal patients. My feeling is that and that if a hospital is going to have somebody on call, if the medical staff is going to provide somebody to be on call, then they have to be on call for everybody, or just don't take call.

And then, really, one of the things that I used to get real mad at the E.R. doc on the other end of the line and just yell and scream and carry on, like I do sometimes, and he is sometimes, usually caught in the middle. E.R. doctors don't have admitting privileges by and large, and they can't admit the patient even if they wanted to. So, they are the victims of the medical staff person who won't admit the patient or the hospital administrator who doesn't want to admit the patient.

CHAIRMAN MARGOLIN: And the theory behind that decision not to admit, in the case of Medi-Cal, you talk about an on-call physician who just doesn't want to settle for the low rate that Medi-Cal reimburses. So that is a money related issue, where they are making a decision that I think you indicated you don't think they should have the right to make, and, I think I would agree with that rather strongly, that they just won't come in and do the surgery or do the procedure.

DR. MAX LEBOW: Yes, these, by the way, I think I mentioned this, these are from Medi-Cal contracting hospitals. These hospitals have a contract with the State of California to provide the care to these patients yet you can see case after case after case where they are not doing it and they're coming over. I think if we are going to be the county hospital who is going to provide all the Medi-Cal care or a great deal of it, we could

really use more Medi-Cal funds ourselves. Of course, this is another issue.

CHAIRMAN MARGOLIN: You indicated earlier on that you have reduced the problems substantially through these protocols you have established, but you still have people coming in periodically who are transferred in a dangerous condition. What are the facts in those cases, typically, in your current state? Currently, when you have someone come to your county hospital in San Bernardino now that you have done some work to reduce the number of, the volume of cases coming to you...

DR. MAX LEBOW: I think it's the same. The circumstances are the same as before only they are occurring somewhat less, but a typical unstable patient is young, a member of a minority group, the victim of trauma and uninsured, often doesn't speak English. This is a very typical kind of patient dumped on our doorstep and you know, its the same sort of patient that we had before. We have managed to decrease it by educating the medical community and letting them know that if they do it we are going to report it to the state board. And the state licensing board out of their offices in Santa Ana, they have been coming out to San Bernardino County and you know, getting the people's attention.

CHAIRMAN MARGOLIN: Any questions from committee members?

ASSEMBLYMAN BILL LEONARD: I'd like to follow up on Mr. Margolin's question. Have they changed at all in their patient status? Are they more borderline stable, have they received some pre-treatment emergency room treatment at all, has that changed or is that the same?

DR. MAX LEBOW: The situation in general is improved. The patients are somewhat less sick, although exceptions naturally are going to occur and they're occurring less often. The fact remains they are still occurring, and it is still a health problem. I think, you know, that we have been very lucky in our county in that my hospital administrators have let me off enough work to spend so much time working on this issue, but I think there still a lot of county hospitals that have not come as far as we have or L.A. County has, and it is still a major problem in the state.

ASSEMBLYMAN BILL LEONARD: But if it's more of a borderline, if they are more stable, then I guess I am less worried about it then otherwise when the previous statistics would be, where you have some real serious unstable cases coming in. Sometimes I know there has got to be just a difference of opinion between two physicians and it is a judgment call and other times it is a clear case. This one is stable, this one isn't.

DR. MAX LEBOW: As you can see from that list, these were not judgment calls. These were clear. It doesn't take a medical education to know that someone who is stabbed in the belly or shot in the chest is not a stable patient.

ASSEMBLYMAN BILL LEONARD: That list is before all of your extra work.

DR. MAX LEBOW: This still occurs and we've done a lot of work to improve it so, you know, we are proud of some of our accomplishments in this area. I guess this is a little off the subject When I first met with Mr. Wulsin about eight months ago and went over 3403 with him, my main complaint with the bill was the fact that stability, the issue of stability was left undefined. Stable patients are basically people that are alive, and they are stable. Sort of stable patients are stable with sort of a double talk circular argument. And what we've done. Most doctors differ in opinion with me on this point I would say. I believe that you need a strict definition of stability, what is considered unstable as guidelines that we can use in our inter hospital transfers.

ASSEMBLYMAN BILL LEONARD: One last question. This Medi-Cal transfer really bothers me. These are Medi-Cal contracting hospitals, transferring Medi-Cal patients.

DR. MAX LEBOW: Yes.

ASSEMBLYMAN BILL LEONARD: Won't that in the long run affect their contract renegotiations with the state?

DR. MAX LEBOW: I hope so.

ASSEMBLYMAN BILL LEONARD: Are you making sure the state is aware. Are you reporting this to the Commission?

DR. MAX LEBOW: This is relatively recent that we've started to zero in on Medi-Cal. I can tell you that most of my time has been spent on the stability issue. Now that I feel that we've made some progress there, this is sort of the next area that we'll be working on. I hope that letting you guys know today will have some impact on it.

ASSEMBLYMAN BILL LEONARD: I would urge you to tell the Commission. This is obviously over and above what you contracted for as a county. These kinds of patient loads weren't calculated in the...

DR. MAX LEBOW: Absolutely not. Absolutely not.

ASSEMBLYMAN LEONARD Thank you.

ASSEMBLYMAN BURT MARGOLIN: Any other questions from the committee? If not, thank you very much for your testimony.

CHAIRMAN MARGOLIN: Our next witness is Neil Andrews, Ventura County Health Department. Mr. Andrews. Mr. Andrews, welcome to the committee.

NEIL ANDREWS: Yes. Good morning ladies and gentlemen. I am Neil Andrews, a consultant to the Ventura County Medical Center and am here to represent them today and to speak briefly on their behalf on the issues for the committee. I believe that I will speak a little more broadly than the committee has focused and I think that's appropriate. I will not present clinical data. That's going to be answered to them by others, I am sure.

Basically, the issue of patient dumping needs to also be addressed in terms of the concept of skimming and so I'd like to take just a moment to ask you to consider both sides of the economic transfer issue, which is basically what we are talking about, and that is skimming and dumping. And, these kinds of transfers occur in basically three ways. One, a patient can be put in an ambulance and sent from one hospital to another - a medical transfer. That can be done for two reasons. One, economic reasons. Two, medical reasons. Either because, for example, a facility does not have equipment or procedures

essential to the care of the patient or because the facility cannot provide the clinical personnel or professional personnel - physicians at 2:00 in the morning and so forth.

There is another way, however, in which you can effectively dump a patient. This is in an non-emergency setting - done by an elective patient and that method is selective admission. You can encourage your medical staff to place a patient in an alternative hospital. You can suggest, for example, that complicated cases are not appropriate for your facility. You might suggest alternatively that certain DRGs are not appropriate for your facility, certain diagnoses. The consequence of that is that effect is you dump a patient on an alternative facility. There is on the skimming side a matter of selective admission. You can suggest to your medical staff that certain diagnoses are appropriate to your facility, those that are less complicated, less expensive on a management basis. And with respect to the potential poor, HMOs and that sort of thing in HMO contracting with Medi-Cal, there can be such a thing as selective enrollment. That can be achieved through geographic definition of your service area or it can achieved literally through demographic selectivity. Those are the variety of methods that are available.

We have experienced at Ventura County Medical Center bad transfers. We know that. I can't give you the kind of clinical documentation that the gentlemen preceding gave you. I would like to share with you an article that appeared in the Star Free Press, which is the local newspaper which describes a case of that type or some cases of those type. Many of the times when we get clinical transfers and we get them from Medi-Cal contracting hospitals as well as non Medi-Cal Hospitals, the transfers are in fact because a physician is not available at 2:00 in the morning at the other hospital. It's, we never refuse such a transfer, but it is in our view inappropriate for a hospital that has contracted to deliver services to any purchaser, in this case Medi-Cal, it is incumbent upon that contractor then to provide those services for which it contracted, and we would certainly encourage you to look into that as a process of contract enforcement.

Another area that I want to draw your attention to and speak briefly about is the area of the elderly, in particular the frail elderly. We are not a provider, no county hospital is a large provider in a Medicare system, we are not a large provider in the Medicare system, we have about 15% of our census in Medicare, and yet we have a curious disproportionate share of the frail elderly in that census and have been growing ever since the development of the DRG System and the imposition of that. Now, where that

effects or relates to this particular committee, I believe, is in the area of the Medi-Medis because that is the people that are Medicare covered but also Medi-Cal covered for the supplemental side. In those cases, they often are in the frail elderly category. And, indeed, the frail elderly are more expensive to manage. They tend to have more complicated cases, they are sicker when they arrive and just generally more difficult, more expensive.

We have found that since 1983, when we began tracking the numbers, our market share of the frail elderly has increased radically. From 1983 to 84, the first year that we had the numbers, we had a increase of more than 50% in the frail elderly. That is those, I am defining frail elderly as those over the age of 75. We started tracking separately those of over the age of 85 in the year 1985 and we found that while the population over the age of 75 had stabilized for us in terms of market share, the population of over the age of 85 was twice as high in terms of market share as the population over 75. So, we are getting a concentration of these more elderly patients in our facility.

By the same token, looking at those over the age of 65 generally, we found that our market share was fairly stable, growing but growing slowly, only a total over a three year period of only 15%. So, what marketshare tells you is that other

hospitals are not receiving these patients and we are, in a far more disproportionate way than our census. So, those types of figures really do indicate that there is an underlying process of selectivity in the admission of these patients and that was the first data we were able to generate that would actually confirm that. That's all I really had to bring to your attention today and I thank you very much Mr. Chairman.

CHAIRMAN MARGOLIN: Mr. Andrews, has Ventura County attempted to implement any of the procedures that have been discussed in your testimony that are being used in L.A. County and in San Bernardino County to reduce the number of inappropriate transfers?

NEIL ANDREWS: I' m sorry, I ran into a traffic problem so I didn't hear most of the earlier testimony.

CHAIRMAN MARGOLIN: Well, we are talking about a system of protocols whereby a hospital that's about to make a transfer has to contact the recipient hospital. There has to be an exchange of information about the condition of the patient, definitions clearly established as to what is stable, what is not stable and before transfer is implemented, a clear understanding of whether it is an appropriate transfer.

NEIL ANDREWS: We've always had a transfer procedure to be followed where the transferring hospital is requested to make a contact in our facility in the emergency department to discuss the case, get the relevant information and so forth and in that discussion, there is ordinarily a discussion of the relevant stability of the patient and the appropriateness of the transfer. Our policy is never refuse a transfer. We feel that to refuse a transfer would be inappropriate for a public hospital. So, we do not refuse a transfer. However, there is an extensive discussion between the physician in the emergency department and the transferring physician if in fact, they do call. Sometimes they don't call and the patient simply shows up at the door.

CHAIRMAN MARGOLIN: So, if they don't call and the patient shows up at the door, it is your policy, of course, to treat that patient that is in serious condition frequently. What happens to that hospital who made the transfer?

NEIL ANDREWS: Our utilization review people will document the case. There will be a contact with the representatives of the hospital that did the transfer and the care will be discussed. We have no authority to do more than that.

CHAIRMAN MARGOLIN: No authority to do more than. Are you changing behavior as a result of that consultation or hospitals

that once inappropriately transferred no longer doing so in the future?

NEIL ANDREWS: I don't have the answer to that.

CHAIRMAN MARGOLIN: Let me focus on the Medi-Cal services issue that you raise. That really reflects on an issue raised in an earlier testimony involving Medi-Cal contract hospitals and their failure, according to earlier testimony, to comply fully with the contract given by them by the state. You talked about a hospital, a Medi-Cal contract hospital with an emergency room license, that may not have a physician, appropriate physician available, at say 2:00 in the morning. You have run across cases like that?

NEIL ANDREWS: Yes.

CHAIRMAN MARGOLIN: And if a person, non Medi-Cal person came to that same hospital would they receive care and treatment to the fact that that person is on Medi-Cal that results in their...

NEIL ANDREWS: We cannot document that a physician might have gone into that hospital, been called in and would have responded to the call if it was a non Medi-Cal patient and we have no way of documenting that.

CHAIRMAN MARGOLIN: But the specifics you are talking about involve on-call physicians, physicians who sign up with a certain specialty to come in should an emergency case arrive at the front door of that emergency room, emergency room physicians in Medi-Cal contract hospitals failing to show up, again, middle of the night, early in the morning, whenever and therefore, there is no one there to discharge the responsibility of that emergency room?

NEIL ANDREWS: That's correct.

CHAIRMAN MARGOLIN: That's an extremely serious problem. It goes beyond the patient dumping issue as narrowly defined. It really goes into the whole question of Medi-Cal contracting. The point that Mr. Leonard was raising earlier on. It is something that this committee has to look at, very very seriously. Are there other questions from members of the committee? Thank you very much for your testimony.

CHAIRMAN MARGOLIN: Our next witness is Dr. Guss, Chief of Emergency Medicine, University of San Diego Medical Center.

DR. GUSS: Good morning. I think the situation in San Diego is a little bit different than those been described to you so far today. What I would like to do is read a prepared a statement

that I had previously made and then really make myself available for questions in hopes of painting a picture of what the inappropriate transfer situation, and some of the economic problems that exist in San Diego.

U.C.S.D. Medical Center is the primary teaching hospital for the U.C.S.D. School of Medicine and serves as both a primary care community hospital and a tertiary care facility. The Medical Center is fortunate to have both a large highly qualified house staff in most clinical specialties of medicine, surgery as well as a clinically active dedicated attending staff.

The medical center is the regional level 1 trauma center, burn center, replant clinic, and spinal cord center for San Diego County. Advanced medical, pediatrics, obstetric and radiologic services are also housed at the hospital. The natural consequences of this concentrated expertise is the referral of patients from surrounding facilities to services not available elsewhere. In fact, referral to specialized services is actively encouraged by the hospital staff and the administration. Unfortunately, in San Diego and neighboring counties, referral through UCSD is all too often instigated for reasons other than the need for medical expertise alone.

San Diego County, like all counties, like many counties in California has a sizable indigent population. Medical care for indigent patients is provided frequently without any compensation or inadequate reimbursement by most area hospitals and health care providers. UCSD Medical Center, for a variety of reasons, appears to be the recipient of the majority of both self-referred and directly-referred indigent patients. Large numbers of indigent patients and undocumented aliens present UCSD Medical Center because they are aware that care will be rendered first while financial screening is relegated to secondary priority. This policy although costly to the hospitals has been the cornerstone of our approach to the delivery of health care. Both the staff and the Administration feel anything less is morally and ethically indefensible.

Beyond the problem of providing care to unfunded patients that find their way to UCSD on their own, is the much larger problem of inappropriately directed referrals. Frequently, inadequately or unfunded patients are referred to USCD from community facilities, hospitals or physicians offices. These referrals occur without regard to geographic proximity or the nature of the medical complaint or diagnosis. The medical facts of this activity has been the compromise of patient care or there is a consequence of delay in care or inadequate monitoring during transport. The secondary effect has been a financial burden to

the medical center and its staff that threaten the unique diagnostic and therapeutic programs sponsored by the hospital, if not the overall physical solvency of the medical center.

Although issues surrounding health care reimbursement are complex what emerges from the quagmire is that our citizens demand health care be available to all that require it regardless of race, religion, or ability to pay. Our current system provides for inadequate reimbursement to health care providers such that provision to care to many encumbers significant capital losses. Historically, these losses have been recouped through indirect taxation of those that can pay in the form of inflated hospital and physician charges. This surreptitious system should not and cannot continue in today's increasingly regulated health care market. The contraction of health care funding has led to increased direction of poorly funded patients to facilities offering the least resistance or perceived as heavily county, state or federally supported.

In the case of USCD Medical Center, while such federal, state or county support is present to some degree, it is clearly not sufficient to offset the cost encumbered by providing care to large numbers of indigent patients. It is clear that both the local, state and federal governments as well as the medical community must take some kind of an action soon. If not, I feel

the consequence would be the closing of many institutions. Unfortunately, this will not necessarily represent the demise of poorly run inefficient hospitals as ideal economic doctrine would dictate but rather facilities that are functioning as places of last resort for America's lowest income health care recipients. What makes this ironic is that while the facilities caring for the poor may succumb, the problem of indigent care will not go away but rather erupt into a more acute, inescapable emergency.

I think that you've heard here this morning from some of the other witnesses testifying before you have been painting a picture a little bit different than that which exists in San Diego and the problem that my medical center faces. The reasons for this are several. For one, San Diego County does not have a county hospital and USCD Medical Center is not a county hospital. However, somewhat to our detriment, we are perceived in the community as the county hospital and treated as such and frequently without the necessary financial support to carry on in that way.

In addition, some of the very dramatic cases that have been presented for you as inappropriate or frankly dangerous transfers relate to trauma issues, and San Diego County over the last two years has implemented and enacted a regional trauma care system which has essentially removed many of the financial concerns that

are related to the delivery of care to severely traumatized patients in the past. Patients are transported to previously designated regional trauma centers based solely on the perceived severity of the injury, either in the field or at a local hospital if they should end up there, and are directed to a trauma facility based entirely on geographic location. And all of the trauma facilities subscribe to this system and it is essentially executed above and beyond any fiscal considerations.

There is nothing similar for non-traumatic cases and we probably have our equal number of horror stories of patients with severe unstable medical conditions. However, and I don't mean to suggest that the situation is appreciably different elsewhere but in San Diego county, I believe we have a very high level of emergency medical service. A large percentage of the physicians practicing emergency medicine in the community emergency rooms are board certified or at least pursue that activity on a full-time basis. And over the years, as a result of that commitment, I think they have worked somewhat in their own facilities to insist that a more ethical and morally acceptable means of health care delivery prevails. Nevertheless, the problem is still significant. And although most of the facilities do their best to accommodate the inadequately or unfunded patient, the fiscal constraints seem to prevail and have endangered the existence of many of these facilities and

certainly put great hardship on our own as I indicated in my prepared statement.

CHAIRMAN MARGOLIN: Dr. Guss, one category of a patient, as I understand you have a special problem with in San Diego, is the pregnant woman about to deliver. Could you discuss for a moment or two the nature of that problem and how that affects your facility?

DR. DAVID GUSS: Well, it occurs in two ways. As I indicated in my statement, the medical center receives patients that are inadequately funded or unfunded in a number of different ways. One way is self-referral and that self-referral occurs as a result of perceived reputation or a deserved reputation that we will take care of the medical problem first. It is extremely rare that anyone is ever transferred away from our institution. The only time it every occurs is when the hospital is completely full.

A large number of the problems in the area of obstetrics, I believe, are self-referrals. They are either unfunded patients or more commonly undocumented aliens who either presented at our front door or are serviced by the emergency medical care pre-hospital system and request UCSD as the facility of choice and are transported to us. Another level of the problem,

however, does occur with respect to transfer from facilities and what we see here is very much akin to what has been described in other categories of medical care or different diagnostic categories and that is a request for transfer because of the claim that they do not have a physician who can provide the necessary service. And, almost always, it is related to the fact that there is no funding for a particular patient in question. It is a hospital that normally does provide obstetric services and it does have a gynecologist/obstetrician on call, or at least potentially available, should a patient in a more fiscally sound condition appear.

CHAIRMAN MARGOLIN: What are the consequences of some of these transfers? When a woman comes in in the last stages of labor and is in the emergency room and she is in great pain and may be having some difficulty in the hospital based upon financial considerations transfers her to your facility, what are the consequences of that?

DR. DAVID GUSS: We have and we have had for quite some time a fairly tight transfer protocol and policy at UCSD and as a result of the amount of time that the system has been in place, most of the emergency care providers in the community are aware of how the system works and what is required. So I am happy to say that it is relatively rare that someone will actually be

referred and just appear on our front door without any prior announcement. We are almost always called in advance and once we establish that unless we do something the patient will simply languish at the other facility and perhaps deliver in an unstable condition without appropriate care, we accept the patient and transfer. We have a aeromedical service in San Diego as well as fairly advanced ground services and when we perceive that unescorted transfer will put the patient and/or the neonate in danger, we send a team and obstetrician and neonatologist to the hospital to treat the patient, performing delivery there if its imminent or else transfer them to our hospital.

ASSEMBLYWOMAN THERESA HUGHES: Since you are located near the border and since you indicated that many of your patients that you service are undocumented aliens, they have not had any previous prenatal care, is that correct?

DR. DAVID GUSS: That's correct.

ASSEMBLYWOMAN THERESA HUGHES: And you are a teaching facility and of course it overloads you. How do you make a decision of which ones you seek to transfer and of the bulk of the patients who come to you who are pregnant are they almost at the point of delivery when they come or do they basically come because they are in some other serious pain or complications?

DR. DAVID GUSS: I will attempt to answer that question but I would like to indicate beforehand that I am not exactly sure why the emphasis has been on obstetric patients. At UCSD Medical Center, I have heard this from our Obstetrics Department, my primary experience involved in this is in the Emergency Department and from my perspective its on a relatively small percentage of what I am involved in, the obstetrics problem that is. Just so that you understand, I cannot speak with a great deal of case representation here.

Basically, in terms of the undocumented alien, you're correct, the majority of them do present in the state when they're in active labor. It's relatively rare that delivery is truly imminent as evidenced by the fact that very few deliveries occur in our emergency room. However, if anyone presents to our emergency area, that's more commonly where they do gain access to the medical center when they're in active labor, they are taken up to the Obstetrics suite and evaluated up there. And if they appear to be in active labor or if there are any complicated situations, the patients are admitted to the hospital and the delivery ensues and whatever care is necessary for the mother, or the newborn is delivered.

As far as transfer requests from other hospitals they would be honored. If there is any reason to suspect, assuming that

they otherwise can deliver obstetrics care at the referring facility, we will nevertheless accept the patient and referral even if there is reason to suspect that the delivery is likely to be complicated or the neonate is likely to be in danger, primarily somebody who has complicated illnesses or is in significantly pre-term labor.

ASSEMBLYWOMAN THERESA HUGHES: But what I am wondering is how do you make a decision especially, and I do imagine because of your geographical location you would be inundated and because there is no county hospital like there is in the city of Los Angeles, unlike U.C.L.A. and our other facilities and USC that you would have a higher volume of complicated deliveries and emergency-type situations, what could government do to help your hospital that was placed there to give relief and is really not serving the same kind of person or purpose that other UC teaching facilities are providing? You are in an elite type of dilemma. What could government do? What could Mr. Margolin or members of the committee do? What kind of recommendations do you have to give to us for your kind of unique situation? It's really different, and you're more on a hot-line, pipeline, or firing line, I think than a lot of other UC or other teaching facilities. What kind of information could you give us? Because I don't want to hear the horror stories because I am sure there are plenty.

DR. DAVID GUSS: Well, I don't understand. And I wish I knew that the emphasis would be in the obstetric area because then I could bring a representative from that division that would have a better perspective on the problem. But from my perspective, as emergency physician, as well as somebody who is involved in a lot of the issues of transfer and economics of health care delivery, I think the problem boils down to dollars. And not just dollars for compensation for the individuals providing the care but dollars to expand the services to increase the area that is necessary to handle the obstetrics load that is incurred as a result of this type of activity.

I think, one of the things that's been very frustrating to the individuals in reproductive medicine is that they find that they're unable to provide adequate service to the patients that they have been following throughout the normal term of their labor and frequently the labor suite is fully occupied by individuals that have had no prenatal care , that have appeared on an emergency basis and then individuals that have been followed by members of the obstetrics division for nine months are unable to deliver their children in our hospital. And, of course, that is most frustrating and is suboptimal for those individuals. Now, that problem could be solved by either stemming the flow of those individuals, which is I think a very complex national and international problem or expanding the facility in order to accommodate all those that need it.

ASSEMBLYWOMAN THERESA HUGHES: Well, let me say this, I think that it is incumbent upon your facility, because you are sitting on a time-bomb, it's just a matter of time before something really horrible happens and it's not your fault. It's just the situation in which you find yourself because, there is no county facility, because you are a teaching facility and people feel that they're free to come there and why am I hopping on the obstetrical thing, because it's unlike other emergency care, because you are talking about two lives rather than the ordinary emergency situation when you are usually talking about one life or one patient.

And so I would hope that your institution would through the University of California would feed to the legislature some concrete recommendations for a situation as unique as yours where you have an influx of immigrant population and where you have a culture that is probably going to be more pregnant as an immigrant group than others, that you give some recommendations to the health committees of the legislature on how we can help you. It's probably a real nightmare for your administration. I am certain it is. You want to do the best thing but you don't want something to come out in the newspaper that says the University of California kills twice as many people in their transfer program as other people because you know, I am not saying that you do that, but it could develop that way as you

have a volume of people coming in and getting this kind of obstetrical care. Now, if I have the wrong impression, you gave me the impression that this was really a big problem with you and I am sure it is and all I want to say is help us and you with your great university minds to see how we can solve it. If we can solve it in San Diego we can solve it in other places in the state.

CHAIRMAN MARGOLIN: Thank you very much Ms. Hughes. Senator Rosenthal.

SENATOR HERSCHEL ROSENTHAL: I have another concern. We've heard from a couple of previous witnesses the problem of Medi-Cal transfers. Have you run across this in San Diego?

DR. DAVID GUSS: I think I can probably dig up a case or two but by and large I do not think we have a major problem. We certainly receive transfers of Medi-Cal patients. They may come from the Medi-Cal hospital, but almost always it's a legitimate level of care consideration. We provide a service that is simply not available elsewhere, there is no problem. Otherwise, the majority of Medi-Cal patients come from a non Medi-Cal contracting hospitals and almost always the condition of the patient is appropriate for transfer.

In terms of the problem for UCSD as opposed to Medi-Cal health care delivery in San Diego, the only problem we're faced with is that we may be requested to accept the transfer when we're not really the closest geographical facility to that requesting the transfer and the nature of Medi-Cal reimbursement by and large is that it is not sufficient to compensate for the cost of care. So, we never deny Medi-Cal transfers but similarly, we are not looking to solicit the activity, but nevertheless for whatever reason, we are identified by all the non Medi-Cal contracting hospitals as the place to transfer those patients.

SENATOR HERSCHEL ROSENTHAL: But, basically, you are not aware of the large scale transfer from Medi-Cal hospitals at 2:00 in the morning?

DR. DAVID GUSS: That's correct. It's not coming from Medi-Cal hospitals. It will, on rare occasions. What's happening and what happens to a significant degree are patients that are in the CMS or Medically Indigent Adult Program. In there it is a very significant problem.

SENATOR HERSCHEL ROSENTHAL: Thank you.

CHAIRMAN MARGOLIN: Thank you very much for your testimony, doctor. Our next witness is from University of California Irvine Medical Center, Dr. Salness.

DR. KYM SALNESS: Good morning. I am Dr. Kym Salness from the University of California at Irvine, located in Orange County. I am the medical director of the emergency department there. I didn't compare notes with Dr. Guss who just preceded me from USCD but in many ways his introductory remarks are very very similar to my introductory marks and perceptions.

Namely, we are a large university hospital, teaching hospital, tertiary care center, with many many services available, some of which are specific and unique teaching service. We were the county hospital, having been purchased by the University by the county in 1976, but for 10 years we have not been the county hospital. We are the university hospital. However, many of the ramifications of having been a previous county hospital, still remain, still contribute to some facets of this problem in Orange County.

As I said, there is no county hospital at all in Orange County. There are some 10 or so hospitals who contract to provide Medi-Cal services in Orange County. There are some 33 hospitals who contract to provide indigent medical service in

Orange County, we are one of those 33 or so. And in regards to the main agenda at hand, namely the transfer of specific unstable transfer of critically ill patients who may have their lives at stake, or their lives at risk by an inappropriate transfer in the middle of the night, in Orange County that is not a common phenomenon. As a matter of fact, it is a very uncommon phenomenon and has been decreasing over the last number of years.

There still are some patients who are transferred very inappropriately, who are unstable, and who could potentially have a serious bad outcome. However, they are few and I personally know of no patients who have died because of an inappropriate transfer of that nature. If you ask why has that happened, I am told that years ago they were patients who were transferred inappropriately and had a bad outcome. I don't know if they were inappropriate deaths or not, but I am told that in the years gone by that used to be a more common phenomena. I wasn't there, I don't know. However, in the last few years that has been decreasing for a number of reasons, one of which is the increasing awareness by the community physicians and the community hospitals that there is no county hospital and specifically there is no county hospital and specifically there is no place to send appropriately or fairly a patient like that where they will be accepted without further discussion.

Furthermore, one of the reasons why we don't have that problem so much any more in Orange County is because similar to San Diego County, we have a very active well organized county organized emergency medical services system whereby anybody who thinks they have an emergency, anybody who thinks that they are critically ill and specifically anybody who has had a serious traumatic injury will be picked up by the paramedics and taken care to the nearest appropriate hospital. That might be one of four trauma centers that we have in our county or it might be one of 33 receiving centers that we have. By agreement, by mandate, by all the rules of this EMS pre-hospital system, all patients arriving at those hospitals must be cared for by the emergency department staff and the physician complement at that hospital irregardless of their condition or their ability to pay. That, especially as far as trauma goes, has decreased this phenomenon to a great extent in Orange County.

Also, my hospital, the university hospital has taken a fairly aggressive stance about following up on any patients who were transferred inappropriately or unfairly, or at potential risk to that patient. We have been very watchful of the situation and have made many follow-up calls, sent letters and are part of the solution, which is currently developing in Orange County.

Lastly, I heard this mentioned before, In Orange County we have what I consider to be a fairly sophisticated...We have 40 hospitals in Orange County, by the way, with a population of some 2 million people. We have 40 hospitals. Most of those hospital's emergency department's are staffed by emergency medicine physicians who are career directed, interested emergency medical people who seem to have a clear understanding and awareness of all the ramifications of this issue and may be caught in the middle. It may not be an easy issue for them to deal with. They may have medical staff questions, they may have hospital financial questions and all sorts of people that they have to deal but by and large, the emergency medical physicians, primarily staff emergency departments in Orange County, have developed acceptable working relationships with their hospital administrators and with their physician on call panel to take care of these patients at their own hospitals as appropriately as can be done at their facility.

I was primarily speaking for the last few minutes about critically ill unstable patients that have been referred to as dumps. That is not to say that there isn't another kind of problem in Orange County and there is another kind of problem that I would like to speak to. We get very few transfer requests at our hospital. The transfer requests that we get primarily are for tertiary services, namely a burned patient or a replantation

patient or a special cardiac or other kind of unique problem for which we are a center. Those patients are always accepted at our facility irregardless of funding as long as they are stable. Our first question is, is the patient stable. And our second question is can we offer a special service for that patient. If we can, we would accept those patients always irregardless of ability to pay. We do not get overwhelming numbers of requests for transfer for transfers in general. The ones we get are for those tertiary type services. We accept them or reject them, depending upon their stability and our ability to provide service for that patient.

However, and this gets to my major point that I'd like to make, we do nonetheless see lots of patients at our facility who have been seen someplace else. They didn't come to us by a transfer call, they didn't come to us by critical dump in the middle of the night. They came to us on the second day or on the third day, so-called "bloodless transfers" , so called "sub-acute emergency". The patient who is suffering from non-resolving medical or surgical minor conditions. That patient has presented to an emergency room because that patient feels they have an emergency. Of course, the patient always feels that they have an emergency, that's why they went to the emergency room. But the medical condition per se doesn't turn out to be a critical or an acute medical emergency. They have a sub-acute emergency that

may get a brief or a moderate degree of evaluation and treatment. The patient then may be referred to another physician or referred elsewhere for followup. These are the patients that we see a fairly substantial amount on the second day or on the third day of their emergency.

At this point, it is not a critical emergency, it's a sub-acute emergency - it's still referred to as an emergency by that patient, but nonetheless by most medical standards not a life-threatening emergency. Those patients arrive in significant numbers, probably in the hundreds and perhaps in the thousands that we can track year in and year out. As we have become more aware of these patients and have been asking them how they came to us, some of them have gotten back to original facilities and told them that we felt that the nature of this problem could have been handled at the original hospital, perhaps should have been handled at the original hospital. We seem to get less documentation accompanying these patients. In other words, they used to come with little prescription pads. They used to come with notes, and with maps and with referrals from other community physicians and emergency centers and hospitals. We no longer see all that documentation. Perhaps because that makes it easy for us to track where the patient initiated in the first place. So, these are second day unannounced transfers, so called "bloodless transfers".

CHAIRMAN MARGOLIN: Dr. Salness, on that point on that second day problem, you are dealing in some of these cases, with Medi-Cal contract hospitals that are transferring to you Medi-Cal patients on the second or third day of their mission?

DR. KYM SALNESS: Sometimes, yes.

CHAIRMAN MARGOLIN: Sometimes it does happen?

DR.KYM SALNESS: There is a better answer to that and that's that most of the time the patient has just had their event. In other words, they have just come down with bronchitis, or they just twisted their ankle and nobody knows if they're going to be a Medi-Cal patient yet. They don't know yet if they are IMS approved, going to be Medi-Cal approved. On the first night, no one knows what their ultimate funding may be. They just know that they don't come with an insurance card in their pocket. That makes them a risk is what it comes down to. It makes them a potential financial risk that for instance, they may be an IMS, or maybe gonna be an IMS patient but nobody knows for sure what percentage of chance you'll have to get them on the IMS Program or what percentage of funding that program then will provide.

CHAIRMAN MARGOLIN: So the transfer occurs after initial stabilization but before their insurance status is fully determined?

DR. KYM SALNESS: Fully administrated and fully declared so that they are a risk and.

CHAIRMAN MARGOLIN: A financial risk.

DR. KYM SALNESS: A financial risk for the physician or institution that might go on to prepare the care and this gets very much back to some of your original orientation, some of your original opening remarks. This issue, in my opinion, has a lot to do with uncompensated care, probably you'll hear some from community physicians or the CMA about the whole issue of uncompensated care, which is a real issue as far as I am concerned and the things I am telling you about probably are a symptom of that whole major issue in our state and probably in our country at this time about uncompensated care.

I have a few closing remarks. We at UCI Medical Center, as part of our university system, know that a big piece of our service mission to the community, includes seeing unfunded and otherwise down and out many patients. We have not ever objected to fulfilling that service mission as a service to the community. Certainly, it's conducive to many of the activities that the university has wanted to serve. However, this situation as I pointed out to you, is we feel unfair for a couple of reasons in that these patients are specifically preselected, preselected

quote undesirable unquote. The gentlemen two speakers before me talked about skimming and dumping. In other words, if we are willing to take, in fact, we do see most of the unfunded or indigent patients in Orange County, and have been for a long time. What I am objecting to about this situation is that these patients one went to their original hospital, original physician, got partially worked up, the nurse initially stabilized, were not dumped but rather were screened, or deflected, or triaged or somehow moved out of that hospital's sphere into our hospital sphere because they represented a high risk in that they probably wouldn't get full funding or that they might be complicated. They might take a lot of energy and resources to work up and the funding systems we are talking for are especially disadvantageous for you to take care of critically ill or complicated patients. Also, it's not fair to the patient who has to go two or three communities down the road to seek his medical care.

CHAIRMAN MARGOLIN: Dr. Salness, did your institution support AB 3403?

DR. KYM SALNESS: I believe that the position of the University of California last year was to support that bill.

CHAIRMAN MARGOLIN: And was that reason behind that support? What was the rationale for endorsing a statewide measure of that sort?

DR. KYM SALNESS: I don't sit on the university's legislative analyst committee. I presume that they felt that as an aggregate perhaps several of the U.C. hospitals, namely San Diego, UCI and Davis, former county hospitals, perhaps might get more than their fair share of inappropriate transfers.

CHAIRMAN MARGOLIN: And that's historically been the case. At least in past years it was the case at UCI. What you've done, if I understand your testimony correctly, is you instituted transfer controls, that in fact are very similar to what AB 3403 would have called for on a statewide basis but you've done that in your own county and have been able to make a significant inroad in cutting back on the problem as a result of that.

DR. KYM SALNESS: I get some of the credit. I am not the hero. Its an aggregate consciousness of the community that has produced that change.

CHAIRMAN MARGOLIN: Let me, Dr. Salness ask you a question which pertains to a hearing we had last year, oversight hearing, and it dealt with a policy of UCI that a doctor in your institution told us about a year ago and I am interested in whether or not that policy is still continuing on. At that time we had testimony that patients admitted to your facility were categorized according to red dots or blue dots and the dot on

their card would indicate whether or not they were indigents or fully insured and the level of care that that patient would receive was directly tied to whether they had the red dot or blue dot. Could you comment on that policy and tell us whether that is still in effect now?

DR. KYM SALNESS: The program as you just spelled out is inaccurate. We did attempt to identify patients who were private patients of the faculty, private patients who work, who planned on getting their care at our institution and being followed up at our institution. We attempted to identify those patients and keep them in the usual follow-up channels. Other patients who might be coming from another community, might be coming from another country and who had no intentions or were not going to be able to seek follow up at our institution for whatever their reasons, their choice not our choice, we attempted to provide all the necessary and appropriate care for that patient and yet not proceed on a complicated esoteric diagnostic evaluation that might require long periods of follow-up or a patient who had no intentions of continuing with our institution.

CHAIRMAN MARGOLIN: When you say complicated or esoteric, if a person was a local resident, fully insured, you would have, medical judgment would have normally involved that procedure being used, that testing done, but, you are saying that medical

judgment that would have normally been applied to a fully insured individual would not be applied to somebody you described as people from other communities, people without the guarantee of payment, that that procedure or that test would not be applied to that individual? Isn't that a case of financial considerations affecting medical judgment?

DR. KYM SALNESS: I think either I am misunderstanding you or you are inaccurate in your conclusion, That first and foremost a patient's medical condition was the absolute driving force of whatever we planned on doing to that patient diagnostically or therapeutically. Always....

CHAIRMAN MARGOLIN: What's a so called esoteric medical test that you'd apply to somebody with a blue dot but you wouldn't apply to somebody with a red dot?

DR. KYM SALNESS: Take a patient who has arthralgias and they may need an ANA and a Leukoses preparation and a segregate and other kinds of testing that won't be available today, in fact, won't be ready for several weeks. It will require a doctor and a patient meeting together at a subsequent date to discuss the results of that test and ongoing plans for therapy. Those tests have imprecise clinical meaning and imprecise clinical usefulness and if a patient isn't going to come back and check out the

results with you anyway, it seems inappropriate to commence or initiate such a....

CHAIRMAN MARGOLIN: You're making an assumption about the patient's future intentions. Somebody who's from outside out of your particular neighborhood or community but who's sick in your community may, in fact, be willing to stay for test results.

DR. KYM SALNESS: I'll say this again. Any patient regardless of their ability to pay, regardless of their background of any sort that needed medical care at our facility was offered that care, was offered that follow-up. And certainly your staff members have, I am sure, told you, what the proportion of unfunded and uncompensated medical care that the university has continued to provide.

CHAIRMAN MARGOLIN: I know you do a great deal. I think you do very high quality of work at the university and I am not in any way suggesting that isn't the case. I am just concerned about this system and we may have a difference of how it is defined. I may have information that differs from the information that you have but the idea of making a distinction based upon whatever the category, and then in any way allowing that to influence medical judgment, even if it applies only to the so called esoteric test troubles me a great deal. And while

we don't have time to go into that issue in great deal this morning, it's going to be a subject of additional discussions in Sacramento next January and February. I wanted to at least raise the issue with you today while you're here. And thank you for your testimony. Thank you, Dr. Salness.

Our next witness is Dr. Larry Bedard, head of emergency department at Marin General. He is also the president of the California Chapter of American College of Emergency Room Physicians. While Dr. Bedard is coming forward, let me acknowledge the arrival of another member of the Assembly, Frank Hill. Frank Hill has joined us here this morning. Welcome. Dr. Bedard.

DR. LARRY BEDARD: Thank you for that nice introduction. I'd like to thank you for the opportunity to come here to discuss this issue. It is a major concern of emergency physicians and members of our college. In California, the California Chapter of American College of Emergency Room Physicians has over 1,300 members. Many of our members are currently on duty now in one of the 738 hospitals in California.

I think we've heard much testimony today which really documents that the problem of inappropriate transfers still exists. I'd like to take a little bit of time and discuss why I

think the problem occurs. In the early 1980's, 1981, and 82 a revolution in health care occurred in this country. It occurred both on the federal and the state level. It involved all patients. In the case of Medicare where we had DRGs, this involved the elderly and the disabled. In the state of California, the Medi-Cal contracting involved indigent, less fortunate members of our society. The Medical Indigent Adult Programs was created and actually only got 70% of the funding. Many people were removed from the Medi-Cal rolls, and inadequate funding for their care was provided. In the case of other patients, private pay patients, we had a revolution which resulted in HMOs, PPOs significantly being increased. We had this managed health care program.

I suggest to you that the source of this revolution was cost containment, and on both the federal and state level, the solution was competition. I think what we needed was a health care policy, I think what we got was a cost containment policy. And I think what we need to do is look at a health care policy. I think with a little bit of vision and foresight it could have been easily predicted in a cost containment competitive mode that certain patients would be left out of the system.

We've heard a few buzz words which are very popular in current medicine such as market share, focus groups. I suggest

to you that you will not hear a commercial on the radio or see one on T.V. in which a hospital or a group of physicians is going to be out marketing for indigent care. I know of no hospital or medical group that has the statue of liberty as a logo and says please give me your poor and huddled masses. I think the fact that we've had this health care competition and cost containment really left out many people who cannot compete and pay for health care.

Most of the discussion today has been on patient dumping. I'd like to suggest that this is only part of the problem. Patient dumping really refers in most cases to indigents. I think this is a real problem. I think it's the most serious problem and I think what these people need is a health care safety net.

I'd like to talk about another issue and this is a second group of patients and these are patients that belong to managed health care programs such as HMOs or PPOs. In our college, we don't refer to it as as a dumping problem. We refer to it as a patient transfer problem.

As an emergency physician I see all kinds of people, rich, wealthy and middle class. People in the middle class, more and more are members of health care, health maintenance

organizations. And what we are seeing as emergency physicians is these patients are being pulled out from under our care. We are in effect being pressured to transfer patients to a health care facility with inappropriate or less than appropriate evaluation and treatment. Many of these HMO's, PPO's have unreasonably restrictive definitions of emergency care. They have incredible bureaucratic prior authorization programs, and if you want to talk about blue tag, or blue dot or red dot system, that exists in many HMOs where a physician has to get on the phone, talk to a nurse to get permission to order chest X-rays, when the results come back get on the phone again to reorder a CBC or blood gas. I think this class of of patients are people with prepaid managed health care system who really need a consumer protection act because many times that there is pressure put on the emergency physician to inappropriately transfer those patients.

I'd like to speak briefly about the role and the responsibility of the emergency physicians. Our college, since its inception has a policy which, I think is universally accepted, that if you say you're an emergency physician you have a moral, ethical and fully a legal obligation to see all patients irrespective of their ability to pay. I think the vast, vast majority of truly oriented full-time emergency physicians meet this policy. I think the law is very clear and it was made more clear on August 1 when federal legislation took in effect which

defined emergency physicians under this law as quote being responsible physicians. It was a nice pat on the shoulder to be named the responsible physician.

Part of this responsibility, however, made us unique in California or almost unique because the responsible physician is defined as one who is employed by a hospital or has a contract. If a responsible physician fails to meet his or her duties or obligations, they can be fined up to $25,000 if the patient is injured. Interestingly, the on-call medical staff, under federal legislation is not defined as an on-call or as a responsible physician, and I would like to say that I think that is one of the issues that needs to be addressed in one of the short term solutions for this transfer problem is clarifying the role and responsibility of on-call physicians.

In recent legislation, there were two bills, 1607 and 3403, which in their final forms did clearly delineate responsibility of the on-call physician and said that physician must see all patients irrespective of their ability to pay, that physician if they fail to discharge their duty was eligible or could be fined up to $5,000. The California Medical Association, in its August Council meeting supported that policy and I assume, and I think that they will continue to support this in the new legislation because I think this is one of the major issues that really needs to be discussed.

As an emergency physician I do not have admission privileges. I think that's appropriate. I cannot do my job to see patients in the emergency department if I am responsible for continuity of care in the hospitals. Even if I did have admission privileges, I do not have the training or the skills to take care of all emergencies that I see. I cannot do brain surgery, I cannot do surgery to take out somebody's spleen. So, even if I wanted to have admission privileges, I don't have the skills, nor do my colleagues, to take care of all emergencies. For this we depend on the on-call physician to discharge their responsibility.

One of the cases you have in front of you is of a Eugene Barnes, which I'd like to kind of give you an idea of what happens to emergency physicians. This is probably the most famous dumping case in the United States. This directly led to federal legislation.

In August I had the opportunity to meet and talk with the emergency physician involved in that case. She had five hours in which she was placed under incredible stress, unimaginable stress, when she tried to arrange care for a patient that she could not get cared for at her hospital. Two neurosurgeons refused to take care of that patient. Eventually, five hours later he was transferred to San Francisco General where that patient died. Within a couple of days Melvin Belli announced in

the newspaper that he was going to sue that physician. In my conversation with her, she kind of laughed and said when he found out I was a "twofer", she was both not only woman, she was also black, that Melvin Belli quickly dropped his case.

The end results though, however, was the hospital terminated the contract with those emergency physicians. All six of them lost their position at that hospital. They lost their income. According to the physician involved, the neurosurgeon who was on-call, who failed to respond, was never called in front of a single hospital committee, he was never asked to account for his actions. So, I think legislation is needed on a state level that would define and the role and the responsibility of the on-call physician. I think that would be one of the short-term solutions.

I think in the next legislative session any transfer legislation also should define the role and responsibility of HMOs to have a realistic definition of emergency services and they should be required to have appropriate prior authorization programs and they should have to be required to pay for a patient who is unstable or needs appropriate tests before they can be transferred.

I think there is another intermediate solution to this. One of them is a further categorization of hospitals. Many of the patients you've heard discussed today were victims of trauma. I think the problems of trauma patients would be solved by getting the patient to the right hospital on the first attempt so transfers would not be necessary. The way to do this is to develop a trauma system in California that is workable. Trauma regulations after two years of discussion finally were formalized in October, and hopefully this will promote a trauma system so that when the patient is picked up, he is brought to a hospital that has made the commitment, both the facility and the medical staff to provide optimal care.

I think a further categorization of hospitals, so hospitals will in effect make a commitment, both the hospital and the physician to take care of certain kinds of problems. Dr. Kizer, Director of Health Services has suggested or has come up with a preliminary draft of the categorization system. Although our college does not agree with his system, we do feel that further categorization of hospitals are needed so hospitals in effect will make the necessary commitment to take care of patients.

One of the solutions to the case of the pregnant woman, would be to develop birthing centers much like we have trauma centers and I think people would need to be educated, then when they went

into labor they could call 911 and they would be taken to a "birthing center". Since I have been president of our college in June, I received two calls from emergency room directors because of an inability to have obstetrical backup to their hospitals. One of them was at the Eisenhower Medical Center in Palm Springs, where the obstetrician/gynecologist essentially upset at that hospital, their only gynecologist, is not available to deliver babies. If that hospital can't get more of a commitment, I don't think they ought to receive any obstetrical care or perhaps gynecology care at that hospital.

I think other categorizations such as overdoses could be taken to a hospital that is appropriately staffed, has the proper equipment and has the medical staff who has voluntarily made the commitment to take care of that hospital's patients. I think these are intermediate solutions. I think the final, and it should it be an intermediate, but most likely will be a long term solution, is really to deal with the issue of uncompensated care.

I think the problem which gets the most discussion is of the most serious patients, those that need to be in a hospital. As emergency physician I see many patients that do not need to be in the hospital. Only about 12% of emergency visits are hospitalized. I, however, see many indigent patients that really have no availability to outpatient care, they can't get well-baby

care, they can't get prenatal care. There are probably more homeless people in this state that there has been at any time since the depression and I can tell you as a physician, I don't feel very good as a doctor, I don't feel very good as a person to take somebody who has bronchitis, not sick enough to be in a hospital, give him a prescription and tell him that I suggest that he sleep in the gutter on the corner of Canal and 4th Street or he can get a cardboard box he can find behind a Safeway. And that is the situation not only an emergency physician but other physicians are faced with.

In the issue of uncompensated care, it is not a doctor's problem, it's not a hospital's problem. It's a society's problem. And you as the elected representatives of this society, I think have a particular responsibility to deal with and provide a safety net to provide the opportunity for all people to get the appropriate and compassionate care that are needed. Thank you for this opportunity.

CHAIRMAN MARGOLIN: Thank you Dr. Bedard. I'd like to ask you a question or two. Before I do I want to acknowledge the tremendous amount of effort that you and your colleagues in the California Chapter of American College Emergency Room Physicians put into the AB 3403 and SB 1607 negotiations last year. We ultimately didn't produce a bill, but you put an extraordinary

amount of time into trying to understand the nature of the problem and educating legislators as to how best we can address it from our perspective.

I want to focus for a moment on the on-call physician and the gap that appears to exist between what federal law would theoretically cover and what the state is trying to cover. You talked about the penalties, the fines that we put into the bill for the on-call physician who would choose not to come in if the person is uninsured or a Medi-Cal patient. I know you are not representing the California Medical Association today. We'll have a spokesman here in a few moments, but the version of the bill that the CMA endorsed with those fines unfortunately also contained a county mandate that would have obligated the counties and ultimately the state to pay for the provision of this care upwards of $200 million dollars.

It was a position that legislatively had no realistic chance of being approved and while we'll look to the financing issue next year and do our best to see if we can pump new money into that system, in my mind, the issue of fines for refusal to care for unstabilized patients really stands as a separate issue and I hope when the CMA spokesman comes forward, we'll be able to see some distinction between fines for that unethical indefensible practice and the need also to get money into the system which we

all agree needs to be done. In your own experience, the failure, in the case of Mr. Barnes, the case you cited, it was the failure of an on-call physician to come in and perform that surgery that produced these difficulties, is not that correct?

DR. LARRY BEDARD: That's true. When Mr. Barnes had a stabwound to the head, to the brain, had come in with a knife in his head, emergency physicians are not trained and it would make no sense to train us how to do neuro surgery. Emergency medicine is a separate specialty of medicine so recognized in 1979, the 23rd specialty, and it's very clear what that specialty can do, what our roles and responsibilities are, and one of those is not to do neuro surgery, not to do general surgery, not to set compound fractures, not to deliver babies in most cases.

CHAIRMAN MARGOLIN: So the on-call specialist is typically a specialist who has certain skills that the ER doctor is not trained to perform and you have people who come in with head wounds or other severe injuries who need those special skills and that emergency room in effect is not capable of fulfilling its obligation to that patient unless that on-call physician becomes part of a team and cooperates and really in the end adopts the same standards that your people do. Isn't that a fair statement?

DR. LARRY BEDARD: I think that's a fair statement. One of my colleagues increasingly says that we're kind of the marines of medicine - we're out there on the front lines, we're taking care of these patients, and my colleagues see them irrespective of their ability to pay, but just like the marine corps needs a back up and assistance, and logistic help from other individuals, other organizations, so does the emergency physician.

CHAIRMAN MARGOLIN: Thank you, Dr. Bedard. Any questions from the committee? If not, thank you very much for your testimony. Mr. Keller of the Department of Health Services.

MR. PAUL KELLER: Mr. Chairman, thank you for the opportunity to appear before you today. Mr. name is Paul Keller. I am Chief of Field Operations of Licensing and Certification, Department of Health Services. My testimony answers questions forwarded last week by a member of your staff to the department. It was as follows: The first question, whether patient dumping in hospital emergency rooms is occurring, what is its incidence, and what has been its increase since the 1982 reforms?

As you know, most general acute care hospitals are surveyed every three years or more often if necessary, by the Department of Health Services, the Joint Commission on Accreditation of Hospitals, and the California Medical Association. In the

interim, the Department of Personnel investigates alleged complaints registered through our district offices. It is through the complaint investigation process that the Department becomes aware of inappropriate patient transfers.

Approximately 7,100,000 patients were treated in acute care hospitals emergency rooms in the past year. Since early 1985, Licensing and Certification has investigated approximately 20 alleged patient dumping complaints. Of these, 40% were substantiated. From this perspective, patient dumping is not a common practice but does occur. It is difficult to ascertain whether there has been an increase in patient dumping since the 1982 reforms. It has only been in the past year that these incidents have come to our attention.

The second question is whether the dumping of patients violates existing laws administered by the department and what are the department's views on the efficacy of the remedies and sanctions available to the department's licensing division to correct these violations? Current law, Health and Safety Code 1317 requires the hospital with an emergency department to provide such services to any person requesting such services for any condition in which the person is in danger of loss of life or serious injury or illness. These services must be provided when such health facility has appropriate facilities and qualified

personnel available to provide such services and care without first questioning the patient or any other person as to their ability to pay. Additionally, acute care hospital's licensing regulations require a physician's determination prior to a transfer that the transfer will not cause a medical hazard to the patient and the transferring facility makes advance arrangements for the transfer.

Our investigations and complaints relating to inappropriate patient transfers have revealed violations of the law and licensing regulations. Current sanctions available to the department to deal with the problems of inappropriate patient transfers consist of the following sanctions in order of severity: one, issuance of a statement of deficiency which requires the facility develop a plan for corrective action within a specified time frame. Two, withdrawal of the department's approval for a facility to provide emergency medical services. Three, a recommendation for decertification from the Medicare and/or Medi-Cal Program to the Federal Department of Health and Human Services Health Care Financing Administration. A recently enacted federal law does impose monetary penalties on hospitals and physicians for inappropriate patient transfers. And, four, revocation of the facility's hospital license. These sanctions represent the extremes in enforcement, from a minor inconvenience to the threat of facility closure.

Currently, there are no intermediate sanctions available to the department such as the use of monetary penalties similar to those used in long term care facilities. The Department would be more than happy to work with the Legislature to address the limitations of existing laws and regulations and to add any specificity, if necessary, regarding appropriate transfers and the requirements pertaining to medical staff membership.

The first question, what has been the role of on-call physicians in the patient dumping incidents investigated by the Department and what is the authority to sanction patient dumping by on-call physicians? The role of the on-call physician in patient dumping involves the hospital's inability to assure the availability of specialist physicians to respond in person when necessary for the provision of basic emergency medical services.

The Department has received approximately 20 complaints relating to inappropriate transfers. Within these complaints, approximately 80 medical records have been reviewed. Of these, three were directly related to the unavailability of or refusal of the specialist physician to respond in person. The overall responsibility for patient care and the provision of basic emergency services in the hospital applies to the Governing body of each hospital and its medical staff. The Department of Health Services does not license physicians. The scope of practice

issues and monitoring of physician activities are not within the ability of the department. The department's authority to sanction patient dumping by on-call physicians is therefore limited to issuing noncompliances related to the governing body and the medical staff by-laws, rules and regulations. Let me reemphasize the department's willingness to work with the legislature in addressing the limitations of the existing laws and regulations and to add specificity as necessary regarding inappropriate transfers and requirements pertaining to Medi-Cal staff membership. Thank you, again, for the opportunity to make this testimony and I am more than willing to answer any of your questions.

CHAIRMAN MARGOLIN: Thank you Mr. Keller. I appreciate very much the willingness of the Department to work with the legislature to put into specificity and talk about because it is apparent there is a need for a statewide standard when it comes to these transfers.

In the case of the patient dumping incidents where you determined that they were substantiated,the 40%, that were substantiated, what action was taken against the hospital emergency rooms that were found to be guilty of those acts?

MR. PAUL KELLER: To the best of my knowledge, we used two sanctions. We issued statements of deficiencies to the hospitals and brought them to the attention of the governing body of the medical staffs and required appropriate plans of corrections. In one particular facility, a recommendation was made to the Health Financing Administration to decertify that facility and to have the Joint Commission on Accreditation of Hospitals remove their status as a hospital deemed to meet all of the federal requirements for Medicare/Medicaid. This was done and the hospital on appeal to the federal government and after a subsequent survey of the hospital's practices was able to have that sanction put aside.

CHAIRMAN MARGOLIN: So, in only one case was there even the recommendation.

MR. PAUL KELLER: No, in all other cases we issued statement of deficiency. But in the one case.

CHAIRMAN MARGOLIN: Right, that's all I'm saying. I understand the statement of deficiency was that letter that you sent to them which, of course, can be complied with, ignored, or half-complied with. There is a range of options. But in only one case was there a recommendation made that a license be revoked. In the end on appeal, that action wasn't sustained. I

recognize your frustration. I think it is implicit in your testimony of not having a broader range of sanction. I am also interested in the relatively small number of cases that your department has investigated, only 20 cases. In the testimony we have heard today, which included testimony from some counties where they have problems substantially down from where it once was, they still talk about cases coming to their attention every few weeks. In some cases, every few days in one single county. You have responsibility for the entire state. It would seem to me that over a year or two period in time there would be more than 20 cases statewide that would require your attention. Is there a staffing problem? Is there a reporting problem? Why isn't there more being done in the area of investigation?

MR. PAUL KELLER: I think it's the lack of a public complaint about patient dumping caused to begin with by a number of factors. One, is the lack of sophistication perhaps as to where to complain. The hospital, by using an internal utilization control mechanism or their problem solving methodologies to correct some of the patient dumping problems as we heard from a couple of major hospitals. The involvement of the emergency medical services authority to review inappropriate transfers in certain areas that they have jurisdiction. But, I can tell you the facts. This is a number of complaints that we receive. If we received more complaints we would be more than happy to go out

and investigate them and take what limited sanction ability we have currently to apply.

CHAIRMAN MARGOLIN: So, again, there is somewhat of a gap here, which I again assume is tied in to the way the state law is constructed right now and the way the system is constructed between what is happening in the field of these individual counties because the range of complaints at the county level is far in excess of what you are being asked to investigate on the statewide wide level. And as we work with you next year to try to change this law and toughen this law, we have to look at the complaint process and how these cases come to your attention. The documents you have provided us today gives us very useful data that we'll use in evaluating the need for legislation next year, and we appreciate your testimony. Other questions from the committee. If not, thank you very much, Mr. Keller.

MR. PAUL KELLER: Thank you.

CHAIRMAN MARGOLIN: Our next witness, I believe is Mr. Leary.

MR. LOU LEARY: Good morning, Chairman Margolin, fellow members. My name is Louis D. Leary, I'm the Chief of the Health Planning Session, the Office of Statewide Health Planning and Development. We've been asked by your committee staff to address

a variety of issues related to the topic of patient dumping of the medically indigent. However, to take the consideration of time constraints, I am just going to focus on some of the underlying financial issues that may contribute or help explain the problem. However, I have submitted to committee staff, summary of some surveys that were taken of community health leaders on a region by region basis throughout the state. Today I'd like to focus primarily on a series of charts that have been provided to you that discuss some of the economic issues related to inappropriate transfers.

Those issues are trends in hospital's net profits, trends in hospital capital expenditures, and trends in reductions from gross revenues experienced by hospitals. That is, the sum of provisions for bad debts, charity allowances and contractual adjustments. Now, figure 1 before you shows that as competition and deregulation have been implemented in California, hospital net profits have more than doubled in five years. However, a note of caution is in order.

Figure 2 presents the same data in terms of percentage profit or percentage surplus by individual hospital ownership category. These data show large differences among the ownership categories. Nonprofit hospitals have the highest average net profit, county hospital show a sizable deficit. The trend in capital

expenditure is also important to examine since high net profits can be produced by minimizing those expenditures.

Figure 3 shows that nonprofit, investor-owned and district hospitals have not minimized these expenditures. They have all increased their quarterly, capital expenditures per bed. In contrast, county hospitals quarterly capital expenditures are significantly lower.

Figure 4 displays a comparison of the total deductions from gross revenue among hospital ownership groups. Deductions from revenue include contractual adjustments and disallowances. Provisions for bad debts and charity allowances are also a large part of deduction from revenue. But deductions for county hospitals are nearly twice as high as the other three hospital groups. The annual rate of these deductions, based on the first quarter of 1986, is $5.62 billion dollars. It should be pointed out that in 1983, the year in which California's competition initially was first felt, county hospitals began experiencing a reduction, excuse me, county hospital's deductions from gross revenue continued their historic increase. But, all other hospitals began experiencing a reduction in deductions from revenue.

This data indicates that the burden of uncompensated and undercompensated care was increasingly borne by public hospitals. Presumably, because of the gradual substitution of prospective payment for the cost base reimbursement which reduced private hospital's ability to cost-shift and subsidize undercompensated and uncompensated care. However, 1984-1985 data showed reductions from revenue again increasing for all hospital categories. County hospitals still bear the burden of a disproportionate share of deductions from revenue including uncompensated care. But, it is again, a growing problem for all hospital ownership categories.

A closer look at the county hospitals, Figure 5, shows a continuing large shortfall between total operating expenses and revenue. This shortfall, however, is reduced by the annual state and county appropriations displayed in Figure 6. We've also selected some 1986 data to illustrate county hospital's current disproportionate share of uncompensated services.

Figure 7 shows data on bad debts and charity allowances per discharge by ownership category. County hospitals provide a bad debt and charity dollars per discharge rate, seven times that of the other three hospital ownership groups.

Anecdotally, counties indicate that one of the reasons contributing to the financial status of county hospitals is that they provide an increasingly disproportionate share of Medi-Cal services as well as nearly all the medically indigent adults services. Figure 8 shows a comparison of the Medi-Cal admissions as a percentage of total admissions. Thirty seven percent of the city/county hospital patients in the first quarter of 1986 were Medi-Cal enrollees as compared to 11 to 13% for the other ownership categories. Now, between fiscal years 1980 and 1981 and 1984 to 1985, Medi-Cal admissions in city/county hospitals have increased 1% and in contrast, between those same fiscal years 80-81, and 84-85, Medi-Cal admissions in private nonprofit, district, and investor owned hospitals consistently decreased between 1.5 and 3.0 percent. Also during this time-frame, a large number of Medi-Cal eligibles were transferred to county responsibility through the MIA transfer.

Fiscal comparative data from the first and second quarters of 1986 are available for the four ownership categories. Figure 9 shows that bad debt deductions from revenue are increasing for all hospital ownership categories; 15% overall, 13% for city-county hospitals. However, this comparison may be somewhat misleading since the total deductions from revenue for city/county hospitals are much higher than the average of the three other ownership categories, 40% as compared to 27%.

I have also developed some new data focusing on bad debts, particularly in each hospital category and we've looked at the first two quarters of 1986 and find that the trend in hospital bad debts alone, this is just the component of deductions from revenues, is increasing for city and county hospitals but has remained relatively stable for investor owned, not for profit, and district hospitals. I'm going to hand this graph in if it isn't in your packets.

County hospital profits or surpluses are nonexistent and their capital expenditures are negligible. County hospitals bear a much greater burden of uncompensated and undercompensated care. Although as we previously indicated, the gap between county hospitals and all ownership categories has narrowed since 1984. The trend away from cost based reimbursement in the private hospital sector may be the ability of private hospitals to cost-shift and thus subsidize uncompensated care while continuing to make a profit. This may encourage private hospitals to transfer indigent patients to county facilities, although, as I discussed in the elaborate testimony, it is impossible at this time with state data to link competition with patient dumping or inappropriate patient transfers. Any questions?

CHAIRMAN MARGOLIN: What specifically did your study say about inappropriate transfers or patient dumping?

MR. LOU LEARY: We surveyed individual regions and found that a major complaint in the Central Valley area, which includes Fresno, Bakersfield, and Tulare counties was a lack of inter-county agreements. When a Tulare County hospital treats a patient who lives in Fresno County, Fresno apparently has been reluctant to pay for that patient and that has reduced Tulare County's willingness to get into a reciprocal agreement. There is also some anecdotal evidence of patient dumping as inappropriate transfers between private hospitals and county hospitals in that area. Another area.

CHAIRMAN MARGOLIN: When you say anecdotal evidence, we have had testimony this morning, testimony in hearings in Sacramento, testimony in hearings in both the Assembly and the Senate that's more than anecdotal.

MR. LOU LEARY: Sir, how about survey data, opinion data rather than anecdotal data. It is impossible, using our current data sources and we do collect data on every admission to California hospitals, it is impossible to distinguish clinically inappropriate transfers from the more appropriate transfers and I think everything else is anecdotal, which is probably a pejorative term and probably survey data instead.

CHAIRMAN MARGOLIN: Survey data, well that's a more precise term. We don't have the technical capacity to make that distinction.

MR. LOU LEARY: That's correct. We are working on it, however, and we hope to have that solved in the future. Other areas were reported problems of inter-hospital coordination were in Riverside, San Bernardino, and I believe that you heard attempts to solve that today.

CHAIRMAN MARGOLIN: Any questions from the committee? If not, thank you Mr. Leary.

ASSEMBLYMAN BILL LEONARD: I just have one. Could you elaborate to the Committee on the inter-county transfer problem, that's one that I have experienced in my county also. Mr. Margolin's constituents who ski in my district and get injured. Los Angeles County won't reimburse.

CHAIRMAN MARGOLIN: We're working very hard to increase the level of skill, Mr. Leonard, I can assure you of that.

ASSEMBLYMAN BILL LEONARD: It's the level of reimbursement I'm concerned about.

MR. LOU LEARY: I can list Mr. Margolin as a medically indigent patient. I'm here to talk to you about patients who are eligible for MISP funds who live in Fresno County but are in Tulare County and need care. Tulare County provides the care and tries to get subsidy from Fresno County and Fresno County says no. That was the problem. A similar problem, I understand, exists between Riverside and San Bernardino County, at least in 1987.

ASSEMBLYMAN BILL LEONARD. Thank you. Our San Bernardino and Riverside is split between high growth and rural tourist oriented areas. And, Los Angeles County and its auto accident victims, and people spending the day in the mountains or out in the desert somewhere who do not have any health insurance. They get in an accident and end up being an L.A. County resident and we get no reimbursement. I understand that's a problem. If your data can help give us some sense of how large that is or how we should deal with that? A second question about your tables, on the figure 7 and 8 where do you put U.C. hospitals?

MR. LOU LEARY: We do not consider U.C. County as strictly as a city/county hospital. Three hospitals that have county contracts that are U.C. operated such as U.C. Irvine. They are not separated in this at all? They are considered private, nonprofit.

ASSEMBLYMAN BILL LEONARD: They are in the private-non profit box.

MR. LOU LEARY: Yes, the nonprofit box.

ASSEMBLYMAN BILL LEONARD: Looking at those boxes, that kind of mitigates against their argument that their level of uncompensated care is as great or is greater than the other county hospitals.

MR. LOU LEARY: While I hesitate to make that conclusion because we are only talking about three hospitals. And, I'd have to look at those three hospitals in isolation and I would be glad to as a follow-up committee to provide that information for us.

ASSEMBLYMAN BILL LEONARD: The other U.C. hospitals are also the nonprofit box?

MR. LOU LEARY: That's correct. Just the three that have county contract.

ASSEMBLYMAN BILL LEONARD: I think it might help this committee if you could distinguish them in terms of your information. They have sold the Governor on it. But I think the jury is still out until all the facts in.

CHAIRMAN MARGOLIN: Thank you very much for your testimony. Mr. Hitchcock, Vice President of the California Hospital Association.

DOUG HITCHCOCK: Assemblyman Margolin and members, my name is Doug Hitchcock. As you know, I am Vice President and Counsel for Government Relations for the the California Association of Hospitals and Health System or CAHHS, until two weeks ago the California Hospital Association.

Illegal patient dumping is soundly disapproved by the California hospital industry. As noted in the background paper, the overwhelming percentage of emergency patients whether insured or uninsured received the highest degree of compassion, humanity and skill. CAHHS has and will continue to be supportive of appropriate and carefully considered legislation addressing clinically inappropriate patient transfers.

At the outset, I'd like to distinguish the problem of medically inappropriate transfers, upon which this committee is focusing, from the phenomenon of patient transfers for economic reasons, and state that while they would never condone a clinically inappropriate transfer of a patient which endangers a patient's life or chance for a full recovery, that health funding and coverage mechanisms adopted by both the state of California

and by private entities providing health coverage, necessitate economic transfers. Let me expand just a bit on that.

In those areas of the state where the California Medical Assistance Commission has negotiated inpatient contracts, non-contract hospitals are authorized to provide only emergency services to Medi-Cal patients. As soon as they stabilize the patient and the patient can be transferred without endangering the patient, they require transfer of the patient to a Medi-Cal contract hospital. Most health maintenance organizations and other organizations which restrict choice of providers in exchange for lower rates, also require transfer of their subscribers to a participating hospital when it is clinically appropriate. And those counties which accept transfers of medically indigent patients for whom the county is the provider of last resort have established policies, as you heard today, for the clinically appropriate transfer of patients from noncounty hospitals.

When your bill, Mr. Margolin, was introduced last year, we found ourselves in the position of fully supporting the intent of the bill but having problems with some aspects of the bill. A process of constructive communication and negotiation ensued involving you and your staff and the supporters of the bill and that culminated in CAHHS' being in full support of the bill.

Those discussions focused on a number of issues which California's public and private hospitals agreed had to be addressed to produce legislation which would achieve its desired objective without undesirable and counterproductive side effects. We think we partially achieved that in AB 3403 and appreciate your willingness to work with us on that.

We know the hour is getting late but I'd like to focus briefly on some important attributes of legislation which we think would effectively address the problem of medically inappropriate transfers without counterproductive or unduly burdensome side effects:

First, is recognition of the distinction between transfers for medical reasons, appropriate transfers for financial reasons, and those transfers which endanger patients. We strongly feel that legislation should not attempt to deregulate, influence or burden transfers made for bona fide medical reasons. We also feel that such legislation should as AB 3403 did, at least implicitly acknowledge the appropriateness under current state health policy of proper and appropriate economic transfers and focus on the objective of effectively addressing medically inappropriate transfers which endanger patients.

Second, we think that legislation needs to provide clear standards to hospitals and physicians which take into account the realities and complexities inherent in the provision of emergency medical services. Every requirement of such legislation should take into account the effect it would have on patient care, the economic and human resources which would be expended in complying with and enforcing the requirement, and the importance of the requirement in achieving the objective of the legislation.

We also feel that legislation should avoid creating incentives which could adversely affect either the availability or quality of services. Unnecessary complexity or excessively punitive provisions could, if maladministered, induce some hospitals who are valuable community providers of emergency care to reduce and downgrade services and could potentially affect our ability to provide on-call physicians. The regulatory agency administering the law should be required to take into account matters such as the frequency or gravity of the violation; whether the violation resulted or is likely to result in medical hazard to the patient, whether the violation was knowing or unintentional. In addition, fines imposed by the state should not duplicate federal fines. AB 3403 addressed each of these issues to our satisfaction.

We also think that, as I said before, the legislation should address only the issue of illegal and medically inappropriate transfers. We feel that it should neither, by design nor effect, inhibit medically safe transfers, for financial or medical reasons, nor should the legislation be linked to the issue of county payment for services.

Having made clear we oppose linkage in this legislation between legislation on patient endangering clinically inappropriate transfers and fiscal issues, I have to reiterate our strong concern with the gross underfunding of both the Medi-Cal and the Medically Indigent Services Programs. I had some doubt as to whether to include it in the written testimony. Mr. Leary already alluded to much of that, so I'll just say that Medi-Cal payments to public and private hospitals which have fallen further below the cost of providing care, and unwarranted and unjustifiable cuts in the Medically Indigent Services Program, are directly affecting access to and quality of health care services for California's poor. They have undermined existing arrangements between counties and non-county hospitals for the transfer of medically indigent patients; and they directly threaten the survival and viability of institutions of last and only resort.

In conclusion, we strongly support the objective of the assuring clinically appropriate transfer of patients between hospitals. We appreciate both the opportunity to testify today and to continue to work with you to assure that that objective is achieved in a way that is in the interest of patients and their health care providers. Thank you.

CHAIRMAN MARGOLIN: Thank you, Mr. Hitchcock. It is clear in your testimony and from earlier discussions we've had, that your organization understands that there is a patient dumping problem in the state of California. And your endorsement of AB 3403, I take it, means that you believe that that particular bill incorporates the balanced approach and you think is most appropriate in dealing with the problem - not interfering with the medically necessary transfer, not interfering with other sorts of appropriate transfers, but only dealing with the specific unstabilized patient in need of emergency care. Is that a fair summary ?

DOUG HITCHCOCK: I think in general that's a very fair and accurate summary. There are some aspects of 3403 that because we reached a compromise on it, you and supporters of the bill, I think gave up some things that you'd like to see in the bill and we are living with some things that we were not entirely comfortable with. But on balance, we certainly think that the

focus of 3403, in focusing on the economic transfers, in attempting to provide meaningful standards and guidelines and appropriate remedies is supportable by the hospitals and we do support it.

CHAIRMAN MARGOLIN: As you know, the California Medical Association's primary opposition to 3403 was the absence of the county payment mandate. Could you give us a moment or two's detail on exactly why your organization opposed that mandate and why you thought that mandate was inappropriate?

DOUG HITCHCOCK: We are extremely concerned about the underfunding, as I said of the Medically Indigent Services Program, and concerned about many hospitals, private hospitals, including many who are disproportionate providers of medical care to the poor who not only see inadequate payments from Medi-Cal, but in some cases, no payment for serving medically indigent adults. However, and we think that problem needs to be addressed and that is the highest legislative priority in 1987. However, we do not see that issue as being properly linked to a bill which is narrowly focused on what we think is a limited and real problem of medically inappropriate transfers.

CHAIRMAN MARGOLIN: Wouldn't you have the effect, if we had a mandate, aside from the fact that the state simply, even though I

might like to see that amount of money applied to health care purposes, the reality is the state is not likely to appropriate that amount of additional money to health care purposes. Isn't it also true that existing county health care services, outpatient clinics, other facilities, would be jeopardized if the mandate existed, given the fact that the pie can't increase that much beyond what it is right now?

DOUG HITCHCOCK: Hoping that I won't offend anybody, I think that the 1982 legislation which transferred the medically indigent adults to the counties with the promise of 70% funding of the 1982 budget, in some ways has been characterized, I think accurately, as one of the biggest dumps ever. The counties have not received the funding they expected to receive. They got patients, they got the funding the first year and I hope is not too strong a language to say that the state really, I know that there are pressing decisions that need to be made about how the state allocates its resources, but the state as I understand it, has in a sense reneged on the commitment that was made to the counties in 1982.

The counties are struggling, and as you've heard in previous testimony, under an increasing burden. 60% of uncompensated care in the state is focused in 10% of the facilities. Its an increasing problem for every facility. But, it's especially

focused on county hospitals, children's hospitals, the university hospitals and other disproportionate providers.

CHAIRMAN MARGOLIN: Thank you, Mr. Hitchcock. Any questions? If not, thank you for your testimony. My next witness is Dr. Thomas Horowitz, representing the California Medical Association and the Los Angeles County Medical Association.

DR. THOMAS HOROWITZ: Mr. Chairman and members, I am Tom Horowitz representing both the California Medical Association, sitting behind the white tablecloth, and the L.A. County Medical Association and I appreciate the opportunity to testify on the subject of patient transfers.

First, I want to emphasize that both CMA and LACMA are in strong support of reducing the potential for any illegal or inappropriate hospital transfers of patients to take place in the future. We fully supported the intent in legislation introduced last year and will continue to do so. To this end, we also continue to seek equal access of quality health care to all Californians. As this policy applies to patient transfers, we believe that it can best be accomplished by increasing the protections against illegal and improper transfers of emergency patients, while at the same time reducing some of the major economic factors contributing to the causes of "dumping".

As we see it, the central problem of patient dumping is the fact that insufficient money has been set aside by some counties for the care of the medically indigent while they become ill or injured, and third party payors are also not always owning up to their responsibilities for these patients. For this reason CMA supported the patient transfer legislation which was embodied in Senate Bill 1607, authored by Senator Maddy.

In this bill we faced the real problem squarely. Originally it was mandated that all parties involved in the funding of health care live up to their responsibilities -- whether they were insurers, health maintenance organizations, counties or other insurers. It was a responsibility to approach the patient transfer problem directly. Unfortunately, this approach, as it applies to counties, had to be modified because we realized that when the state transferred responsibility of care to the medically indigent adults from counties in 1982, it granted counties less than 70% of the previous funding. It became a guarantee for problems, and we are seeing the problems now. In final form, SB 1607 contained the following provisions: It established clear guidelines for appropriate transfers of patients who are admitted to hospitals in emergency conditions. It would have established the requirement for third parties which were ultimately responsible for providing emergency services to patients to pay for such services when they were responsible.

Although the bill would not have established a mandate for payment from counties for emergency services rendered to county indigents, it would have established a "maintenance of effort" requirement for those counties which currently pay for such services, and encourage those which didn't to begin as soon as possible.

CHAIRMAN MARGOLIN: Dr. Horowitz, how does that differ from a maintenance of effort standard. I am reading that paragraph as you're speaking it and when you say that it would require those counties that currently pay to continue to pay and then says that those counties that don't pay have to soon begin paying, how does that as a practical matter differ from your original maintenance of effort standard? You're talking about in the end requiring as a mandate that every county in the state of California become the deep pocket for private emergency care. You're doing it in this final version you refer to here in a phased fashion. That was the compromise, I understand. But, the net result of the dollar standpoint is the same. How does that differ?

DR. THOMAS HOROWITZ: It gives it time for rebudgeting, for adjusting. Most important of all, as the old statement goes "there is no free lunch", and there are some counties which are not reimbursing anything. We're running into some problems in our county which I will get to in a bit. Where if this

continues, we're talking a severe shortage of emergency services in some communities. So, we feel this is absolutely necessary.

CHAIRMAN MARGOLIN: Before you continue, I want just one other clarification. When you say here that SB 1607 in its final form contained these provisions, that's not entirely accurate. In its final form, SB 1607 was merged with AB 3403 and Senator Maddy who originally authored your bill joined forces with. Mr. Cate?

GEORGE CATE: Mr. Chairman, George Cate, representing the California Medical Association. I would disagree with that. SB 1607 was not changed, it never was heard in the Assembly Health Committee. You're speaking about another bill, which was SB 1952.

CHAIRMAN MARGOLIN: Correct on a technicality. The bill number stayed the same, but Senator Maddy who authored the bill, became a supporter of a compromise between 1607 and 3403, which is.

GEORGE CATE: We did not.

CHAIRMAN MARGOLIN: Right. But the impression conveyed here is that Senator Maddy continued to support these provisions. I

just wanted to state for the record that Senator Maddy understood the importance of the patient dumping bill and understood the difficulty of the county mandate, which even though you've restructured the way its implemented, still exists in this final form of 1607. Please continue on Dr. Horowitz.

DR. THOMAS HOROWITZ: As you know, last year, Assembly Bill 3403, we did show opposition to. The reasons being we believed that this would most likely result in a worse situation that we currently have. We were concerned of hospitals closing emergency rooms or reducing their levels of services, having problems maintaining on the call lists or that the services would cause many of these changes. Additionally, we were concerned that other counties would join the few which currently do not pay for emergency services we render to county indigents and the net result would be that there would be decreased access to emergency services to all Californians. We feel that the bill did not address the primary economic cause of illegal, inappropriate patient dumpings. It would simply have expanded the basis for determining violations while increasing the penalties for such violations. Furthermore, the protocols and transfer criteria established by the bill were too restrictive and might also prohibit safe transfer of stabilized patients and even prohibit transfer of some patients altogether. Overall, we did not see how the approach contained in the assembly bill would cure the patient dumping problem.

CMA has recently adopted a policy to sponsor legislation similar to SB 1607, the Maddy bill, during the 1987-88 session. The Association stands ready to work with you in addressing, and we hope solving, the real problem associated with the causes of illegal patient dumping.

This concludes the CMA statements. I'd like to bring you up to date on some L.A. County Medical Association work. We have organized an ad-hoc committee for the care of the medically indigents. It is comprised of members from our Emergency Services Committee, some community members at large, and additionally, Hospital Council of Southern California and L.A. County. We're still in our early phases of development. However, we are starting with few assumptions and goals, which we hope we will be able to maintain. We want to maintain an emergency medical system that provides a reasonable level of care for everybody.

We know that we can't work in a vacuum and want to take care of the interest of both the hospitals, the county, insurers, employers, and the community. We know there is a need to have the ability to contract for services between physicians and hospitals and whoever is responsible for the payment because care costs money and without it the system can't work. With no lubrication the grants would stop. We're also working on

developing a good data base for what is really happening in our county. Fortunately with the MAC system we have apparently less problems than some of the areas. The secret is to have a system that has incentives for hospitals and physicians to provide the care. To merely put an ax over the head with no incentive is an unbalanced approach. As Newton put it, for every action there is an equal that offers a reaction. If you have an action with nothing in it for the people affected by it, there can be reactions which are not necessarily what we want. The idea is a balanced piece of legislation, which is a a give and take from both sides rather than a give on one side and take on the other. Any questions?

CHAIRMAN MARGOLIN: Yes, Dr. Horowitz. I'd like to first of all indicate that on the question of financing indigent care, I've certainly worked along with members of this committee to do all we possibly can to put more money into county health services, to put more money directly into Medi-Cal reimbursement. We are doing all we can in that area and it's a struggle. It's difficult. No simple solution to it. So we have that issue to deal with. At the same time we have this question of patient dumping. Of someone who comes into a hospital emergency room in an unstabilized condition with a life-threatening wound being turned away because they lack proof of insurance. To me they are while linked in one respect, separate questions.

And they are separate in the sense that I don't see how the California Medical Association or the L.A. County Medical Association can countenance during the period of time we are working on the larger funding question, the continuance of that practice, whether it applies to 50 cases or 500 cases. Do you believe Dr. Horowitz that the Hippocratic oath requires, absolutely requires, that a doctor respond to an emergency?

DR. THOMAS HOROWITZ: No, as I said, my feeling is when you find inappropriate physician behavior, it is not necessarily something that should go to that type of action. To me that is something that should be reported to BOMQA. There is a reason to evaluate how could a physician make a decision. When I heard a story of a knifewound to a chest, that is well documented.

CHAIRMAN MARGOLIN: Well, that's exactly Dr. Horowitz what this bill in its amended form would do. We in response.

DR. THOMAS HOROWITZ: And as I said, we totally, totally agree. If you find....

CHAIRMAN MARGOLIN: But you want the money first. That is what comes down to. The guarantee of payment first. My question is that the physician has the obligation to treat the unstabilized person. We agree. Why then are you insisting on

absolute guarantee of payment through the statewide system, something we'd like to all provide you with and working to provide you with, but why do you insist as a precondition to effective penalties for that behavior the absolute guarantee of payments? And I was trying to point out a moment ago that as part of the negotiation with California Medical Association, we gave BMQA the authority to rule on physician behavior. We also gave them the civil penalty which they don't currently have for this particular activity. But, if you can focus on the question I've raised, why is the commitment of dollars a precondition to guaranteeing that every emergency room patient is properly cared for?

DR. THOMAS HOROWITZ: It is sort of like if someone comes to me and says doctor I have this disease, treat it, but I don't want to take any medicine, I don't want any surgery, but if you're a good doctor you'll take care of me anyway. If you tie hands, if you don't give the tools to work with, it's not going to work. And, our concern is, without there being some intent, that if there is not a light at the end of the tunnel to speak, if the hospitals aren't sure, the physicians aren't sure, the answer may be we can't provide services in communities. Right now there is one central Los Angeles hospital, running about 1/3 medically indigent patients. They can't function that way. If they're not relieved everything is going to go to L.A. County or

Martin Luther King. A lot of miles. They've even downgraded from a trauma system. It didn't work. What is happening to the paramedics who see a guy bleeding in the back. They are going there. It is the closest.

CHAIRMAN MARGOLIN: Dr. Horowitz, with all due respect, you are talking around the issue. We're in agreement, that that hospital in South Central needs more funding. We need to work to get them more funding and keep them in operation. In the meantime, if they have a licensed emergency room, under the terms of their license they are mandated to care for people who come in unstabilized. In the few cases where that isn't happening the position of your organization is a civil penalty is inappropriate because it is a meat ax. Well, if the meat ax or the ax is there to obligate or to encourage or guarantee that a health care professional does what they are licensed to do and what the law requires them to do then that's what those kinds of laws are constructed for.

And I'd like to get a response to the specifics of under what circumstances should emergency room physician or an on-call physician be allowed the discretion not to come in and deal with a life-threatening emergency?

DR. THOMAS HOROWITZ: No, as I said, we are totally in agreement, you know, our first concern is quality of care.

CHAIRMAN MARGOLIN: Seems to me your first concern is the guarantee of reimbursement.

DR. THOMAS HOROWITZ: No. As I said, our first concern is the quality of care. However, if we're going to get legislation, as I said, if someone comes in as we're saying we don't want red sticker legislation and blue sticker legislation. Let's do good diagnostic work, let's not just put a band-aid on this problem, let's attack it. Let's take this aggressively. Let's keep working and grind it out and find an answer - not just put a band-aid on it.

CHAIRMAN MARGOLIN: Dr. Horowitz, we are trying to do that. In the meantime, if you're an indigent in L.A. County or in San Bernardino County or in Marin County or Alameda County and you go to an emergency room after an auto accident. You're taken there, you've got a severed artery or some other major internal injury or bleeding and there is a call placed to the surgeon who is on call, whose skills are needed to save your lives, under what possible set of circumstances can you justify, regardless of what problems we have with the larger financing of the system - that surgeon is signed up to be on call, not come in and do the surgery?

DR. THOMAS HOROWITZ: There is none. That is his responsibility.

CHAIRMAN MARGOLIN: Then why don't you, why doesn't your organization support the civil penalty as the final guarantee that that physician and surgeon is going to perform their obligation?

GEORGE CATE: Mr. Chairman, Dr. Horowitz was not as close to the policy decisions made by CMA. We had him as a witness today because of his involvement in this task force in Los Angeles County. But, I can stipulate to you, that CMA's policy is and has always been that we think we ought to deal with the problem and the causes of dumping. We do not believe that your proposal does that. We know that the causes of economic dumping are economic and that's why we are trying to solve those problems.

CHAIRMAN MARGOLIN: So, therefore, because we are underreimbursed.

GEORGE CATE: If you just go forward with your proposal, the chances of ever solving the economic problems are lessened.

CHAIRMAN MARGOLIN: I don't believe it. When you say the cause, let's talk about cause and effect. If the cause is

undercompensation, then of course, the effect is on that on-call physician who because he or she is guaranteed less compensation, he or she is choosing not to come in and do that service. Now, I can see us disagreeing, struggling over how we best fund the needs of that on-call physician on that hospital. But I don't under - that the causes...

GEORGE CATE: Let me explain to you what our policy is based on.

CHAIRMAN MARGOLIN: Yes, please do.

GEORGE CATE: Our policy on your bill, AB 3403 of last year, with just the penalty provisions, nothing to deal with the causes as we see them was to oppose that. The reasoning was that if your bill was passed, emergency rooms are going to have to close because the on-call lists are going to shrink. Physicians will with the added penalties and nothing to address the problem at hand are going to remove their names from on call list.

CHAIRMAN MARGOLIN: Two points, Mr. Cate. When I met with the leadership of your organization and that horror story scare of emergency rooms closing was raised, we talked about the state case of Texas where they recently passed legislation requiring up to ten years in prison for serious acts of this sort of patient

dumping, where injury occurs. Far more draconian, far more serious than what we have here in California. We are only guaranteeing that emergency rooms will do what they're licensed to do. And I asked your organization to provide me with examples of emergency rooms closing in Texas and I didn't receive any research that revealed a single example of that, point one.

Point two, Mr. Cate, said the final compromise version of this bill, that Senator Maddy and I together introduced and supported on the floor of the State Senate, which you vigorously opposed and your organization help to kill, we put $25 million in new funding for uncompensated care that would come from a new source - penalty assessments, $25 million dollars of new funding, and even though I didn't want to link the two issues, we looked at the fiscal realities of state government and with Senator Maddy's support and innovation, we got the new source and even with $25 million of new guaranteed funds, which I was fearful the Governor would have vetoed if it got into his desk because of the size of that funding, you still adamantly opposed it. So, if you think the issue is linking money to the penalties, why weren't you in support of the final Maddy/Margolin compromise which did exactly that?

GEORGE CATE: We did not support that because it did not contain any requirements on those counties, the worst problems in

this state. It was not even a maintenance of effort on those counties on those counties that currently pay. It felt far short of addressing our most serious problem.

CHAIRMAN MARGOLIN: So, until $100 or $200 million dollars of new state money is somehow freed up which, again, I'd like very much to do, if it was in my power to do that, until that money is freed up, you're willing to say that an on-call surgeon who receives a call from his emergency room indicating that someone is there in critical condition, that that on-call surgeon can continue to have the discretion to go in or not go in to do that surgery and save that person's life. That's what this really is about, Mr. Cate, in the end.

DR. THOMAS HOROWITZ: The big issue here is that that person is already acting in an inappropriate and unethical fashion. The hospital staff should deal with it, the State Department of Health Services will deal with it. They are not doing it because it is o.k. to do it. It is inappropriate, but they shouldn't be doing it, and we already have tools to go after them.

CHAIRMAN MARGOLIN: If you listen to the Department of Health Services' testimony today, they don't have adequate tools to deal with the problem. That's made extremely clear from their testimony. Testimony over the last year. And, if again, your

commitment was really there to seeing the practice end, I would think, I thought a year ago you'd be cosponsors of the bill to create civil penalties.

GEORGE CATE: Mr. Chairman, I think and we have thought from the C.M.A. standpoint, that the best way to do this is in a joint effort of all parties concerned to address the problem, the cause of the problems. If we had that instead of doing the battle that we did last year over your bill and Maddy's bill and we all focused on doing battle with the Administration we might have been successful, and we may be this year.

CHAIRMAN MARGOLIN: Mr. Cate, with all due respects to the California Medical Association, we have in the State of California a joint collective effort, however you want to phrase it. We had the California Hospital Association in support of the bill. We had the Emergency Room Physicians remove their opposition. We had every source of opposition to the final approach to this bill removed with only the California Medical Association as the only major organization in California opposed to it. And, again, we tried to meet you more than half way with new funding. And, again, what is clear to me and I was hoping I'd hear something different in the testimony today is that your bottom line position is still "we want not just $25 or $40 or $50 million dollars, we want the full $200 million dollars up-front

in cash, so to speak, before we are prepared to allow a bill to go forward that establishes sanctions on our members", sanctions designed to have them in effect do what the Hippocratic oath, demands they do, anyway.

GEORGE CATE: My response to that would be what we want to do is address the cause of the problem before we make it worse. Your bill, in our opinion, will make it worse.

CHAIRMAN MARGOLIN: There is no evidence of that, Mr. Cate, that penalties on physicians who engage in this kind of heinous behavior will make it worse. If, Mr. Horowitz, if Dr. Horowitz' point was accurate that we had the tools right now, then we wouldn't have this problem. We don't have adequate tools. That's why we've had this fight for the past year and why other organizations like the California Hospital Association have endorsed this approach and I find the CMA entrenchment on this issue puzzling and not understandable. Mr. Hill.

ASSEMBLYMAN FRANK HILL: I hate to interrupt. I thought you were getting close to a compromise. It seems to me that essentially CMA's argument is, which I, because of my problems with the first draft of AB 3403 endorsed. I think, essentially, your argument, is you want to deal with the big picture, we don't want to let any pressure off the tea kettle. We want to deal

with the whole cause, the economic big picture. Maybe that's a $200 million dollar problem.

Another critical reality of the state, an economic reality of the state, and that is that we have got a Gann limit problem facing the state that essentially says we may have as much as $2 billion dollars of money in the state that we legally cannot spend. The Governor who has just been reelected says he is opposed to changing the Gann limits. I know the Republican caucus philosophically is opposed to changing that Gann structure. It seems to me there still may be some creative ways that deal with that $2 billion dollar surplus outside the preview of the Gann limit. My instincts tell me that's what is going to happen is that all state government spending that runs up against the Gann limits, that basically everything is on hold. For us to pass a bill that cost $200 million dollars, it literally means now we have to take that money from somebody else. And I don't think politically that's going to happen. Has the CMA looked at the idea on the income side of the equation, of coming up with tax credits for physicians and for hospitals. That may still cost the state $200 million dollars but in effect it is $200 million of less revenue coming in the state, thereby not counting against the Gann-limit amount and also at the same time not taking that money from somebody else.

GEORGE CATE: Yes, Mr. Hill. We have looked at that. We have asked through a legislator for the Legislative Analyst's office to come up with a proposal that could possibly work and address that in a fashion. It was in relation to Medi-Cal, and some kind of a tax benefit in lieu of increasing reimbursement rates or even in lieu of billing the program. Unfortunately, due to the fact that the state's maximum tax bracket which is 11% or 10% with corporations, there is not enough room there. The only way you can really make any tax.

ASSEMBLYMAN FRANK HILL: Not enough room there. You mean the physicians aren't paying enough in taxes to where we could really help them that much?

GEORGE CATE: The problem is that you have to go to a tax credit rather than just a write-off in order for it to be meaningful and then the state loss revenues. And the loss of revenues is something that no one would go along with.

ASSEMBLYMAN FRANK HILL: Well, I understand that and I am firmly in support of a tax credit versus a deduction concept. My point is that the political dynamics, I think and the economic dynamics have dramatically changed from a year ago and two years ago, and that is that I think the state is going to have much less concern in terms of less revenue. If it doesn't have

revenue, we can't spend any more money than we got already. So, if the Governor at one point last year was concerned about $100 million dollars on a bill I was very interested in on child care, it seems to me the dynamics change if you got $2 billion dollars legally that you can't spend. We have to return it to the tax payers, so my instincts tell me we probably send everybody an extra $18 which doesn't amount to anything, it doesn't mean anything to anybody. The fact that we're up against that Gann limit now for the first time in this budget year dramatically changes that whole equation. Why should we care if we have $100 million less revenues coming in the state because we can't spend it any way. And I think the whole tax credit concept becomes a lot more viable than a year a or two ago.

CATE: The problem with that is that at the same time, the size and the magnitude of the problem of facing uncompensated care is also growing and we don't just have a $200 million program. We have a billion and a half to two and half billion dollar problem. As Dr. Bedard mentioned earlier, our major effort this year is going into looking at all aspects of uncompensated care and the county involvement or the dumping is only one small piece of that.

HILL: I appreciate that, but I still think that with the potential of $2 billion dollars of money that we can't spend, there ought to be some very innovative ways to.

GEORGE CATE: We are looking at all options, including those that you have raised.

CHAIRMAN MARGOLIN: I think Mr. Hill has raised an important point. It is a new ball game in Sacramento. As we look at the funding issue in the coming months, we need to look at the tax credit option, innovative approaches to that including the dynamic never before experienced in the state. If there are no further questions from the committee, we thank you for your testimony. We appreciate your coming today. Our next witness, we only have two other witnesses on the schedule so if you can bear with us for a few more minutes, is Cheryl Gelder-Kogen, Research Director for the California Association of Public Hospitals.

CHERYL GELDER-KOGEN: Thank you Mr. Chairman. We appreciate the opportunity to testify today and in the interest of time I'll attempt to summarize.

I've given you some written testimony. First, I do want to commend you and your staff for all of the efforts and leadership you have shown in the patient dumping issue, particularly with respect to AB 3403. We really believe that you have worked and been quite reasonable in your accommodation of the concerns of the California Hospital Association and other parties and the

accords that were reached were for the most part sensible and responsible with respect to both the needs of the patient and the hospitals.

Very briefly, we'd like to address two subjects of relevance to this legislation. First, I'd like to summarize what we know about the scope of the problem and outline our plan to supplement that information with a survey of our membership over the next few months.

Secondly, I'd like to review some newly available new data and I will summarize that. Some of that was already mentioned by Lou Leary and Doug Hitchcock. I'd also like to briefly go over some results of the National Association of Public Hospitals' survey of patient transfers which identified over a thousand transfer patients in 26 hospitals located in 12 different states over a month long period.

47% of those transfer patients were self-pay, 13 were Medicaid recipients, 13.4% had private insurance and 11% were Medicare beneficiaries. 72 1/2% of those transfer patients required emergency care. 15% of those patients arrived in the hospital with no paper work - a strong indication that there had been no contact between the sending and receiving institution. We infer from this data that it's that small group of transfers

that constitutes the problem which needs to be addressed and which is addressed in your bill, AB 3403. We really believe that the data in the National Association of Public Hospital survey as well as that survey conducted by San Bernardino County Medical Center demonstrates that the majority of transfers, while they may in fact be due to economic situations of the patients and pressures on providers, are deemed proper transfers by our hospitals. It's that small group of clinically unstable transfers and those where proper protocols were not followed, that we believe has to be addressed.

We are quite sympathetic with the pressures that are being placed on public and private providers alike and in competitive market place in California, and while we had opposed the fundamental shift to a competitive approach, and instead wanted a more rational but aggressive approach designed and implemented, our preferences were not heeded and we believe that the forces that have been unleashed pointing specifically to the Medicare reimbursement system and the less than generous Medi-Cal contracting systems have put substantial pressures on all providers.

And in addition to these forces, private payors are arguing aggressively for similarly discounted fee arrangements. These private payor dynamics are having a vastly broader impact on the

private provider facilities than on public providers and in addition, the 1982 transfer of the MIAs as you know has contributed significantly to the underfunding of public provider systems and to some relatively modest increases in the bad debt and charity care provided in the private sector.

We've been relatively successful in helping the private hospital community to understand the relative contribution of emergency care to former MIAs in the context of the overall financial pressures in the industry. Unfortunately, we haven't been quite as successful with the physician community which has been less cognizant or interested in these facts.

Because of the importance that county payment for private sector losses played in the debate of AB 3403, we feel it is important to take this opportunity to set the record straight regarding the role of potentially MIA related losses in the scheme of private sector health economics. There is a table in the testimony which I gave you which adjusts data, shows the care adjusted in 1981-82 constant dollars, going from a fiscal 81-82 to fiscal 84-85. I believe that, as you can see here, counties increased their burden of bad debt and charity care during that time period 172.7%. Non-profits increased their burden by almost 37%, investor owned by a little more than 24%, and districts by 20.6%. The total of private, that is non-county bad debt charity

care constituting less than 25% of the total statewide increased burden. While this increase burden is considerable, it is important to note that the increases in both absolute dollars and percentages paled beside increased losses from other sources.

For example, using reported figures, private hospitals' Medicare losses have increased no less than $957 million dollars or 90.3% during that time period. Medi-Cal losses have increased 86% and other allowances, presumably attributable to private sector discounts, have gone up 105%. Using unadjusted bad debt and charity care figures they show that the private increase in bad debt and charity care constitutes only 13.3% of $1.6 billion dollars in total private reported losses. It is important to note here that after allowing for all of these losses, private facilities have continued to report an increasing level of net income from $486 million in 1981-82 to $961 million in 1984-85.

We believe that many other dynamics other than the transfer have contributed to these patterns, most notably the declining coverage of dependents and other private employer reductions. At the same time that there has been a 40% increase in the number of unsponsored, uninsured patients nationwide. I noted above the uncompensated care burden contributes only approximately 13% of the overall new underfunding burden on California's private facilities.

We are still uncertain as to how private providers feel that they can right a massive health care financing dilemma by turning to counties to assume the deep-pocket role to compensate for the pressures posed by many of the payor dynamics confronting all of us. We think it would be better to divide these complex financial issues from the single and narrow issue addressed by AB 3403. In addition, we welcome the opportunity to work with all segments of the legislature, the providers and consumer community for more adequate financing of existing programs to develop a new revenue stream or a new revenue stream that can assure maintenance of our societal goals and fairness and justice in the context of the new health care business climate.

In summary, we are anxious to help you in any way we can to insure passage of AB 3403 in the coming session. We will be attempting to improve the information base by a survey which we will conduct of our membership over the next few months. Some of that will be modeled and coordinated with the surveys conducted by San Bernardino County Medical Center. We're hopeful that all elements of the private provider community will come to appreciate a more complete assessment of the financing problems besetting the industry. We hope that cooperation between all of the providers who are concerned about protection of the public from some of the potential down side risks of competition can work together to insure the availability of an adequate level of

humane care for all. Obviously, we have many further tasks in assuring more equitable payment programs. However, the current lack of knowledge about the demographics of the population as well the complexities imposed by the Gann expenditure limits will no doubt insure that a more comprehensive solution is not immediately forthcoming. Therefore, the least we can do in the short term is to ensure a minimum of patient care - while we work aggressively and collectively together to develop an advocate for more sound planning of policies.

CHAIRMAN MARGOLIN: Just one question for you, briefly. Have you been able to sit down with the California Medical Association and make any progress at all in working out an accommodation? As you can see I haven't had much luck myself this morning.

CHERYL GELDER-KOGEN: No, we haven't, but we will be happy to sit with you.

CHAIRMAN MARGOLIN: O.K. we hope we'll have more sessions like that. And if there are no further questions, thank you very much for your testimony. The final witness for this morning is Vicki Mayster, Director S.O.S. Free Medical Clinic, Costa Mesa.

VICKI MAYSTER: Good afternoon. I direct the S.O.S., which stands for Share Our Selves free medical clinic in Orange County

in Costa Mesa. We're a clinic that's been open just about a year-and-a-half, and we opened exclusively because of some of the problems you are talking about today. Patients who could receive care nowhere else, who were being turned away from all other services and going without needed medical care and we're staffed by an all-volunteer staff of physicians, nurses, receptionists, interpreters, laboratory technicians, and are seeing a growing patient load each month. I work now as the Director of the clinic but also the advocate for the patients that are trying to get active medical care, especially for those patients who cannot be served at our clinic and need further more specialty, more advanced care.

One of the main trends that I have been seeing, especially in working with local hospitals and patients that need hospital care is that there seems to be emerging a more and more restrictive definition of the word emergency in terms of emergency room care. The type of examples of patients that we've had and we have had who have come to us who have been turned away from hospital emergency rooms for lack of coverage have been patients with broken bones, that's probably one of our most common, and impacted, infected teeth. There was a man who came to us with four impacted, two infected teeth, could find nowhere to get taken care of. The local MIA funding approval period was three to four weeks and his teeth were impacted and infected now. He

had no way to get care. Patients who have symptoms of vomiting blood, difficulty breathing, gallstones, severe pain, and the list could go on and on.

Another problem we see very regularly are those problems that are not life and death emergencies right now but may well be fatal in the future: cancer, for example. In a recent study done at U.C.I. Medical Center by an organization called the Orange County Task Force on Indigent Medical Care, we documented patients who were turned down for care because, turned away both by the hospital and the local funding program such as Medi-Cal and the MIA Program. Problems were documented such as cervical cancer. It wasn't an emergency yet, but it sure would be down the line. Breast cancer, possible breast cancer and tumors, treatment had been delayed several months due to some of the approval procedures of the MIA Program in our county. So, we really see a blurring definition of what it means to have an emergency. The way I read the law most of the patients that I mentioned have emergency problems. Their bodily organs and bodily functions can be impaired if this treatment is not received. But that is not the way the term is defined by many, many of our local hospitals.

Another area in which we find real problems for patients are those people that need follow-up visits after they have been to

the emergency room and our most readily available example is that of casts. The patients will get a cast put on in an emergency room. They come back for a followup visit. Sometimes they get one without a deposit but if they ever have to come back again they owe a large deposit up front in many cases. And, we've had cases of children walk around with casts on because no one will take them off - because they didn't have the $75 to get back into the hospital clinic or the private doctor that they were referred out to.

Certainly, my feeling is that part of the problem comes from the fact that our MIA Program in the county really concentrates more on emergency care than outpatient care. There are many low-income areas in our county where it is virtually impossible to find outpatient care without an approval letter from the MIA funding source. And even with some recent changes in the system it still takes close to three weeks to get that. So with our patients that come to us with congestive heart failure, diabetes, they need medication, they need insulin, tumors - three weeks can really make a difference. So, we are put in a position of watching a patient's condition deteriorate to the point that maybe in three weeks they will indeed be able to qualify as a true life or death emergency. But right now they can't get care.

I have run into situations recently regarding Medi-Cal funding reimbursement and hospital problems. Just last month I worked with a 54 year old woman who has gallstones and was in severe pain and we had a specialist at our facility evaluate her, sent her to an emergency room, which was a Medi-Cal contract facility. At that point she was unfunded, and they said she hadn't "blocked" yet. It wasn't life or death. She hadn't turned jaundiced, turned yellow, so she was given a shot of Demerol and sent home. This happened four times. She went to the Emergency Room with severe pain, was on her third vial of Tylenol and Codeine and her second or third shot of Demerol. No one would see her or admit her because she was unfunded. She was able to get emergency Medi-Cal stickers, and I thought great we've got the problem solved. The hospital still would not admit her until they received a written authorization from Medi-Cal which took an additional 15 days to get. I spoke with the Director of the hospital who would not take a verbal authorization from Medi-Cal because he was afraid that that would not hold up for funding or reimbursement. So, the woman was made to wait another 15 days during which time she finally blocked and was admitted to the hospital. They found that she also had kidney stone problems and over a period of another 30 to 40 days she finally got the kidney stone taken care of and the gallstones taken care of. But it took her a two month wait and severe pain, even with Medi-Cal for her to get that type of surgery done.

I also question how many of the patients that come to us are turned away from emergency room hospitals really get the type of medical evaluation they need. Most of our patients state that they are turned away by the person at the front desk. Hardly ever do they state they have been by a doctor and I am really not aware if that front desk is staffed by a nurse at all times or not. But I sometimes get the feeling that a patient really has not been evaluated and they are just told " here are some addresses - go down the street - they can see you and they are free and we are going to charge you money so you go down there."

Basically, the stories I have to tell comes from the front lines and I do see the problem not being much better. In fact, in many ways, it is worsening. Especially as health care dollars tighten and as the financial situation in some hospitals becomes tighter.

CHAIRMAN MARGOLIN: Thank you very much for your testimony. We appreciate your coming here today. We've run a little bit over on our allotted time but again we want to thank everyone who came here today to participate in this hearing, members of the committee who came as well. We've developed quite a bit of new information that we'll use in our deliberations on the emergency transfer issue next year and, again, this has been a very constructive hearing. Thank you for your participation.