

24. More MediCal

Henry: Last time I was talking about my being head of something called the “surveillance unit”, which had the responsibility to analyze the performance of a program called MediCal in this state; in all the other states I think it’s called Medicaid, which was passed in 1965 by the Congress, at the same time that it passed the Medicare program. Each state had a responsibility for administering the Medicaid portion of the total package, whereas it was uniform in all the states when it came to Medicare.

There was a tussle between the CA dept. of social welfare and the state dept. of public health as to how the responsibilities would be divided for running the MediCal program. The leader of the public health dept. at that time was a man named Lester Breslow, who I knew fairly well since he had been one of my advisors when I was with the University doing the bracero study. I had a very high opinion of his abilities, but for some reason he ended up with a very small fraction of the total responsibility for MediCal. The social welfare dept. got about 95% of the pie, I suppose because of its experience with handling means-testing programs, as they call it in the trade, whereas the public health dept. didn’t. They knew all about establishing people’s eligibility for a program in which everything depended at first upon whether they could afford to pay or not.

In any event, after the dust settled the program went into effect in this state in Jan of 1966, and it took a while for the welfare dept. to draw up the forms that would be used when the providers of services started submitting claims, and all those kinds of administrative details. I might add the health dept. didn’t know what the welfare dept. was doing, even though we might have had some thoughts about how to design these claim forms, when it came to information about the diagnoses and the qualifications of the provider of service, and so on. But in the due course of time, claims started flowing in from the providers of service of all kinds. This was very broad program. The whole idea was that it would abolish any difference between the type and quality of health services that were being provided to the people with low incomes and those that people with higher incomes were enjoying all along.

Doctors, for example, were specifically informed that they were allowed to charge this new program their “usual and customary fees”. That was certainly something new under the sun, because in the past physicians services to people on welfare were essentially available only at county hospitals and clinics, where the doctors were working salary rather than for fees.

After the provider of service had a bill to submit, they sent it to the social welfare dept. in Sacramento, and it would look at the recipient to make sure it was eligible for participation in the program, having filled out whatever forms were necessary to establish its resources, and then the welfare dept. passed this claim along to what they called a “fiscal intermediary”. The welfare dept. itself didn’t write the checks. The fiscal intermediaries consisted of the Blue Cross program paying individual vendors, and the Blue Shield program – I think was actually called the CA Physicians Service – would handle the providers of institutional services – hospitals, nursing homes, and so forth. They’d write the checks, and the resulting information would be sent in

the form of tapes, by way of the welfare dept., to the “bureau of tabulation services”, I think, was the name of the bureau within the public health dept. that did data processing.

The fact that they called it the Tabulation Unit, I thought, gave some indication of how far behind the times they were, because they did a great deal more than just running off tables, which is all that they had been able to do in the old days when everything was done by hand, and when I started everything was done by IBM punch cards. By this time the health dept. had quite a state-of-the-art computer, I think, I don’t know that much about the history of computers, but I think they had a pretty good one, and they could have looked at these tapes in various ways, if we had known enough about the potentialities to take full advantage of them. It was all very new to everybody else in the surveillance unit, including myself.

So we had a meeting in I guess March of 66, when these tapes started coming in from Sacramento, a meeting between the assistant director of the dept., a doctor named Robert Day, and the head of the whole medical care studies unit, who was another public health physician, who had formerly been in private practice, so he knew a lot about clinical medicine, and I was the head of surveillance unit. We had to decide among ourselves what was meant by the term “surveillance”. There had never been anything like it before. And somehow the term had occurred, I guess, to the assistant director, Robert Day, that our principal function, at least at the beginning, was something known as “overutilization by vendors”. The term “vendors” itself to me seemed rather curious, because it evoked images of their standing on street corners and selling whatever they had to offer. I think it would have been more professional if they had been called “providers” or something more neutral.

So we just had to dream up some rather crude measurements of so-called overutilization, and I believe I mentioned some of these last time we talked, such as the number of services, the average number per patient, and to some extent the types of services and as I said before, there was a lot of overutilization, including such things as routine injections given to every patient with every visit – at least they claimed they had done so – and sometimes there would be claims of routine chest X-rays for everybody who walked in the door. These raised red flags, we thought, and so we began getting tapes with identification of the license numbers of the doctors who fell into these extreme outlying rates of utilization. When we got these numbers we would then request more detailed printouts of 15 or 20 of the most extreme outliers, in various categories, and subject them to even more detailed examination, such as the location of their practice, and their education, whether they were specialists or GPs, and so on.

In a number of cases we were able to find that there was a rational explanation. For example, there are some specialties in which it is common for them to see a patient once a week for some extended period of time – I think that’s true for specialists in the field of allergies, for example, and in the field of mental health, psychiatrists see a patient every week, commonly. So we wouldn’t subject them to further scrutiny. But there were always a number of cases in which it seemed to us that the pattern of practice could not be rationally explained, other than that the vendor was taking advantage of the system, and we sent that person’s name and ID# and a write-up of the reasons for our thinking that they should be scrutinized, sent that to the dept. of social welfare, which if anybody had the right and indeed the responsibility of making

sure that fraud was not taking place, the fiscal intermediaries didn't have the responsibility of this portion of their activities. The Blue Shield and Blue Cross plans, of course, had a lot of private health insurance plans that they administered, and at least in theory they were responsible for seeing that the vendors in those programs weren't cheating. But that's another story.

Well, it was a great frustration to us that the social welfare dept. apparently never did anything about these curious anomalies, and we began writing up increasingly explicit and ironic, almost deliberately humorous, explanations of what thought these people were getting away with.

In Nov. of 1966 an event took place which eventually proved to have a great deal to do with the participation of the public health dept in the MediCal program, and a very great deal to do with my career, and that was the gubernatorial election between the incumbent, Edmund G. Brown, commonly known as Pat Brown, the father of the present governor Brown. Pat Brown was running for a third term, having won overwhelmingly twice before, but this time he was running against Ronald Reagan, who was venturing into politics for his first time, and he was something of a joke among a lot of Democrats. They didn't think that anyone with no experience whatever had a chance against an extremely experienced politician who had a well-oiled political machine. But as a matter of fact, Reagan won very handily.

Everything went along for a while very much as it had. In Jan of 67 the surveillance unit in the public health dept. moved from an adjunct office building on Shattuck Ave to the main public health building on Berkeley Way, and for the first time I had a private office, which I suppose gave me a certain cachet. It wasn't completely private because it had a door with a window in it, a clear glass window, but it was nice in some ways.

I had two clerks working under me to start with, but as time went by we found more and more suspicious-looking claims, vendors with suspicious-looking patterns of practice, and so I think eventually I ended up with 4 or 5 clerks working under me. I got along well with all of them, mostly, but there was one woman who seemed to take a dislike to me, and I didn't know why. But I think it may have had something to do with the fact that her father was a physician in practice in San Francisco, who was in some exalted specialty, I think he might have been a surgeon of some kind, and his daughter probably thought I was being too suspicious of physicians in general, and she might have been right. I certainly didn't try to be blatant about it. I always thought that the medical profession itself ought to care more than anyone else about bad apples within their own barrel, because it tended to bring the whole thing into disrepute.

In any event, I began to think that we were placing too much emphasis, in fact we were placing sole emphasis, upon this phrase "overutilization by vendors". I thought a really mature concept of surveillance would include the quality of care as well as the quantity of care, and in theory at least it should have been possible to take advantage of the raw data that was on these tapes, to look at the relationship between diagnoses and the treatment that was given – was this an appropriate relationship, given the best quality available. It would have required accuracy in diagnosis. There was no doubt about – in some cases there probably should have been doubt about accuracy of the service rendered – but there was no doubt in my mind that there was

inaccuracy in diagnosis also, and I thought that in some cases when a diagnosis seemed clearly to be in error, that it would have been appropriate to instruct the social welfare dept., or the fiscal intermediary, to withhold payment until that were cleared up. Well, this never happened.

I also took it upon myself to talk to persons in the Blue Cross and Blue Shield plans about statistical analyses that they have done, to look for the possibility of fraud within their private health insurance plans, and there was usually somebody, sometimes even a department, within the overall structure, which had the wherewithal to do research analogous to surveillance, and I finally found a key person, who might have been able to help me out with suggestions as to the kinds of things that we might look for in our surveillance efforts, but I was surprised to find that they didn't have anything of the sort that I thought they should have, because it made some difference in the kind of rates that they'd be able to charge for premiums of the private health insurance plans, if they were to root out waste, fraud, and abuse, as the unholy trilogy always had it.

But I was quite surprised to learn that they did little if anything of this sort. It's almost as though they felt it was OK to accept some waste, fraud, and abuse, in order to stay on the good side of the vendors. This was certainly the attitude of the social welfare dept. They were deathly afraid that people in the fields of medicine and dentistry and eye care and podiatry and so on would simply stop cooperating with the program, and wouldn't accept MediCal recipients at all, unless one stayed on their good side.

So we just had to continue pretty much without any suggestions from other providers of large-scale health plans until the day came that the election of Ronald Reagan began to have unintended consequences – I'm sure he intended them, but we certainly didn't anticipate them. Reagan began to talk about what he called "fundamental philosophical differences" between himself and the director of the health dept., Dr. Breslow, and this got into the newspapers. We would ask Breslow, I guess the reporters also used to ask him, what these philosophical differences might be, and Breslow said he had no idea, that the governor had never talked to him about it.

But for one thing, Reagan had the idea that all of the health functions of government ought to be administratively located in Sacramento, as well as the welfare functions and other broad departments of the state government. He wanted to have them all close to where he was able to keep an eye on what they were doing; I guess that was the theory. And so along about Sept of 1967 there was a radical shakeup, and most of the functions of the state health dept. were ordered to relocate in Sacramento. A few were allowed to remain elsewhere because they didn't have the equipment. For example, there was a branch of the health dept. called the Division of Laboratories, and they were allowed to stay in Berkeley, but those of us who worked with the data were told that studies of the Medical program, if any, were to be relocated, including the surveillance unit.

I assumed that I would be allowed to retain my position if I were willing to move to Sacramento, or if I were willing to commute between Berkeley and Sacramento (which in fact a

good many of the people in the health dept were willing to do; it can be done in about an hour each way, if you exceed the speed limit by a judicious amount).

But I learned that the movers and shakers of this reorganization already had somebody picked to be the head of the surveillance unit, even if I were willing to move or commute. So I talked to the head of the overall medical care studies field, by this time he was also changed from the physician who had been in that job, to a new doctor named Jim Harrison, and so I tried to talk to Dr. Harrison like a Dutch Uncle or whatever the expression is. I asked him to be quite frank with me as to why I wasn't given the option of moving if I wanted to, because I thought I had done a fairly good job in this new position that really was pioneering. And so he was pretty frank with me, and among other things he said – I was sufficiently moved to write down his exact words as soon as this interview was finished – he said that I “didn't have the type of personality that got along with everybody”. He also said that I sometimes worked on my own projects. He also said that I kept somewhat irregular hours. He also said that I had too much imagination.

Well, it was quite a bill of particulars, and I had to agree with a lot of what he said, and yet I thought that some of it must have been passed along by the woman who had taken a dislike to me because I was critical of certain the medical profession, and there had admittedly been times in which I kept very irregular hours. Often I would come in late, but then I would work straight through, without taking a coffee break, whereas almost every other employee in the whole health dept. would take extended coffee breaks, both morning and afternoon, which were on the books supposed to be 15 min each – they averaged about 45 min apiece. I never did that, and I would frequently work through the lunch hour, which nobody else did, but I couldn't deny that there were times when I used the health dept.'s typewriter to type stencils which were not part of my official job. I would sometimes type stencils for the magazine that I was editing for the organization I headed, called Citizens for Farm Labor.

I certainly couldn't deny that I sometimes used my imagination, and I have to admit that I did not suffer fools gladly. When I would go into meetings with the representative of the social welfare dept., in which I would attempt to get them to see that this program was being taken advantage of, and that it was work against the best interests of everybody concerned if something wasn't done about that, and I could see that I wasn't getting through to them, either because they weren't very bright, or they didn't like the competition between the health dept. and the welfare dept., whatever their reason. I wasn't able to mask my feelings, I have never been good at that, and it's gotten me into trouble many times over the years.

Well, I was able to stick with my work without a portfolio even after this shakeup was finished. I was able to stay on in the health dept. with temporary assignments on paper for one bureau or another within the dept. where I was allowed to continue finishing up because Breslow was still the director and was still interested in what I was doing, including my writing a paper to be submitted to the American Journal of Public Health, regarding our activities in the surveillance unit. Apparently it was unique in the entire country, because all the other states had Medicaid programs, but apparently none of them had anything quite comparable to the surveillance unit. So Breslow was willing to see that I was allowed to stay on while I finished up writing this

article. There were other things that he helped me with, for example there was a convention of the American public health association in Miami Beach, I think it was in the fall of 1967, maybe October, and he arranged to have me appear on a panel in which I would give a summary statement on our activities in the surveillance unit. It was held in the Fontainebleau Hotel, if I remember.

In Jan of 68 I finished up this article, which was in fact published in the American journal of public health, and then in the latter part of Jan 68, Breslow himself was fired. Reagan had what amounted to the president's power to select his cabinet. So he fired Lester Breslow, who was the best director of public health there had ever been, I'm certain. And so I lost my protector, and started looking around for some other position within the health dept., in some kind of research or statistical capacity, whatever it might have been called. I still had a temporary job classification called "health program advisor", so I would have had to revert to my permanent job classification, which was "associate public health analyst". So I looked around the department for anybody who might have an opening in that classification, and they only one I was able find was in something called the Bureau of Air Sanitation, which did not sound very exciting. In fact it sounded deadening, and so I began looking very seriously at leaving the health dept. entirely, in fact leaving state employment entirely.

I looked in on an old friend of mine, dating all the way back to the time I was with the Agricultural workers organizing committee, and he had just gotten a degree in sociology from the University, and I got him a job with the US dept. of labor, because he was very interested in the farm labor, and his job had something to do with that subject. And he had gotten along famously in the federal bureaucracy, and particularly when Lyndon Johnson began the so-called War on Poverty, Rick Wakeford, that was his name, got quite a handsome position within the war on poverty, with an office in San Francisco. So Rick remembered me well, and had a number of suggestions as to where I might get a job in the federal bureaucracy, and I began interviewing people and had a couple of leads that were very promising, one of them having to do with surveillance of health programs in the western states that were being financed under the auspices of the Office of Economic Opportunity. There were one or two others, but that was the most promising.

However, that job, attractive as it would have been in some ways, required that I be in the field much of time, if not most of the time. The western states covers a lot of territory. Now it happens that at this time, Stephen, David and Rachel were in Ecuador for a year. If I had taken this job with the war on poverty, I would in effect have substantially lost contact with Eugene and Dorothy, and that I was not willing to do. So I said thanks but no thanks, and I reconciled myself to a clerical position, is what it amounted to, in the bureau of air sanitation, under a guy named Stan Hanks, and I'm afraid I was not able to mask my feelings. When I asked Mr. Hanks, when I had just started in this position, whether air sanitation was improving or not, because they had measuring stations scattered all around the state, which would send in readings every week or two, and they would be faithfully recorded and filed away, and that was the last that anybody would hear of them, and Mr. Hanks said that it was not their mission to analyze these data. I'm sure my face must have spoken volumes, that I thought he was an idiot. It was just the worst possible dead-end, intellectually deadening.

So after a month or whatever I really redoubled my search for some way out. And there's a phrase from Greek tragedy, *Deus ex machina*. At the very end of the drama, something miraculous happens to solve the dilemma, and the hero or heroine is saved, and in my case I was saved by being told that a job had just opened up in a unit called the Community Studies on Pesticides. I didn't even know such a thing existed within the public health dept. A very small unit, but it seemed heaven-sent, because if you talk about pesticides, you're bound to talk about farm workers, right?

I interviewed with the head of that modest little unit, and he liked the cut of my jib, and I liked the cut of his jib, and he agreed with me that they should logically have been doing a lot in the field of the effects of pesticides on farm workers, but had never had the person who was just right to make that connection. So I filled their bill, and they filled mine.

I'll just wrap up briefly to say that even at this late date – in fact it was even some time later than this – I heard from a fellow that I had known back when the surveillance unit of the medical unit was just getting started. His name was Joseph Piffet. I had a call from him. It seemed that he had moved along, and had a job back in Washington DC, which I believe had something to do with surveillance not only with the Medicaid programs taking place throughout the country, but also with the grand-daddy of them all, the Medicare program. He wanted me to come back there and speak to a meeting of some of the senior staff about things that they might do in the way of surveillance, because they, like the CA medical program, in fact all these public programs, were having serious financial problems. They were all running over budgets. They were all being taken advantage of by a certain class of vendors.

And so I flew back there to Washington and spoke to this group of high-ranking staff members, and as usual I was not impressed by them. They didn't know any more about it than I did, and I knew very little about it. I had to admit that our surveillance programs had been quite simple-minded by comparison with what would have been possible, given the oceans of data that were flowing in. I'll have to say that I was witness to a tragedy, that the opportunities were there for these programs to have done much greater things than they ever did, because of the failure of the people with sufficient skills and passion, which is what would have been required. There would have had to be a coming together of people who knew something about medical practice, who knew more than something about computers, and who cared about the fact that the public treasury was being raided, and that eventually it was going to work against the very existence of these programs. I regretted very much that I myself didn't have the necessary skills to pull these possibilities together.

David: In your journal paper, and in the panel you attended, did you talk about fraud, or did you just talk about methods?

Henry: Well, yes, I could hardly avoid saying that what we were doing was in effect looking for crooks. I tried not to use such inflammatory language. Yeah, after the first year of the Medical program, it was already running \$200M in the red – that is, claims flowing in much more than had initially been anticipated by the legislature, which had enacted the program, and had allowed a certain amount of money, an amount that they thought was sufficient, and it was

nowhere near sufficient. We estimated, and it was a horseback estimate, that if there had been adequate surveillance enforced, it would have saved somewhere between a quarter and a third of the amount being spent on those programs. I think that's probably true at the federal level also. And yet they go on, year after year.

I neglected to mention, when this big red ink flowed in after this very first year of Medical, I made the pitch that even if our estimate of the amount of waste was exaggerated, even if it were only half as much, it would still come close to bringing the program into balance financially. But nobody paid any attention to that. All they could think of to do was to chop certain services, and so at the end of the first year they eliminated dental care, for example. They eliminated eyeglasses. They eliminated physical therapy, and so on. They took it out of the recipients, rather than the vendors.

And even after I left any connection with that program, I was still concerned, so angry, I would make clippings whenever there was anything in the papers or magazines about somebody who had been caught with his hand in the cookie jar, and these sorts of things came to light every so often, and they were the really extreme cases, they were criminal cases – they were so bad that the FBI or somebody with no normal connection to the program became involved, and this was so commonplace that eventually I gave it up because I had archive boxes full of these clippings, showing how the programs were being abused, and it's still going on. I see it even in the medical practice that I rely on myself for care. They play fast and loose with the rules, I can see it.

It is, as I believe I said last time, the fact that the whole practice of fee-for-service medicine is incompatible with public programs, or with insurance programs in general, it's true even in private health insurance plans. It's not true in the case of the Kaiser plan. The Kaiser physicians have absolutely no financial incentive to overutilize the system. The other systems do have such incentives. That's why I say it's incompatible with the whole fee-for-service system.