

Health Care Services Master Plan Task Force

Health Care Finance

OVERVIEW

In 2009, the US spent \$2.5 trillion on health care, or about \$8,086 per capita.^{i, ii} While health care spending increased by only four percent from 2008 to 2009 – an all-time low and the smallest annual increase on record – health care spending continues to occupy a large share of the nation’s economy, representing 17.6 percent of the nation’s gross domestic product (GDP);ⁱⁱⁱ current projections indicate that health care spending may exceed 25 percent of the nation’s GDP by 2035.^{iv}

While US health care spending far exceeds that of other developed nations, US health outcomes often fall short. For example, according to a recently released Commonwealth Fund-sponsored study, the US placed last among 16 high-income industrialized nations in terms of preventable deaths related to timely access to effective health care.^{vvi} US health care expenditures also pose other concerns. For example:

- Devoting a large portion of the US economy to health care means that the country may not be investing in other sectors that impact health and wellbeing, such as education.
- Research indicates that health care spending growth may have eliminated real income gains for the average US family of four with employer-based health insurance, a particular burden in the current economic recession.^{vii}
- As costs escalate, health care often becomes less accessible for those who need it, particularly for low-income persons who are un- or underinsured.

GDP

A nation’s gross domestic product, or “GDP,” refers to the market value of all final goods and services produced within a country in a given time period. GDP is considered one measure of a country’s economic health. Generally speaking, the larger a country’s GDP, the stronger its economy.

This briefing paper will take a broad look at health care financing, looking at the flow of health care dollars as costs and reimbursements. This paper will also examine the incentives created by current finance policies, particularly as they impact patient access to needed health care services.

NATIONAL, LOCAL, AND REGIONAL TRENDS

Understanding National Health Care Costs: Snapshot of US Health Care Spending Trends

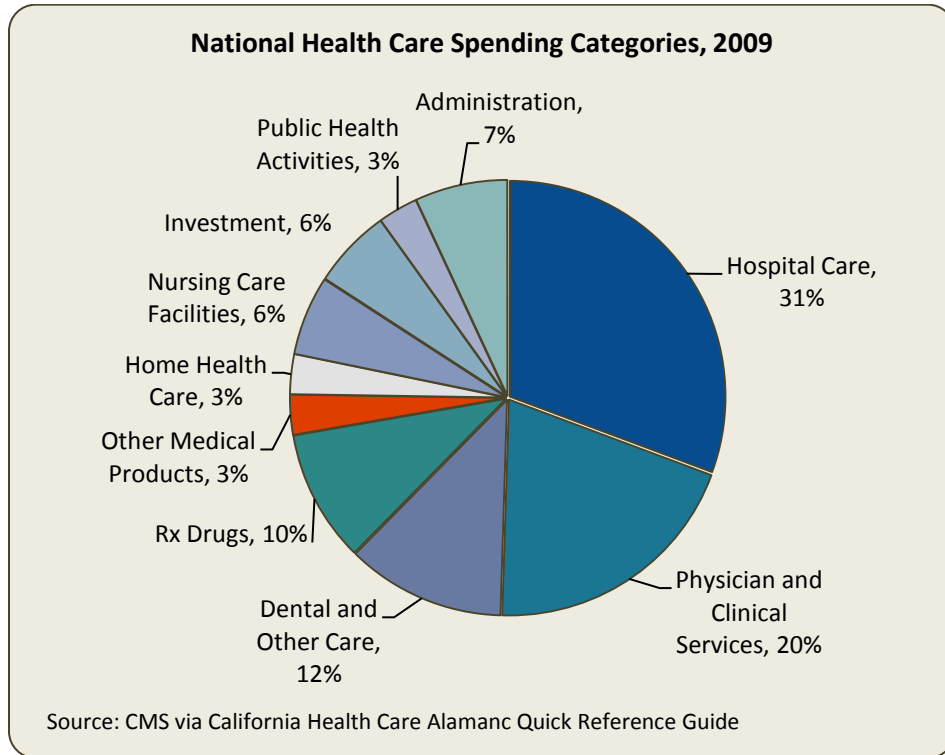
\$2.5 trillion

US dollars spent on health care in 2009.

The national-level information that follows comes from 2009 data released by the Centers for Medicare and Medicaid Services (CMS).^{viii} This information mirrors the National Health Expenditure data released by *Health Affairs* in August 2011. For health care spending projections from 2010 to 2020, [please see the larger Health Affairs report.](#)

The US Spends More Than Half of All Health Care Dollars on Hospital and Physician/Clinical Care

As illustrated below, the US spends half of its health care dollars on hospital and physician/clinical care. Data also indicate that the US spends approximately 84 percent of its health care dollars on personal health care (all categories except investment, public health activities, and administration).

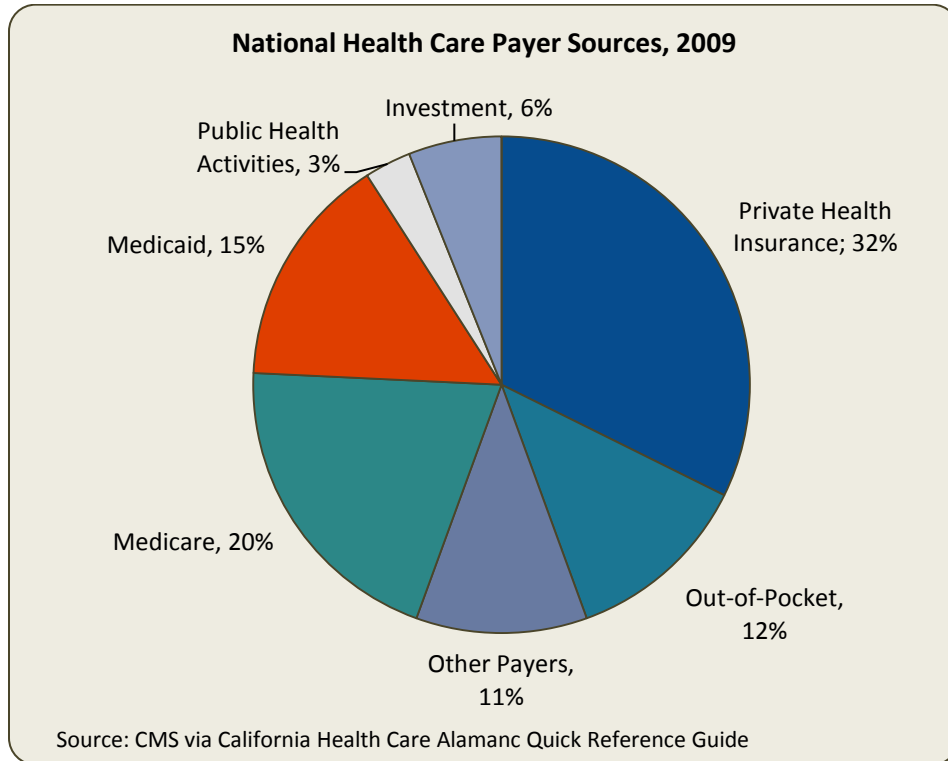


Households Contribute the Largest Single Portion to Health Care Financing, Followed by the Federal Government

Households contribute approximately 28 percent of all health care financing, just surpassing the federal government (27 percent). When combined, federal, state, and local government contribute 43 percent to US health care financing.

Private Health Insurance the Largest Single Health Care Payer Source

As illustrated below, private health insurance is the single largest health care payer source nationally, representing 32 percent of health care payment in the US. Medicare and Medicaid follow at 20 percent and 15 percent respectively.



Private Health Insurance and Medicare Most Likely to Finance Hospital and Physician/Clinical Care, Consistent with National Health Care Spending Patterns

Private Insurance, % of Total Spending by Category, 2009	
Hospital Care	33%
Physician and Clinical Services	30%
Prescription Drugs	14%
Medicare, % of Total Spending by Category, 2009	
Hospital Care	44%
Physician and Clinical Services	22%
Nursing Home/Home Health Care	12%

The table at left indicates the top three spending categories of both private health insurance and Medicare in 2009, most of which is concentrated in hospital and physician/clinical services. Medicare, however, is more likely to pay for nursing home and home health care, likely because of the age of the population served (age 65 and older.)

Understanding the Health Care Finance Landscape in California: State Ranks in Bottom 10 for Personal Health Spending, Lowest in Medicaid Personal Health Care per Enrollee Spending

According to a recent report released by the CMS Office of the Actuary,^{ix} California was the ninth lowest ranking state in terms of personal health care spending per capita in 2009.^x (Personal health care spending includes the total amount spent to treat individuals with specific medical conditions, but excludes expenditures resulting from government administration, net costs of health insurance, government public health activity, non-commercial research, and investment in structures and equipment.) Only eight states – Georgia, Virginia, Arizona, Texas, Colorado, Idaho, Utah, and Nevada – spent less. California personal health care per capita spending (\$6,238) also fell below the national average of \$6,815 per capita.

50th

California ranks below all other states for Medicaid personal health care spending per enrollee, likely because of the state's low reimbursement rate.

States with the lowest per capita personal health care spending had lower per capita income and relatively younger populations with less access to health insurance. These states will be most likely to have the greatest number of people eligible for Medicaid expansion or health benefit exchange coverage upon implementation of Health Reform in 2014. While San Francisco enjoys higher rates of insurance and higher per capita income than California as a whole, the reliance of more Californians on California's already struggling Medi-Cal program could be problematic statewide. California currently ranks 50th in Medicaid personal health care spending per enrollee (\$4,569 vs. \$6,826 nationwide), likely because of the state's low Medi-Cal reimbursement rate, which impacts not only spending but access to care.

Regional Variations in Health Care Spending Increase Overall Health Care Costs – Without Improving Health Care Quality

Research indicates that health care spending varies widely across the country and within regions, greatly impacting US health care costs – without corresponding improvements in health care quality.^{xi} For example, one study found that, among large California hospitals, per patient Medicare spending for chronically ill patients in their last two years of life ranged from less than \$20,000 to nearly \$90,000 due to variation in service use.^{xii} (This research studied care received by chronically ill Medicare patients who died between 1999 and 2003.)

The Congressional Budget Office (CBO) examined the geographic variability of Medicare spending based on 2005 data and found that:^{xiii}

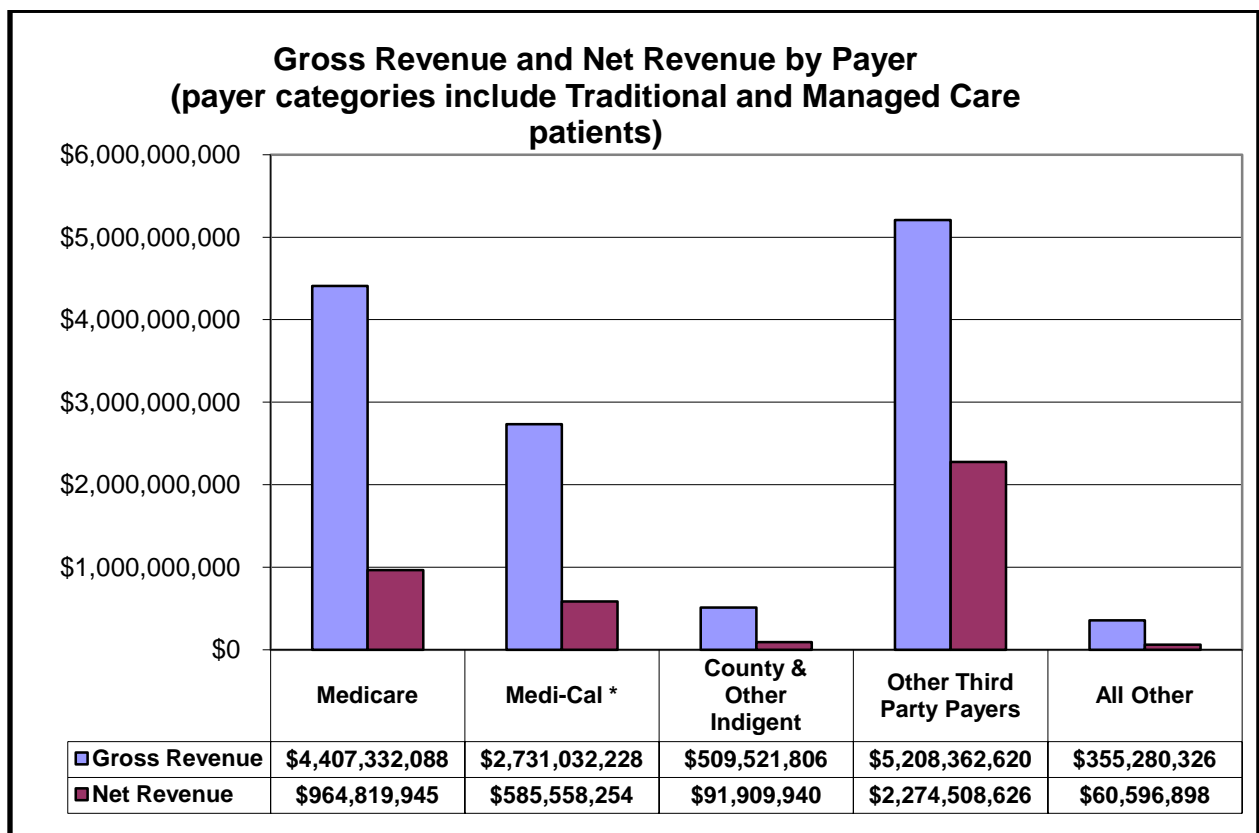
- The price of health care services and severity of illness explain less than half of all geographic variability.
- Individual preferences explain little of the geographic variability of health care spending.
- Much remains *unexplained* regarding spending variability: Some regions are more likely than others to adopt low-cost, highly effective patterns than others.

CBO research also found, however, that geographic variations in Medicare spending were less pronounced than overall health care spending nationally. The CBO attributed this finding, at least in part, to changes made in Medicare reimbursement policy, suggesting that health care policy mechanisms have at least the potential to impact health care spending trends while increasing attention

on care coordination and quality.^{xiv} Subsequent findings have strengthened the connection between care reimbursement mechanisms, degree of care coordination/integration, and cost. Research has shown, for example, that health care cost and use variation among older adults (age 55+) is greatest among fee-for-service systems compared to Health Maintenance Organizations.^{xv}

Understanding the Health Care Finance Landscape in San Francisco: Hospital and Clinic Revenue by Payer Source

The following chart illustrates gross and net revenue by payer source for all San Francisco hospitals reporting to the Office of Statewide Health Planning and Development in 2010. As indicated below, “other third party payers” – representing both traditional and managed care health plans – contribute the greatest share of gross and net revenue to reporting San Francisco hospitals.



DRIVERS OF HEALTH CARE COSTS

In an effort to curb the US's current health care spending trajectory, much research has focused on identifying the drivers of national health care costs. Primary among them are:

- Medical Technology: Research indicates that medical technology has contributed to between 28 and 65 percent of health care spending growth in the US, largely because technology expands the number – and cost – of available treatments.^{xvi}
- Health Status, Particularly Obesity and Chronic Disease: Research suggests that obesity accounts for an estimated 12 percent of health care spending growth in the US.^{xvii} Viewed collectively, health care costs associated with chronic disease account for more than 75 percent of US health care spending.^{xviii}
- Administration and Inefficiencies in the US Health Care System: The US spends significantly more than other developed nations in terms of drug prices and insurance administration. In addition, inefficiencies exist within US health care systems. For example, about 7 percent of US health care spending goes toward administration;^{xix} however, administrative costs are much lower for the Medicare program (less than two percent) because it is operated by a single entity – the federal government.^{xx}

The aging of the population and medical malpractice contribute only minimally to increasing US health care costs.^{xxi}

THE STRUCTURE OF MEDI-CAL, CALIFORNIA'S MEDICAID PROGRAM

Before discussing the impact of health care reimbursement more broadly, it is important to have a basic understanding of Medi-Cal's financing structure. (Medi-Cal is California's Medicaid program.) In California, approximately half of all beneficiaries receive their benefits through Medi-Cal managed care and half through the fee-for-service (FFS) model.^{xxii}

Fee-for-Service

Under the FFS model, Medi-Cal beneficiaries may seek services from any participating provider, and providers are paid for each service they provide (e.g., an office visit, test, procedure, or other health care service). The FFS model allows greater flexibility for Medi-Cal beneficiaries to see the physician of their choice. However, it is also seen as a barrier to coordinated care because the system incentivizes providers to provide more services (whether or not they are needed) and provides few incentives to reduce cost, coordinate care, or increase quality.

Understanding Health Care Speak: Fee-for-Service and Managed Care

- Fee-for-Service (FFS): Payment for health care based on the charges for each service or item use. The more services provided, the greater the reimbursement, creating an incentive to provide more care than is necessarily needed while driving up health care costs.
- Managed Care: The use of a manager to control medical service use and contain health care costs. Managed care incentivizes appropriate levels of care, thereby containing health care costs; however, patients have less choice in which providers they may see.

Managed Care

Twenty-five of California’s 58 counties operate Medi-Cal managed care programs, though the model of managed care delivery varies. (Please see below for more information.) The remaining counties rely on FFS Medi-Cal. Under the managed care system, beneficiaries enroll in a health plan and see providers within a designated network participating in that plan. Members choose one main physician, called a primary care physician (PCP), who is responsible for the beneficiary’s basic care and coordinates other medical needs, including referrals to specialists. Managed care is intended to integrate the payment and delivery of health in an effort to deliver the highest quality services at the lowest possible cost.

Three Models of Medi-Cal Managed Care

There are three models of Medi-Cal Managed Care:^{xxiii}

- **Two-plan Model:** The Two-Plan Model is the most common of the Medi-Cal managed care programs. Under this model, the State Department of Health Care Services contracts with two health plans: the Local Initiative, which is a quasi-governmental entity developed by public providers and local stakeholders with a governing board established by the county board of supervisors; and the Commercial Plan, which is a private plan selected through a competitive process. The Two-Plan Model covers the most populous areas of the state and is implemented in the following 12 counties: Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare.
- San Francisco’s Two-Plan Model**

San Francisco administers its Medi-Cal Managed Care program as a “two-plan” model. San Francisco’s Medi-Cal Managed Care beneficiaries may choose between two health plans:

 - San Francisco Health Plan (the Local Initiative); or
 - Anthem Blue Cross (the commercial plan).
- **County Organized Health Systems:** County Organized Health Systems (COHS) are single-plan models operated by counties that accept full risk for a broad scope of services. COHS operate with special approval under federal law. There are five COHS operating in the following nine counties: Santa Barbara, San Mateo, Monterey, Solano, San Luis Obispo, Santa Cruz, Napa, Yolo, and Orange Counties.
 - **Geographic Managed Care:** Operating in San Diego and Sacramento counties, the Geographic Managed Care Model is a multi-plan competitive model, which is similar to the Medicaid managed care programs used in the majority of other states. In this model, most of the commercial health plans in a geographic area participate in the Medicaid managed care program. Plans negotiate with the State to establish final payment rates.

Medi-Cal Managed Care’s Mandatory Enrollment Populations

In counties that offer Medi-Cal Managed Care, nearly all beneficiaries are required to enroll in managed care. Prior to June 2011, children, non-disabled parents, and pregnant women were required to enroll in a Medi-Cal Managed Care plan to access their benefits. These populations are still required to access the

Medi-Cal benefits to which they are entitled through managed Medi-Cal. As of June 2011, seniors and persons with disabilities (SPD) are also required to enroll in Medi-Cal Managed Care under California’s current 1115 Waiver. SPDs constitute a small share of the Medi-Cal population – 16,000 – 20,000 in San Francisco – but a large portion of Medi-Cal spending, and participation in Medi-Cal Managed Care will allow for better care coordination and management of the SPD population’s chronic conditions. Managed care enrollment of the SPD population is now mandatory for all Medi-Cal-eligible SPDs with the exception of individuals who are dually eligible for both Medi-Cal and Medicare. Foster children, beneficiaries who pay a portion of their Medi-Cal costs, and people in long-term care remain exempt from mandatory enrollment in Medi-Cal managed care.

Capitation

Under Medi-Cal Managed Care, health plans received a flat rate from the State per member per month, no matter how frequently or infrequently patients access care. Similarly, under full capitation, health plans pay their member providers a flat rate per patient, per month, no matter how frequently or infrequently they see that patient. In return, health plans assure the State and providers assure health plans that beneficiaries receive all necessary covered services. Under this arrangement, health plans have a finite amount of money with which to contract with providers for services. Providers assume financial risk should the cost of care exceed total reimbursement.

Carved Out Services

Some medical services are “carved out” of the capitated Medi-Cal Managed Care model. That is, they are covered under a different payment arrangement. These carved-out services include: specialty mental health, dental services, services for seriously ill and disabled children, home and community-based services, and long-term facility care. Carve-outs were created for several reasons, primarily to increase access to qualified professionals that provide highly-specialized care that is not always readily available in or accessible to all-inclusive managed care organizations. Further, the appropriate treatment for specialized health care needs can contribute to overall cost-effectiveness by removing barriers to timely and effective care and consolidating specialized care into fewer administrative structures.

However, by their nature, carve outs promote non-integrated care. The fragmented care that results when individuals with complex health conditions are required to obtain the care they need from multiple systems often results in poor health outcomes, duplication of services, and unnecessarily high costs.^{xxvi}

The California Context: Historical Shifts in Managed Care Reimbursement^{xxiv, xxv}

Reimbursement structures advanced under Health Reform increasingly require providers to share the financial risk of patient care – creating incentives for better care coordination and cost containment. California, given its long history of managed care, is no stranger to risk-sharing. In the 1990s, for example, managed care plans increasingly transferred financial risk and care management to physician groups and hospitals, resulting in greater consolidation in both hospital and provider group markets. This “California Model” largely fell out of favor by the end of the decade as a result of poor management, perceived inadequate payments from health plans, and reduced opportunities for cost containment as the managed care system became more efficient.

Implementation of Medicaid Reforms Will Fall Heavily on Medi-Cal Managed Care

Medi-Cal managed care plans are expected to face particular challenges under Health Reform and California's 1115 Medicaid Waiver.^{xxvii} Both initiatives demand that managed care plans:

- Accommodate increased patient enrollment as part of Medi-Cal's expansion – including the mandatory enrollment of SPDs and other designated populations.
- Expand their provider networks to ensure their ability to serve Medi-Cal patients, a particular challenge given Medi-Cal's low provider reimbursement rate.
- Contain costs. Given that managed care, by definition, leans against FFS reimbursement in favor of capitation – and that managed care already emphasizes care coordination – it is unclear to what extent managed care plans will be able to decrease expenses further given the high health care costs associated with those it serves (e.g., SPDs).
- Improve health outcomes, again a unique challenge given the composition of Medi-Cal managed care's patient population.

The ability of Medi-Cal managed care to respond to these demands will likely depend on government assistance in the form of policy and fiscal support, the latter of which seems particularly unlikely given the grim financial situation facing all levels of government.

HEALTH REFORM'S IMPACT ON REIMBURSEMENT

Health care reimbursement most often reflects an indirect, third-party transaction based on rates negotiated between health plans and providers – not the actual cost of providing care. As such, reimbursement models have the power to create significant incentives to increase health care quality and patient access – or not. This section provides an overview of how Health Reform advances various reimbursement structures that impact patient care, particularly for low-income vulnerable populations, as well as policy changes that promise to offer new opportunities and challenges for health care delivery going forward.

General Impacts

As of 2016, the CBO estimates that 92 percent of US residents will be insured as a result of federal Health Reform. In San Francisco, this translates to approximately 740,816 residents who will have employer-based coverage, purchase insurance through the California Health Benefit Exchange, be part of California's expanded Medi-Cal program, or maintain coverage through Medicare or another public source. San Francisco's growing insured population will put increased demands on the existing health care system, though hopefully resulting in expanded patient access to care and better health outcomes.

Through an extensive patchwork of reimbursement incentives and demonstration programs piloting new care delivery models, Health Reform attempts to curb health care spending while simultaneously improving health care affordability and

Cuts in Medicare Rates Likely Mean Cuts for All

Reimbursement rates – including reimbursement from private insurance plans – are often tied to the Medicare reimbursement rate. If the federal government reduces Medicare reimbursement rates, which is likely given the current fiscal crisis, other plans and programs are expected to follow suit.

access for patients. Key to Health Reform’s efforts is decreased reliance on FFS reimbursement in favor of incentives that reward providers for performance; however, the savings generated by such changes remain unclear – particularly in California, a state with a more extensive managed care network that is already focused on cost containment through capitation models of reimbursement. Also uncertain is the question of whether providers will be equipped to serve an expanded patient population efficiently and cost-effectively without shifting substantial costs to the privately insured, thereby driving up insurance premiums and health care costs more broadly.

Hospital Systems Will Be Heavily Impacted by Reimbursement Changes Under Health Reform

Medicare to Launch Hospital Reimbursement Reforms as Performance Incentives

As of Federal Fiscal Year 2013, the Medicare program will launch two hospital reimbursement reforms, one of which is mandatory and the other voluntary:

- Hospital Readmissions Payment Reductions (Mandatory): In an effort to curb “excess readmissions” for specified conditions (heart attack, heart failure, pneumonia in 2013 and 2014),^{xxviii} Medicare will reduce a hospital’s base Diagnosis Related Group (DRG) payment for the specified condition if readmissions for that condition exceed the expected rate. To avoid financial penalties through this reform, hospitals will be forced to carefully manage a patient’s care and discharge – a particular challenge for safety-net hospitals that typically serve a sicker population more likely to require readmission.
- Hospital Value-Based Purchasing Program (Voluntary): Under this initiative, hospitals meeting certain requirements will receive incentive payments. Specifically, Medicare-designated hospitals that meet certain performance metrics and have sufficient infrastructure in place to meet CMS reporting requirements are eligible for payment rewards. Participation in this program is voluntary; however, hospitals that are able will likely engage in the program as a means of offsetting Medicare base payment reductions.

Medicaid to Adjust Hospital Payments for Hospital-Acquired Conditions

Under Health Reform, Medicaid will adopt a reform already part of the Medicare program: Payment adjustments for hospital-acquired conditions (HACs). Following implementation, Medicaid will no longer reimburse hospitals for 10 types of HACs and other injuries and illnesses considered preventable. Medi-Cal will have until September 30, 2012 to propose to CMS an implementation plan for this reform.

Health Reform to Decrease Medicare and Medicaid Disproportionate Share Hospital (DSH) Payments, Extent of Financial Impact Unclear

64,400

Number of San Franciscans expected to remain uninsured after Health Reform implementation in January 2014.

The DSH program provides special funding to certain hospitals in recognition of the higher operating costs they incur in treating a large share of low-income patients. Health Reform makes annual reductions to both the Medicaid and Medicare DSH programs starting in 2014, coinciding with Medicaid’s expansion, implementation of health benefit exchanges, and the effective date of private insurance requirements. Health Reform directs the Secretary of Health and Human Services to develop a methodology for imposing DSH reductions but provides no guidance on how states are to

allocate DSH funds to individual hospitals. While DSH reductions are expected to be offset somewhat by a decrease in the number of uninsured patients seeking care after Health Reform implementation, the question remains as to whether DSH recipients will ultimately face a funding gap, potentially limiting their ability to serve those in need.

Need for Hospital Charity Care Will Persist After Health Reform Though Future Program Funding Uncertain

Charity care is currently the primary source of hospital care for low-income uninsured and underinsured San Franciscans. Charity care is the provision of services to low-income individuals without the expectation of reimbursement. Charity care is one component of the community benefit non-profit hospitals provide in exchange for their tax-exempt status. In 2010, San Francisco hospitals spent approximately \$178 million in charity care services. San Francisco hospitals provide charity care both within and outside of the Healthy San Francisco program. Within Healthy San Francisco, the hospitals' charity care commitments are leveraged in coordination with a primary care medical home to provide comprehensive health care services for participating uninsured San Franciscans. In addition, hospitals provide charity care to uninsured San Franciscans not participating in Healthy San Francisco.

With implementation of Health Reform, while hospitals will certainly see a decline in the number of uninsured utilizing hospital charity care services, there will still be demand for charity care services. As mentioned previously, 92 percent of US residents will be insured after Health Reform implementation; this leaves an estimated uninsured population of 20 million^{xxix} that includes approximately 64,400 San Franciscans. One-third of the uninsured will be undocumented immigrants. Many of the remaining two-thirds are likely to be unable to afford the coverage options that are available to them.

Hospital charity care has historically been funded largely through cross-subsidization by privately insured patients. However, as hospitals must negotiate lower rates with insurers to remain competitive, the amount of funding available for community benefit will be diminished. Additionally, other funds that are currently relied upon to support charity care programs may also diminish after Health Reform. For example, donors and other funding sources may perceive a reduced need for funding due to Health Reform or find it difficult to support care for what is perceived to be a group comprising only undocumented individuals or those unwilling to comply with the law.

Federally Qualified Health Centers Receive Incentives to Serve Expanded Insured Population – Increasing Patient Access to Care – Though Base Funding Threatened

The nation's Federally Qualified Health Centers (FQHC) provide a pivotal service to low-income persons through the provision of preventive and primary care. In California, for example, FQHCs serve 16 percent of the state's Medi-Cal population but represent only 1.7 percent of the state's total Medi-Cal spending.^{xxx} Under Health Reform, FQHCs – also known as Community Health Centers – are expected to double their patient capacity while generating cost savings to the health care system. Health Reform legislation sets forth a number of provisions that support FQHCs financially while expanding patient access to care. In recognition of their care of low-income and vulnerable populations, FQHCs receive cost-based reimbursement. (See inset below for more information.) While Health Reform relies heavily on FQHCs for many of its initiatives and also provides various avenues of support, some believe that the future of their cost-based reimbursement mechanism may be in question in the face of Medicaid cuts.

Understanding FQHC Medicaid Reimbursement: Medicaid Prospective Payment System (PPS)

The Medicaid PPS reimbursement system is a kind of **bundled payment**. A “bundled payment” is a single payment for all services related to the treatment of a particular condition. In addition, under the Medicaid PPS System:

- The PPS payment rate is based on each FQHC’s costs and scope of services;
- Rates are based on expected costs and are not unrestricted;
- FQHCs must meet certain performance standards as overseen by the US Health Resources and Services Administration.

Bundled payments are seen as a cost-effective reimbursement method that incentivizes care coordination and collaboration among providers. Beyond FQHCs, Medicaid and Medicare are piloting other bundled payment-based demonstration programs.

Federal Government Commits New Funds to Aid in FQHC Expansion

Quantifying FQHC Cost Savings Under Health Reform

Research estimates that, between 2010 and 2019, FQHCs are expected to generate \$122 billion in *total* health care cost savings nationally. Of that amount, \$55 billion would be savings to Medicaid.^{xxxix}

To help FQHCs meet increased patient demand under Health Reform, the federal government has committed \$11 billion of new funding to the Community Health Centers Trust Fund.^{xxxix} Dispersed over five years starting in Federal Fiscal Year 2011, \$9.5 billion of the new funding is intended to help FQHCs expand their operational capacity and enhance their medical, oral, and behavioral health care services; the remaining \$1.5 billion will address the capital needs of FQHCs under Health Reform, allowing existing centers to expand and allowing also for the construction of new facilities.

Health Reform Aligns Private Insurance FQHC Reimbursement with Medicaid’s Reimbursement

Health Reform requires that any health plan offered via a health benefit exchange include full participation by safety net providers – including FQHCs. In addition, Health Reform requires that FQHCs receive no less than their Medicaid rate from private plans offered on the exchange. This provision ensures that FQHCs will not *lose* money by serving patients with exchange-purchased insurance – and also increases patient access to necessary health care.

Despite Apparent Boost from Health Reform, FQHC Base Appropriations Threatened in Federal Budget

Despite the boost FQHCs will receive under the Community Health Centers Trust Fund and various other Health Reform provisions, FQHCs are under threat of reduced base funding in the federal budget, leaving in question whether FQHCs will be fully equipped to serve their expanded patient base under Health Reform. In Federal Fiscal Year 2011, FQHC base funding was reduced by \$604 million compared to Fiscal Year 2010. Though specific numbers are unknown, FQHCs anticipate additional base appropriation cuts in Federal Fiscal Year 2012. While some losses would likely be offset by the provisions noted previously, the extent to which base budget losses will impact FQHCs’ ability to expand is unknown.

Federal Medicaid Primary Care Reimbursement Incentive Unlikely to Drive Significant Expansion of Primary Care Providers Serving Medicaid Recipients – Particularly in California

Under Health Reform, the federal government will increase the Medicaid primary care physician reimbursement rate to match that of Medicare – but only for 2012 and 2013. An effort to increase primary care provider participation in Medicaid, this reimbursement strategy will likely fall short of making a significant impact, particularly in California, where physicians have been historically reluctant to serve the Medi-Cal population, most often citing the state’s low Medi-Cal reimbursement rate as a factor.^{xxxiv} Additional research suggests that even when fees are raised, physicians may not be more willing to participate in the face of other obstacles, such as delays in payment for services, and the administrative burden of the Medicaid program (e.g., credentialing, prior authorization requirements, and claims processing) – both real and perceived. In fact, the San Francisco Medical Society notes that some physicians may prefer to provide charity care to Medi-Cal patients rather than engage in Medi-Cal’s cumbersome reimbursement process. These factors can be particularly onerous for sole practitioners or small group practices that may feel forced to limit the number of Medi-Cal beneficiaries they serve so as to remain financially viable.

47th
California has the 47th lowest Medicaid reimbursement rates in the nation.

The State’s fiscal crisis may also deal primary care providers a blow, as the State has tried to reduce provider reimbursement rates still further – a question that will ultimately come before the US Supreme Court. Given that San Francisco is expected to see a 24 percent increase in its Medi-Cal population following the implementation of Health Reform – translating to about 30,000 new Medi-Cal enrollees – the question of creating incentives for primary care providers to serve new Medi-Cal patients is of particular concern.

Patient-Centered Medical Homes Emphasize Primary Care Case Management, Disease Management, and Care Coordination by Leveraging Physician Extenders

Health Reform and California’s 1115 Waiver collectively emphasize the importance of primary medical care access through the Patient-Centered Medical Home (PCMH) model. The PCMH is founded on the idea that a high-functioning primary care system can improve health care quality – and the patient experience – while lowering costs. The ongoing patient-provider relationship is key to the PCMH model, allowing each patient’s designated primary care provider to take a more comprehensive, holistic approach to patient care.

PCMH pilots under Health Reform, though currently unfunded, would emphasize the PCMH model for persons with chronic conditions by relying on the capitation method of reimbursement to incentivize the formation of interdisciplinary health teams that prioritize primary care case management, disease management activities, care coordination, and the use of home- and community-based care providers such as “physician extenders” (e.g., nurse practitioners, physician assistants). Medi-Cal, given its existing network of managed care plans that operate within the capitation framework and that serve a patient base with chronic conditions, could be well-positioned to participate in the PCMH pilot if and when federal funds for the project become available. Additionally, PCMH’s use of physician extenders could help bridge the Medi-Cal provider gap.

Special Challenges for Long-Term Care

12 million

The number of older US adults (age 65+) expected to need some type of long-term care.

According to the US Department of Health and Human Services, adults age 65 and older have a 40 percent chance of entering a nursing home,^{xxxv} a significant proposition for San Francisco given that nearly half of the city's residents are projected to be age 50 or older by 2030.^{xxxvi} These numbers also pose a financial challenge for the Medi-Cal program, which constitutes 49 percent of the state's total nursing home revenue compared to the 28 percent of revenue generated by Medicare.^{xxxvii}

While older adults constitute the majority of US residents with long-term care needs, Medicare will fund only "medically necessary" home health care or skilled nursing care – and only if certain conditions are met. Medicare will not fund custodial care and will only finance a person's first 100 days at a nursing home, leaving Medi-Cal to support the lion's share of California's long-term care costs.^{xxxviii} For example, Medi-Cal is currently the primary payer of 67 percent of California's nursing home residents.^{xxxix}

What is long-term care?

"Long-term care" refers to a variety of services – both medical and non-medical – for persons who have a chronic illness or disability. "Institutional" long-term care refers to skilled medical and therapeutic care offered by licensed nurses for a continuous and extended period of time (e.g., care at skilled nursing facilities and nursing homes). Examples of HCBS include but are not limited to In-Home Support Services and other personal services that help chronically ill and disabled persons with their activities of daily living (e.g., eating, bathing, dressing) at home or in a non-institutional community-based setting (e.g., assisted living, residential care facility).

States have tried various measures – from capping Medicaid reimbursement rates for long-term institutional care to halting construction of nursing homes (California ended its certificate of need program in 1987^{xl}) – to contain long-term care costs; however, the answer may lie in better incentivizing home- and community-based service (HCBS) options over institutional care. For example, research suggests that the Medicaid dollars needed to support one person in a nursing home would be nearly enough to fund HCBS services for three adults.^{xli} In addition, HCBS offer the added benefit of providing persons access to the care they need in the least restrictive setting.

Health Reform advances the prioritization of HCBS options through several initiatives into which Medi-Cal could opt. Through HCBS 1915(i) Waiver, for example, Medi-Cal could offer long-term care services through a state plan option rather than through a more cumbersome federal process.^{xlii} While HCBS may not be the cure-all for long-term care cost containment – HCBS require significant up-front investment and are resource intensive (e.g., In-Home Support Services labor demands) – they do offer the possibility of curbing costs while more appropriately meeting patient needs.

Beyond Health Reform, San Francisco is exploring a local approach to long-term care cost containment and access

Long-Term Care Financing: Historical Context^{xliii}

Medicare was passed in 1965, a time when society largely viewed a person's long-term care needs as a family responsibility – not something within the purview of medical insurance. Medicaid, in contrast, was seen as a program designed to serve the needy, as a kind of welfare. As such, long-term care financing fell to the Medicaid program and now constitutes nearly one-third of all Medicaid spending.^{xliiii}

to better care: integrating long-term care and primary/acute care services via a managed care framework as part of California’s 1115 Medicaid Waiver. Though only in the initial stages of development, San Francisco’s Long-Term Care Integration (LTCI) Project would build on the current 1115 Waiver, which requires SPDs to enroll in one of two Medi-Cal managed care plans for their primary and acute care services. By adding long-term care services to this managed care framework, patients would receive access to better coordinated and more comprehensive care – while likely containing overall costs to the Medi-Cal program.

In addition, San Francisco community members have noted the potential impact of providing supportive services – such as escorting patients to medical appointments – as a means of better serving seniors and persons in long-term care, allowing them to live more independently while improving access to care. Such services also have the potential to benefit other populations (e.g., multiply diagnosed persons and those with mental health and substance abuse issues), all while curbing expenses and decreasing reliance on costly emergency medical services.

PRELIMINARY POLICY CONSIDERATIONS

*Recommendations: The Health Care Services Master Plan shall include policy recommendations to promote an equitable and efficient distribution of health care services in the City; the elimination of healthcare service gaps and medically underserved areas; and the placement of Medical Uses within the City in a manner that is consistent with the character, needs and infrastructure of the different neighborhoods, and that promotes and protects the public health, safety, convenience, and general welfare. **San Francisco Ordinance No. 300-10***

The HCSMP Task Force is an advisory body charged with developing possible HCSMP recommendations informed by data and community feedback. The San Francisco Department of Public Health (SFDPH) will consider these possible recommendations for inclusion in the final HCSMP. However, given the collective expertise of the Task Force – and given that Task Force discussions will likely yield ideas beyond the scope of the HCSMP – SFDPH presents below a series of policy considerations that may inform both the HCSMP’s development as well as San Francisco’s broader health planning efforts.

LAND USE-SPECIFIC POLICY CONSIDERATIONS

The Task Force may wish to recommend that SFDPH consider including the following in the final HCSMP:

- Explore the possibility of incentivizing Medical Use projects that participate in the Medi-Cal program and provide a significant amount of care to Medi-Cal beneficiaries.
- Explore the possibility of incentivizing the construction of new and/or expansion of existing FQHC facilities in underserved neighborhoods in San Francisco.
- Explore the possibility of incentivizing projects that provide community-based long-term care services.

POLICY CONSIDERATIONS RELEVANT TO BROADER HEALTH PLANNING EFFORTS

The Task Force may wish to recommend that SFDPH consider the following in its broader health planning efforts:

Federal Level

- Advocate for extending mandated increased Medicaid primary care physician reimbursement rate beyond 2014.

State Level

- Advocate for California to expand Medi-Cal long-term care services through the HCBS 1915(i) Waiver option.

Local Level

- Improve collection and availability of health care finance data at the local level.
- Promote support services (e.g., escorting patients to medical appointments, case managers to help patients navigate the health care system) for those patients most likely to struggle with accessing and following through with health care (e.g., multiply diagnosed persons, those with mental health and substance abuse issues, etc.).

LISTED ACRONYMS

Acronym	Definition
CBO	Congressional Budget Office
CMS	Centers for Medicare and Medicaid Services
COHS	County Organized Health Systems
DSH	Disproportionate Share Hospital
FFS	Fee-for-Service
FQHC	Federally Qualified Health Center
GDP	Gross Domestic Product
HAC	Hospital-Acquired Condition
HCBS	Home- and Community-Based Services
HCSMP	Health Care Services Master Plan
LTCI	Long-Term Care Integration
PCMH	Patient Centered Medical Home
PCP	Primary Care Provider
PPS	Prospective Payment System
SFDPH	San Francisco Department of Public Health
SPD	Seniors and Persons with Disabilities

ⁱ California HealthCare Foundation. "US Health Care Spending." California Health Care Almanac Quick Reference Guide. <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HealthCareCostsQRG11.pdf>.

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- ⁱⁱ The Centers for Medicare and Medicaid released 2009 national expenditure data in January 2011.
- ⁱⁱⁱ California HealthCare Foundation. "Health Care Costs 101." California Health Care Almanac. May 2011. <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HealthCareCosts11.pdf>.
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- ^v Commonwealth Fund Press Release. "New Study: U.S. Ranks Last Among High-Income Nations on Preventable Deaths, Lagging Behind as Others Improve More Rapidly." September 23, 2011. <http://www.commonwealthfund.org/News/News-Releases/2011/Sep/US-Ranks-Last-on-Preventable-Deaths.aspx>.
- ^{vi} According to the study, the US could save up to 84,000 lives annually if it lowered its preventable death rate to that of the top three performing nations (France, Australia, Italy).
- ^{vii} Auerbach D., Kellermann A. "A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains for an Average US Family." *Health Affairs*, 30, No. 9 (2011): 1630-1636.
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- ^x According to CMS, "personal health care spending" includes the "total amount spent to treat individuals with specific medical conditions, but excludes medical expenditures resulting from government administration, net costs of health insurance, government public health activity, non-commercial research, and investment in structures and equipment."
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