HEALTH CARE FINANCE

Presentation to the Health Care Services Master Plan Task Force

December 22, 2011

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Presentation Objectives

1. Provide overview of health care spending trends – and those factors that drive health care costs.
2. Explain the basic structure of Medi-Cal, California's Medicaid program.
3. Describe Health Reform's impact on health care reimbursement structure and how such changes may impact access to care.
4. Initiate discussion of land use-specific and other policy considerations.

Presentation Preview

- Health Care Spending Trends + Cost Drivers
- Medi-Cal Basics
- Health Reform + Reimbursement
- Summary + Policy Considerations

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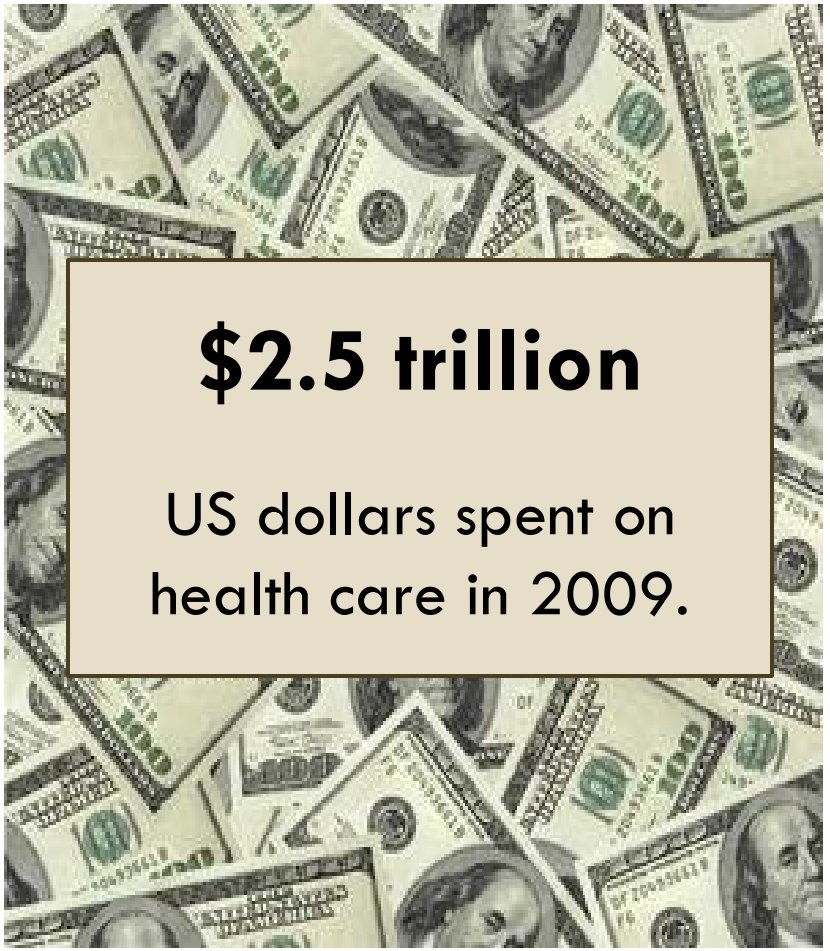
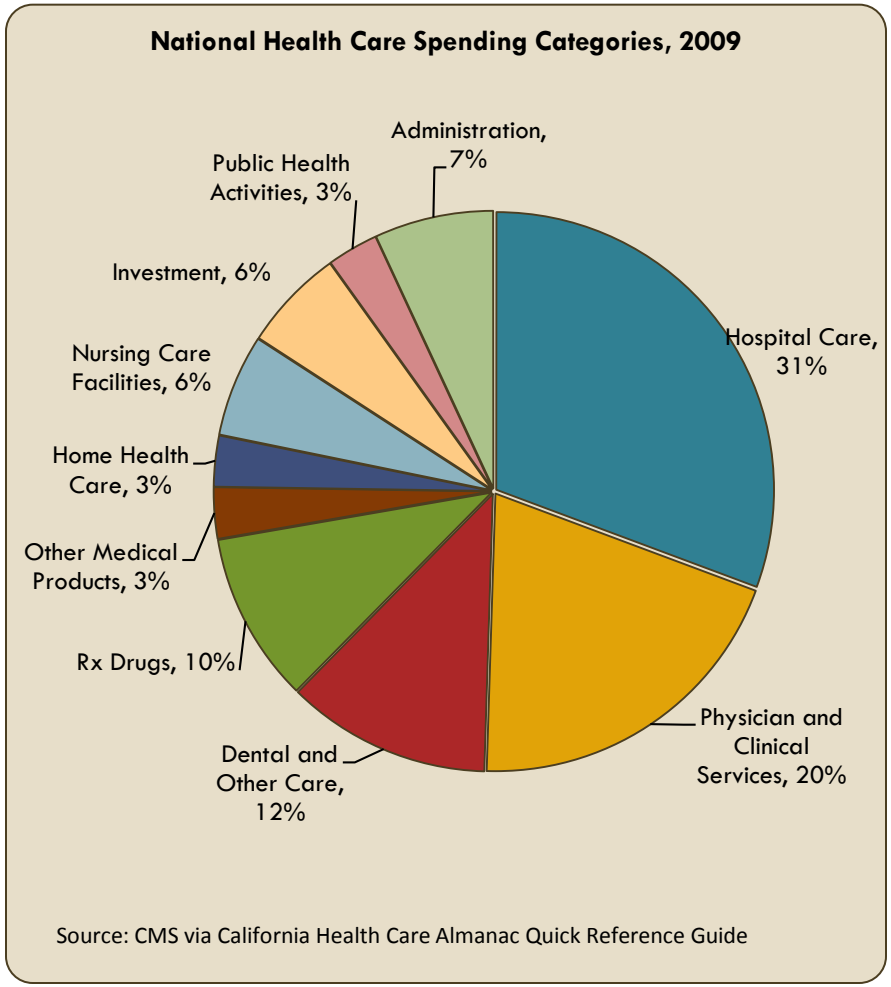
Health Care Spending Trends + Cost Drivers

Overview

- Summary of 2009 Health Care Spending:
  - $8,086 spent per capita
  - 17.6% of gross domestic product
- Possible Impact:
  - Less investment in other sectors (e.g., education)
  - More expensive and **less accessible care**.



National Spending Trends



- > 50% of spending on hospital and physician/clinical care
- Households contribute largest single portion to health care financing
- Private insurance the largest single health care payer source
  - Most likely to finance hospital and physician/clinical care

California Ranks Among Lowest in Personal Health Care Spending

- 9th lowest overall ($6,238 vs. $6,815 nationwide) in personal health care spending (2009).
- States with lowest per capita spending had lower per capita incomes
  - Possible signal of future reliance on Medi-Cal and health benefit exchange coverage as of 2014.
  - 50th per Medicaid enrollee ($4,569 vs. $6,826 nationwide)

50th

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

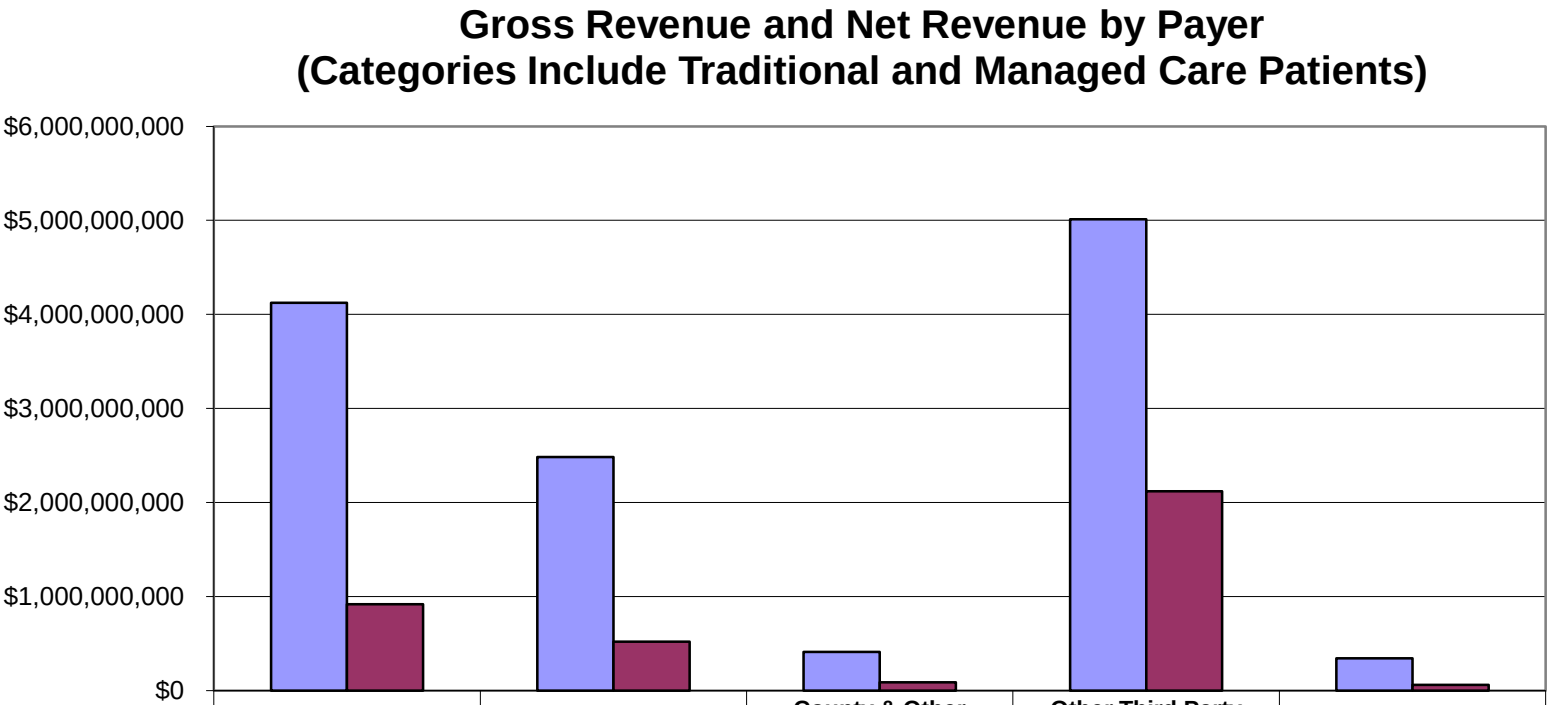
Source: CMS Office of the Actuary

Regional Message: Increased Spending Does Not Necessarily = Better Care

- Significant regional variation in Medicare spending
- Reasons for cost variation:
  - Cost of services + severity of illness explains < 50% of all variability.
  - Individual preferences explain little.
  - Much is unexplained.

Research suggests **reimbursement mechanisms** influence cost variation.

Local Spending Picture Less Clear



	Medicare	Medi-Cal *	County & Other Indigent	Other Third Party Payers	All Other
Gross Revenue	$4,124,429,279	$2,482,330,962	$411,884,069	$5,011,210,119	$342,917,285
Net Revenue	$917,774,038	$517,994,563	$88,188,277	$2,118,339,023	$60,054,122

Health Care Cost Drivers

- Medical Technology
  - 28 – 65% spending growth
- Health Status: Obesity + Chronic Disease
  - 75% or more spending growth
- Administration + System Inefficiencies

Medi-Cal Basics

Medi-Cal Reimbursement: Fee-for-Service vs. Managed Care

Fee-for-Service (FFS)

- FFS: Payment based on charges for each service or item use
- Patients can seek care from any provider (+)
- Does not incentivize care coordination or cost containment (-)

Managed Care

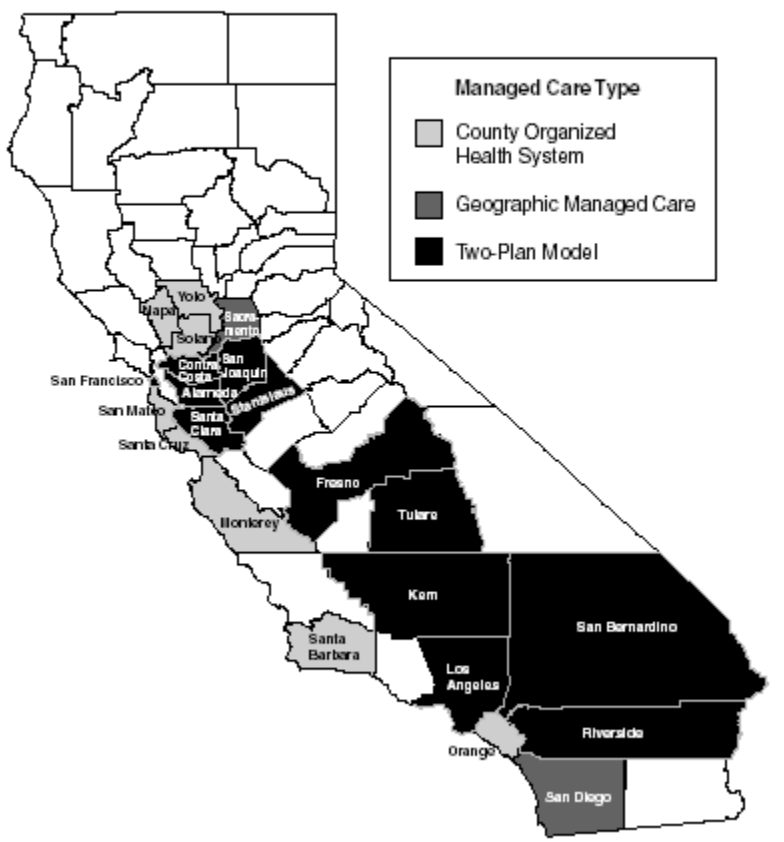
- Capitation: Flat monthly per patient payment rate
- Less choice, patients must seek care from specific providers (-)
- Incentivizes care coordination and cost containment (+)

Medi-Cal Managed Care

- 43% of California counties administer Medi-Cal via a managed care model:
  - Two-Plan Model
    - San Francisco
  - County Organized Health Systems
  - Geographic Managed Care

Figure 3

Map of California's Medi-Cal Managed Care Counties



Medi-Cal Managed Care: Current Mandatory Enrollment Populations

- Children
- Non-disabled parents
- Pregnant women
- Seniors and persons with disabilities

Medi-Cal Fragmentation: Carve Outs

- Specialty mental health
- Dental
- Long-term care
  - Institutional
  - HCBS
- Seriously ill and disabled children

Health Reform + 1115 Waiver to Strain Medi-Cal Managed Care

- ↑ enrollment, including mandatory enrollment of SPDs and others
- Push to expand provider networks
- Cost containment
- Improve health outcomes despite sicker patient population
- Timely access standards

47th

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

Health Reform + Reimbursement

General Impacts

- By 2016, 92% of US residents insured
- 30,000 new Medi-Cal enrollees in San Francisco (24% increase)
- Up to 64,400 uninsured San Franciscans post-Health Reform

Hospital Reimbursement Impacts

- Medicare
  - Hospital Readmissions Payment Reductions (Mandatory)
  - Hospital Value-Based Purchasing Program (Voluntary)
- Medi-Cal
  - Payments adjusted for hospital-acquired conditions
- ↓ DSH Payments

Charity care needed for up to 64,000 uninsured post-Health Reform.

FQHCs to Serve Expanded Insured Population, ↑ Access to Care

$122 billion

Amount of savings (national) FQHCs are expected to generate between 2010 and 2019. Of that amount, $55 billion would be savings to Medicaid.

- New federal $ for FQHC expansion
  - Community Health Centers Trust Fund
    - $11 billion over five years ($9.5 billion for capacity + $1.5 billion for capital)
- Health Benefit Exchange: Private insurance reimbursement aligned with Medicaid
- Federal base appropriations threatened

Expanded Medi-Cal Population Faces Access Barriers

- Temporary ↑of Medicaid primary care reimbursement rate (2013-2014)
  - Not likely to have significant impact
- California challenges
  - Low reimbursement rate
  - State trying to reduce rates further

30,000

Expected number of new Medi-Cal enrollees in San Francisco after Health Reform implementation.

PCMH Emphasizes Care Coordination + Quality + ↓ Costs

PCMH model strives to:

- ↑ Care quality
- ↑ Care coordination
  - Interdisciplinary teams (e.g., primary care physicians, case managers, RNs, etc.)
- ↓ Costs
  - Capitation

PCMH pilots not specifically funded though other opportunities exist.

Challenges for Long-Term Care

- Challenges
  - SF population aging
  - Institutional care $$$$
  - Medi-Cal = primary payer

- Possible Options
  - Health Reform emphasis on home-/community-based services
  - Long-Term Care Integration
  - Support Services (e.g., escort)

Summary + Policy Considerations

Summary

- US spends a significant amount on health care – without yielding better health outcomes.
- Less comprehensive health care spending data is available at the state and local levels, making those realities less clear.
- The US health care system is fragmented, likely leading to less coordinated and more costly care.
- Health Reform will pilot programs to test reimbursement and health care delivery innovations that incentivize better care and curb costs.
  - Unclear to what extent California can meet demands given its existing reliance on managed care (a care coordination and cost containment strategy).
  - Medi-Cal Managed Care expected to be strained under Health Reform.
  - Hospitals facing more stringent reimbursement reality, need for charity care to continue.
  - FQHCs will likely be strained under Health Reform despite incentives.
  - Special challenges face long-term care, which is primarily funded by Medi-Cal.

Preliminary Policy Considerations for Discussion

Land Use-Specific Policy Considerations

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

Broader Policy Considerations

- Extend the increased Medicaid primary care physician reimbursement rate beyond 2014.
- Improve collection and availability of health care finance data at the state and local levels.
- Promote support services (e.g., escorting patients to appointments).

QUESTIONS + TASK FORCE DISCUSSION

Thank you!