HEALTH CARE FINANCE

Presentation to the Health Care Services Master Plan Task Force
December 22, 2011

Lori Cook, Senior Health Program Planner
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
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.

$2.5 trillion

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

Source: CMS via California Health Care Almanac Quick Reference Guide
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

### Gross Revenue and Net Revenue by Payer
(Categories Include Traditional and Managed Care Patients)

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

- Gross Revenue and Net Revenue categories include traditional and managed care patients.
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 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 (+)
43% of California counties administer Medi-Cal via a managed care model:

- Two-Plan Model
  - San Francisco
- County Organized Health Systems
- Geographic Managed Care
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

Funding + system fragmentation lead to fragmentation in care.
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

![Medical Invoice](image)

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>$</th>
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</thead>
<tbody>
<tr>
<td>Office Visit</td>
<td>125.00</td>
</tr>
<tr>
<td>Lab Work</td>
<td>225.00</td>
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<tr>
<td>X-Rays / Abdominal</td>
<td>350.00</td>
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<tr>
<td>Surgery</td>
<td>7,500.00</td>
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<tr>
<td>Anesthesia</td>
<td>7,000.00</td>
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<tr>
<td>Pathology</td>
<td>531.00</td>
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<tr>
<td>Medical/Surgical Supplies</td>
<td>357.00</td>
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<tr>
<td>Post-Op Care</td>
<td>482.00</td>
</tr>
</tbody>
</table>

**TOTAL CLAIM:** $10,570.00

**LESS DEPOSIT:** $0.00

**BALANCE DUE:** $10,570.00
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!