

Redesigning California's Medi-Cal Program: Examining the Potential for Cost Savings and Program Improvements

Briefing Paper

This hearing has been scheduled in the wake of the release by the Department of Health Care Services (DHCS) of a concept paper that contemplates significant changes in the state's Medi-Cal program. The concept paper proposes improved management and coordination of care and strengthening the state's safety net. It focuses on the following four groups within Medi-Cal who are the most seriously ill and who do not have a specific method to organize or coordinate their care within Medi-Cal:

- Seniors and persons with disabilities (SPDs)
- Dual eligibles (Those eligible and enrolled in both Medi-Cal and Medicare)
- California Children's Services (CCS)
- Those requiring specialty mental health care.

The concept paper proposes that the state seek federal approval for a new Section 1115 waiver. By way of background, under the federal Medicaid program, certain laws and rules can be waived to grant states greater program flexibility. Medi-Cal is California's version of the federal Medicaid program.

Medicaid waivers

Section 1115 of the Social Security Act allows the Secretary of Health and Human Services to authorize pilot or demonstration projects that can help promote the objectives of the Medicaid programs. Section 1115 waivers are generally used to allow states to institute demonstration projects and provide federal funding that would not normally be eligible under federal law. To avoid Congressional approval, these waivers must be budget neutral over the life of the waiver, meaning that they cannot cost the federal government more than it would normally pay under Medicaid in the absence of the waiver. All waivers are subject to approval by the Centers for Medicare and Medicaid Services (CMS), the Office of Management and Budget and the Department of Health and Human Services.

Waivers allow states more flexibility in their programs. Under waivers, states have instituted new systems of care delivery, expanded service eligibility for non-Medicaid eligible populations and provided services that may not be a covered benefit under Medicaid. States such as Indiana, Massachusetts and Vermont have reformed their health care systems using federal Medicaid waivers. A common element in these state programs has been expansion of eligibility for each state's Medicaid program. However, states have gone beyond eligibility expansions and have combined expansions with additional programs such as investments in prevention, care coordination and management and quality improvements.

Medi-Cal waivers

California has 16 different waivers currently, including a section 1115 Medicaid waiver, entitled the Medi-Cal Hospital/Uninsured Care Demonstration Project, or the hospital waiver, as it is commonly known, which expires on August 31, 2010. The hospital waiver was implemented by SB 1100 of 2005 (Perata and Ducheny). SB 1100 had widespread effects on both public and private safety net hospitals. This new proposed waiver outlined in DHCS's concept paper would replace the hospital waiver.

The result of SB 1100 was a wholesale change in how both designated public hospitals (as defined in the waiver) and private and other public hospitals are paid under the Medi-Cal program. The current hospital waiver also contains a coverage component that provided \$180 million in federal funds annually to the state. The first two years of that funding were conditioned upon the state mandating that seniors and persons with disabilities be enrolled in managed care modes of delivery service. The state did not enact legislation that would have allowed the state to use that portion of the funds. The remaining three years of the waiver provided \$180 million in federal funds for a coverage initiative, which were pilot projects for covering the uninsured.

Since the hospital waiver's enactment, there have been numerous discussions about the form of the next waiver. Important among these efforts was the work of the Blue Shield Foundation which funded a work group of stakeholders who had a series of meetings and discussions that focused both on changing hospital payments and expanding coverage. As a result of that and other efforts, a variety of reports have been produced that contemplate changes in the state's hospital waiver.

California's new pending waiver

In the 2008-09 May revision, Governor Schwarzenegger signaled an interest in making improvements to fee-for-service Medi-Cal. The May revision stated that slowing the rate of growth in health care expenditures is an essential component of efforts to restore the state's fiscal balance and to achieve coverage for all Californians, noting that the Medi-Cal program is the largest purchaser of health care in California. It was also noted that a disproportionate share of Medi-Cal spending is concentrated among a small segment of enrollees, the majority of whom have complex chronic medical conditions, including behavioral health conditions, and that emphasizing prevention and increased use of

primary care services offers the promise of better health outcomes and slower rates of growth in costs. The administration concluded that it is committed to working with the Legislature and stakeholders to identify enhancements to the Medi-Cal fee-for-service system that improves health outcomes and slows the overall rate of cost growth.

With the expiration date of the hospital waiver rapidly approaching, the administration and the Legislature began planning for a new, more comprehensive 1115 waiver. One of the budget trailer bills, the recently enacted AB4X 6 (Evans), outlines the goals of a new comprehensive waiver:

- strengthening California’s health care safety net;
- reducing the number of uninsured individuals;
- optimizing opportunities to increase federal financial participation;
- promoting long-term, efficient and effective use of state and local funds;
- improving health care quality and outcomes; and
- promoting home and community-based care.

The bill also directed that the new waiver shall be developed for the purposes of providing the most vulnerable Medi-Cal enrollees with access to better coordinated and integrated care that will improve outcomes in the Medi-Cal program and help slow the long-term growth in program costs. DHCS was directed to realize the goals of the bill by considering better care coordination for seniors and persons with disabilities, enhanced coordination of Medi-Cal and Medicare coverage, improved coordination and integration of care for children with significant medical needs and improved integration of physical and behavioral health.

The focus is on these groups because of the seriousness of their medical conditions. As a group, those with the most serious chronic illnesses, consume the largest share of Medi-Cal expenditures. For example, an estimated 10 percent of beneficiaries account for about 75 percent of program costs. Most of these are enrolled in Medi-Cal fee-for-service program, which does not currently offer an easy method to manage and integrate their care.

Department of Health Care Services concept paper

DHCS has released a draft of the concept paper for the new waiver and held a public meeting to gain comments on the paper earlier this month. The revised concept paper will be submitted to the federal Centers for Medicare & Medicaid Services (CMS) to initiate discussion on the design of the waiver. California will then work with CMS to develop and secure approval of the waiver application. The concept paper is truly that, a conceptual proposal that lacks important details, but appropriately so given the early stage of the process in developing a new waiver.

The concept paper has been developed through coordination between the Legislature and the Governor and through the input of stakeholders. DHCS states that this input has been helpful in shaping the concept paper.

The concept paper argues that many Medi-Cal enrollees have a coordinated system of care through their enrollment in managed care plans of various types. In Medi-Cal, families generally are subject to mandatory enrollment in managed care while other groups, including seniors and persons with disabilities, may voluntarily enroll in managed care, but most elect to stay in fee-for-service Medi-Cal. The exception is in counties where Medi-Cal is provided by a county organized health system. In those selected counties all beneficiaries are enrolled in a county-created managed care plan.

The concept paper argues that fee-for-service, does not provide consistent and coordinated care for California's most vulnerable populations, which are the four target groups called out in AB4X 6—the SPDs, children with special health care needs, Medicare and Medicaid dually eligible individuals and children and adults with serious mental illness. The concept paper highlights the problems with lack of coordination of care:

- The program does not integrate the primary, acute, behavioral health, and long term care needs of the SPD populations.
- Even those SPDs enrolled in managed care face a similar problem of lack of integration when they seek specialty mental health services, because such services are carved out of Medi-Cal managed care.
- Fragmentation between Medi-Cal and Medicare contributes to poor outcomes and results in care being provided in inappropriate and expensive settings.
- Caring for the 200,000 children with special health care needs is split between Medi-Cal and CCS programs because, CCS services are carved out of Medi-Cal managed care.

The concept paper identifies four initiatives for achieving the goals:

Promote organized delivery systems of care. Such systems will place a strong focus on primary and preventive care and evidence-based services which should be able to provide the appropriate care in the right setting at the right time. The concept paper does not recommend a delivery system for this, acknowledging that the state could use the existing managed care delivery system or newly developed enhanced medical home models and whatever mode is chosen could vary throughout the state. The overall goal will be to improve access and care coordination and slow the long-term growth rate of the Medi-Cal program.

Strengthen and expand the health care safety net. The waiver will help the safety net by providing a role for designated public hospitals in a system of care for seniors and persons with disabilities, preserving and supporting state and county health care programs, and increasing federal financial participation for designated public hospitals. While the concept paper details the role of the designated public hospitals, it is silent with regards to private hospitals and other safety net providers.

Implement value-based purchasing strategies. The purpose of these new strategies is to change payments to improve health care quality and outcomes and to slow the

long-term growth rate of Medi-Cal. In particular, California will work to design value-based purchasing strategies for the program and for the new systems of delivery. The concept paper lists as possible options, pay for performance for providers, healthy rewards and incentives for beneficiaries and nonpayment of health care acquired conditions.

Enhance the delivery system to prepare for national health care reform. The concept paper notes that the last waiver funded a coverage initiative, which resulted in DHCS awarding 10 grants in different counties. DHCS would now like to see these programs made more consistent and align them more closely with the organized delivery systems for SPDs. DHCS also proposes expanding the number of coverage initiatives, reforming payments and improving enrollment into the coverage initiative.

While not specifically identified as an initiative, the concept paper does acknowledge that investments in health information technology will be critical in improving health care quality and outcomes.

The concept paper discusses the possible use of medical homes. Nationwide, medical homes are being used more widely because they are seen as a way to curb the growth in health care costs. Medicare and many other states currently have medical home projects. Medical homes can be described in a number of ways, but are generally seen as an enhanced model of primary care in care teams provide to the various needs of patients and allow comprehensive and coordinated patient-centered care to be provided. Medical homes can exist in managed care or fee-for-service. Medical homes are not a new concept, but have evolved. The current debate focuses on the concept of a “patient centered medical home,” which is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient’s family and has been agreed to by four major groups of physicians.

The concept paper is being prepared and submitted against the backdrop of possible federal health care reform. The concept paper argues that the proposal will help the state prepare for the enactment of federal health care reform and will also be implemented several years prior to the implementation of the federal initiative.

DHCS acknowledges that waiver implementation will take time to design and implement more organized and accountable approaches. ABX4 6 requires that there be a stakeholder process, that it will be used to develop the implementation plan based on the concept paper. The implementation plan is another requirement of ABX4 6. The plan must be submitted to the Legislature at least 60 days prior to any appropriation. The paper does provide some additional detail on a stakeholder process. DHCS envisions the stakeholder process will be used for implementation of the waiver.

Next Steps

In a formal sense, there are relatively few steps that have to be taken to begin the new waiver.

1. DHCS must revise the concept paper in response to comments and submit it to CMS.
2. Stakeholder process must be organized and commenced.
3. Final Terms and Conditions of Waiver must be prepared by CMS and agreed to by the state.
4. The Implementation plan must be prepared.
5. Implementation plan must be submitted to Legislature, 60 days before any implementation that requires an appropriation.
6. Any necessary legislation enacted by end of 2010 session.

Informally, there is a large amount of work that must be done in a relatively short period. One of the main tasks will be the stakeholder process and how DHCS will keep stakeholders, including the Legislature, informed and involved as negotiations continue with CMS. At this point, DHCS has released little information on the stakeholder process and the partnership role for the Legislature and stakeholders during negotiations.

Relevant Legislation

SB 208 (Steinberg and Alquist) requires DHCS to submit a waiver request to implement a demonstration project to improve Medi-Cal and conditions the waiver upon subsequent statutory enactment. *This bill is in the Assembly Health Committee*

AB 342 (Bass) is identical to SB 208. *This bill is in the Senate Health Committee.*

Background on programs and services likely to be impacted by the new waiver.

The California Children's Services (CCS) program. CCS is administered by the Department of Health Care Services (DHCS) and provides medical care and medical therapy for children with certain physical limitations and chronic health conditions or diseases. Eligibility is limited to children under 21 years of age who must have one or more of the specified medical conditions and be in a family that meets one of three family income eligibility criteria. The eligibility criteria are: the families have an adjusted gross income of \$40,000 or less, the children have Healthy Families coverage, or the family has medical care costs in excess of 20 percent of the family's adjusted gross income. Originally established in 1927, CCS manages the care of children with special health care needs such as leukemia and other cancers, cleft palate, congenital heart disease, HIV, spina bifida, diabetes, cerebral palsy, sickle cell anemia, muscular dystrophy, premature birth and other serious life-threatening conditions.

The CCS program is not a comprehensive health insurance program, but provides medical care, medical therapy and case management services related to a child's specific qualifying condition. CCS provides these children with a state-certified pediatric specialist provider network, highly specialized treatment plans and multi-disciplinary pediatric case management teams. The CCS program will only pay for medical services provided by a CCS-approved provider. Less than two percent of California's children have special health care needs that fall within the jurisdiction of CCS.

Specialty mental health

Within the Medi-Cal program, specialty mental health services include medically necessary inpatient and outpatient services delivered by a mental health professional to patients who meet certain diagnostic and impairment criteria. These services have been “carved out” of the Medi-Cal program, meaning they are the responsibility of DMH and county mental health programs and not the Medi-Cal managed care plan. These services are provided by counties through mental health managed care plans that operate in individual counties and contract with DMH, using the managed care model of service delivery. Each county mental health department is responsible for providing specialty mental health services to Medi-Cal recipients in their county, and may provide those services itself, or through contracted providers.

Drug Medi-Cal

State law also establishes the Drug Medi-Cal program administered by the Department of Alcohol and Drug Programs (DADP). Drug Medi-Cal benefits are optional Medi-Cal benefits that the state has chosen to offer. Drug Medi-Cal services provide medically necessary alcohol and drug treatment to at least some eligible Medi-Cal recipients. Services include outpatient drug free treatment, methadone and naltrexone treatment, day-care rehabilitative treatment and residential treatment. All pregnant and postpartum women receive the broadest array of services related to drug and alcohol abuse. Other recipients receive varying levels of services.

DADP administers Drug Medi-Cal through an interagency agreement with DHCS. DADP contracts with counties or other providers to provide Drug Medi-Cal services. State law specifies which programs can be part Drug Medi-Cal if federal financial participation is available.

Current efforts by DHCS to manage care

Generally, Medi-Cal is responsible for providing both physical and mental health care services to beneficiaries. Medi-Cal services are provided by a combination of fee-for-service providers and Medi-Cal managed care plans. For those beneficiaries enrolled in managed care, the state pays a plan a capitated rate and the plan is responsible for arranging treatment. Certain conditions are “carved out” of Medi-Cal managed care, meaning that they are not the responsibility of the managed care plan. These include California Children’s Services (CCS) and specialty mental health.

Within fee-for-service, DHCS has several programs to manage the care of beneficiaries. Existing law authorizes DHCS, where it is expected to be cost-effective, to establish a program of aggressive case management of elective, non-emergency acute care hospital admissions for the purpose of reducing both the numbers and duration of acute care hospital stays by Medi-Cal beneficiaries. This program is known as the medical case management program.

In addition, DHCS was required to apply for a waiver of federal law to test the efficacy of providing a disease management benefit to Medi-Cal beneficiaries. The enabling statute

requires the disease management waiver benefit include the use of evidence-based practice guidelines, supporting adherence to care plans; providing patient education, monitoring, and healthy lifestyle changes. While the pilot is still underway, there is growing disenchantment with disease management because traditional disease management programs focus on a defined population of members with a specific health condition such as diabetes or asthma. By comparison, case management programs target members with a wide array of health conditions and risks, including multiple chronic conditions, and establish care plans that are customized to the needs of individual patients.

Agenda
Informational Hearing

Senate Health Committee

**Redesigning California's Medi-Cal Program: Examining the Potential
for Cost Savings and Program Improvements**

Wednesday, November 18, 2009

State Capitol – Room 4203

1:30 p.m. – 4:30 p.m.

- I. Opening Remarks (10 minutes)**
 - Senator Elaine Kontominas Alquist, Chair
 - Other members present

- II. The State of California's Concept Paper for a Comprehensive Section 1115 Waiver for Medi-Cal (30 minutes)**
 - David Maxwell-Jolly, Director, and Toby Douglas, Chief Deputy Director, Department of Health Care Services

- III. Challenges and Opportunities in Coordinating and Managing Care (20 minutes)**
 - Kathy Kuhmerker, Managing Director, The Lewin Group

- IV. Fiscal Implications for the Medi-Cal Waiver (10 minutes)**
 - Meredith Wurden and Farra Bracht, Legislative Analyst's Office

- V. Discussion of Concepts for the Medi-Cal Waiver (45 minutes)**

- Kim Roberts, Chief Executive Officer, County of Santa Clara Health and Human Services Agency
- Elizabeth Landsberg, Legislative Advocate, Western Center on Law and Poverty
- Michael Powers, Chief Executive Officer, County of Ventura Health Services Agency
- Louise Rogers, Director, Behavioral Health and Recovery Services, County of San Mateo
- Bradley Gilbert, MD, Chief Executive Officer, Inland Empire Health Plan
- Beth Capell, Health Access California

VI. Perspectives on the Medi-Cal Waiver (45 minutes)

- Anne McLeod, California Hospital Association and Melissa Stafford Jones, California Public Hospital Association
- Lyman Bo Greaves, MD, California Medical Association and California Academy of Family Physicians
- Marty Lynch, PhD, Executive Director/CEO Lifelong Medical Care and California Primary Care Association
- Laurie A. Soman, Director CRISS Project, Lucile Packard Children's Hospital
- Kathy Ledesma Ochoa, SEIU Local 721, Director Strategic Initiatives
- Lisa Rubino, President, Molina Health Care California and Board Member, California Association of Health Plans

VII. Public Comment (15 minutes)

VIII. Closing remarks (5 minutes)