

AGENDA
ASSEMBLY BUDGET SUBCOMMITTEE NO. 1
ON HEALTH AND HUMAN SERVICES

Assemblymember Judy Chu, Chair

MONDAY, MAY 5, 2003
STATE CAPITOL, ROOM 437
3:00 PM

ITEMS TO BE HEARD

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ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 1: EFFECT OF MEDI-CAL REDUCTIONS ON PUBLIC HEALTH SYSTEMS

Public Hospitals and Health Systems

1. Denise K. Martin, President and CEO, California Association of Public Hospitals and Health Systems
2. Peter Bryan, CEO, Kern Medical Center
3. Robert Sillen, Executive Director, Santa Clara Valley Health and Hospital System
4. Ken Cohen, CEO, Alameda County Medical Center

Department of Health of Health Services

1. Stan Rosenstein, Deputy Director Medical Services

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL**ISSUE 2: COMMUNITY ADMINISTRATIVE SERVICES ORGANIZATIONS****BACKGROUND:**

Individuals who qualify for Medi-Cal on the basis of disability are medically complex, and their health care can be costly and difficult to coordinate. Typically classified as a group, the disabled are a heterogeneous collection of persons with an array of disabling conditions, including persons with physical disabilities, mental retardation/developmental disabilities or mental illness. Many of the disabled have multiple conditions; it is not uncommon for disabled beneficiaries to have both physical and mental related conditions. Both the health and social service needs of disabled beneficiaries are distinct and greater on average than those beneficiaries without disabilities. For the disabled, access to specialty care, management of chronic conditions, use of pharmaceuticals, and use of medical supplies/equipment are major issues. Non-medical issues, including behavioral health, social service, transportation, and housing are critical aspects that often need to be addressed in caring for the disabled.

Compared to fee-for-service Medi-Cal, enrolling the disabled in some form of managed care delivery system could help the state generate budget savings and provide higher quality care and more accessible care for the disabled. A Community Administrative Services Organization (CASO) is an alternative to health maintenance organizations (HMOs) or insurance plans. HMOs contract with a sponsor (employer or state) to administer and provide a specific set of covered services to the sponsor's covered population for a fixed payment per member per month. The CASO would be accountable to local community interests, which would include disabled advocates, providers, local government and other local stakeholders. A governing board comprised of local stakeholder representatives would direct each CASO.

A CASO would accept little or no medical risk on behalf of the sponsor; the sponsor would retain the risk for the cost of care. Instead the sponsor contracts with the CASO to provide all of the managed care administrative functions on behalf of the sponsor. The sponsor determines the overall parameters of coverage (eligible population, benefit package, payment rates, cost sharing), while the CASO arranges for and administers the services using managed care principles. The CASO carries out managed care health plan functions, charging the sponsor an administrative fee. The CASO, in exchange for an administrative fee from the state, would provide the following managed care administrative function: develop and maintain a contracted provider network; pay provider claims; perform service authorization functions; manage pharmacy services; perform case management functions; collect, analyze and report program data; perform customer service functions; monitor quality of care; credential providers; provide health education/wellness promotion services/perform financial management and accounting functions; and operate a well-designed care coordination program. The arrangements work to the benefit of the sponsor by cutting out the middleman – savings generated by applying managed care principles accrue directly to the sponsor.

In Medi-Cal, the state would retain overall risk and fiduciary responsibility for the disabled beneficiaries. The state on a regional or local basis would contract with CASO to help the state manage the services provided to disabled beneficiaries in each region. The state would pay each CASO an administrative fee (on a per member per month basis) to carry out specific

managed care administrative functions, placing the CASO at-risk for its administrative operations. To ensure high performance by each CASO, the state would also include incentive payments based upon the specific operational or quality performance goals.

Under the CASO model, the contracted provider network would be set up as a preferred provider network, and providers would be reimbursed on a **fee-for-service basis**. Disabled beneficiaries would receive care from a contracted network of primary care or specialist physicians. Many disabled members rely on specialists to provide primary care services, so under this model, disabled members could directly select certain specialists as their primary care provider. Disabled members could also have standing referrals to seek services from specialists and to obtain certain services without prior authorization, if part of an approved care plan. To check utilization and to ensure high quality and cost effective care, the CASO would impose utilization criteria. Specific medical procedures would be subject to prior authorization, as would be certain drugs, medical supplies and medical equipment, if not part of an approved plan.

The underlying principle of CASOs is care coordination. Care coordination programs are important in managing care for disabled beneficiaries because they guide high-risk beneficiaries through the maze of medical and social providers and help to reduce duplicate or unnecessary services. The state would require each CASO to operate a care coordination program to manage both the medical and psychosocial needs of this population. CASOs would generate savings while promoting quality care:

- In establishing a contracting provider network, the CASO would be able to negotiate more favorable rates based upon volume, particularly in the areas of medical supplies and durable medical equipment. The CASO would also use provider credentialing and quality standards to weed out marginal providers, thereby ensuring a network of high quality providers.
- The CASO's case management and care coordination functions would help to ensure that disabled beneficiaries receive the right services at the right times. The care coordination programs would include both the medical and psychological needs of the population. The care coordination program would extend beyond referrals to social services agencies, instead focusing on coordinating a full range of medical and social services both offered inside and outside of the CASO (housing, transportation, access to mental health services, other social services).
- By maintaining specific service criteria and prior authorization services not included in the patient's care plan, the CASO would be able to ensure timely access to needed care and reduce unnecessary or marginally beneficial services.

The disabled beneficiaries, their representatives and health care providers express skepticism about mandatory enrollment of the disabled into managed care. The CASO concept addresses many of the concerns. Because the CASO is not at risk for the cost of care, the CASO does not have a direct financial gain from denying services or constraining access. The CASO model eliminates the middleman; there is no third-party health plan taking a percentage of the providers' reimbursement. By establishing a CASO within a community governance framework, both the disabled and provider communities have input into how the CASO is structured and operated.

COMMENTS:

Department of Health Services, what has been the state's experience with CASOs? Do they have merit in the delivery of health care to the disabled population?

Department of Health Services, has the state ever conducted a pilot study to compare what savings a CASO could achieve compared to what the state receives in its fee-for-service program?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL**ISSUE 3: LOS ANGELES COUNTY – HEALTH AUTHORITY LAW
ENFORCEMENT TASK FORCE****BACKGROUND:**

In 1999, Los Angeles County created the Health Authority Law Enforcement Task Force (HALT) to investigate complaints of Medi-Cal fraud. According to a letter from the Los Angeles County Board of Supervisors, HALT has assisted in saving the state an estimated \$27 million per year through its investigation and arrest of unlicensed medical practitioners and corrupt licensed medical providers and pharmaceutical companies. According to the Board of Supervisors, HALT combines the expertise and authority of the County Health Officer and law enforcement agencies to investigate and arrest individuals who are involved in Medi-Cal fraud. Since April 2000, HALT has cooperated with the State Department of Health Services in the investigation of Medi-Cal Fraud cases.

The state and the county operate under a Memorandum of Understanding and the state does not provide any funding to the county to cover its expenses. The Department of Health has a full time investigator to work with HALT. To date the cooperative effort has worked 42 provider fraud cases where four providers had a mandatory license loss, five had a temporary loss of license and two have been placed on reimbursement withholds.

The Board of Supervisors requests the Legislature redirect a portion of the cost savings and enforcement fees resulting from HALT's efforts. The Los Angeles County Department of Health Services funds the team at a cost of approximately \$600,000 per year. The county states that any funds provided to the county would be utilized to offset the cost of the team and increase the enforcement activities.

COMMENTS:

Department of Health Services, please outline for the Subcommittee the working relationship between the Department and Los Angeles County Department of Health Services on Medi-Cal fraud investigation.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 4: ENHANCED MEDI-CAL BUDGET ESTIMATE REDESIGN – FINANCE LETTER**BACKGROUND:**

The Finance Letter proposes to shift the development and implementation of the Enhanced Medi-Cal Budget Estimate information system from outside vendors to in-house staff. Utilizing in-house staff, the department will save \$575,000, \$144,000 General Fund. The Enhanced Medi-Cal Budget Estimate information support system was adopted in the 1999-2000 Budget. The system will replace the existing system for estimating the state's Medi-Cal expenditures.

COMMENTS:

Department of Health Services, please provide an overview of the development of the Enhanced Medi-Cal Budget Estimate information system and when it will be incorporated into the budget process.

No issues have been raised.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL

ISSUE 5: BREAST AND CERVICAL CANCER MEDI-CAL POSITIONS – FINANCE LETTER**BACKGROUND:**

The Finance Letter proposes to increase General Fund expenditures to restore funding for 13 existing positions to administer the Breast and Cervical Cancer Treatment Program. The General Fund replaces Tobacco Settlement Fund monies to pay for the positions. The tobacco settlement funding is not available because the tobacco settlement securitization did not occur. Phillip Morris was required to post a bond of \$12 billion in Illinois and the market for the state's security evaporated on the news that the company became bankrupt.

COMMENTS:

No issues have been raised on the Finance Letter.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL**ISSUE 6: CHILD HEALTH AND DISABILITY PREVENTION – NEWBORN****BACKGROUND:**

Under the Child Health and Disability Prevention (CHDP) Program Gateway to be implemented July 1, 2003, eligible children under 19 will be able to enroll temporarily into health insurance at pediatricians' and clinic offices. The Department of Health Services believes the launching of CHDP will be July 1, 2003, as it projected. However, to continue coverage in either Medi-Cal or Healthy Families beyond the month after the CHDP visit, a family will have to complete and submit a regular application for the child. If the application is not received at the single point of entry before the end of the month after the CHDP visit, the child's coverage is automatically terminated by the computer program.

For certain infants under the age of 1 year, however, the automatic termination of coverage would violate federal and state law. These are infants whose mothers had Medi-Cal for the delivery. Such infants automatically acquire continuous Medi-Cal eligibility for the first year of life; under federal law, they are specifically deemed to have applied for Medi-Cal and to be found eligible until age 1. According to Maternal and Child Health Access (MCHA), the state thus has no authority to end Medi-Cal for these infants before their first birthday for failure to submit a regular Medi-Cal application after starting Medi-Cal through the CHDP Gateway.

MCHA states the solution is to modify the CHDP Gateway to confirm an infant's deemed eligibility by verifying the mother's Medi-Cal coverage for the delivery and to continue the infant's Medi-Cal until the first birthday without requiring the family to submit a regular application. MCHA believes that without such a modification, the CHDP Gateway will be inconsistent with federal law, the state may be vulnerable to litigation, and deemed eligible infants will miss out on coverage.

In addition, MCHA proposes modifying the electronic CHDP Gateway to streamline deemed eligible infants' enrollment into Medi-Cal for the year. This would be much more efficient administratively than processing unnecessary applications for these infants through the single point of entry or at county social services offices. MCHA states that "Modifying the gateway to conform to federal law would also help address the many problems families now face with the current 'manual' process for enrolling deemed eligible infants at the county..." MCHA states that the modification of the CHDP Gateway for these purposes has been estimated by the Department of Health Services to cost \$196,000 General Fund. MCHA also notes trailer bill language will be needed to implement the Gateway for the newborns.

A new subsection (b) would be added to the Welfare and Institutions Code 14011.7 and existing subsection (b) would become (c):

"(b) In addition to the implementation of a program of pre-enrollment of children into Medi-Cal or Healthy Families programs as described in subdivision (a), the Department may, at its option, use the electronic application described in subdivision (c) to also serve as a means to enroll newborns into the Medi-Cal program as is authorized under 42 United States Cod section 1396 e)(4)."

COMMENTS:

Department of Health Services, please summarize for the Subcommittee the issue of Medi-Cal infant eligibility.

Department of Health Services, is the \$196,000 General Fund estimate of the Gateway modification accurate?

Department of Health Services, does the estimate cover all categories of deemed eligible infants?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL**ISSUE 7: DISEASE MANAGEMENT****BACKGROUND:**

The Legislative Analyst's Office (LAO) notes costs associated with chronic diseases play a significant role in the increase in health care costs. For a disease to be chronic it must last a year or longer, limit an individual's physical activities and require medical care. Chronic diseases include asthma, diabetes, and heart disease. Nationwide, more than 25 percent of adults on Medicaid have a chronic condition. Extrapolating that to California would mean that at least 700,000 adults on Medi-Cal suffer from a chronic disease. The LAO in the Medi-Cal Analysis of the Budget concludes that the State of California could save hundreds of millions of dollars annually and improve the care for patients with difficult to control health conditions by employing disease management in the Medi-Cal program.

Disease management is a strategy to get individuals to take better care of their chronic health conditions. Such a program can improve the quality of life of patients by catching health-related problems early, enabling patients to subsequently avoid high-cost medical treatments and procedures – especially those associated with hospitalizations. The following chronic conditions are typically covered by disease management programs: coronary artery disease; diabetes; chronic heart failure; chronic obstructive pulmonary disease; hypertension; and asthma.

Disease management programs combine the following key approaches to help ensure that patient care is coordinated and that patients adhere to treatment programs:

- ◆ Individuals who are willing to participate are identified by a nurse or physician as someone who could benefit from disease management using information about their use of pharmacy and lab services, clinical data, and patient surveys. After adjusting for the severity of health care needs, appropriate interventions are developed to address the special needs of individuals with severe chronic medical problems. Obtaining and interpreting patient data from Medicaid enrollees can be challenging because individual beneficiaries often repeatedly enroll and disenroll in the program depending on their need for medical services and frequently change residences.
- ◆ Disease management relies upon the use of telecommunications and computer technology to create a more closely knit and better-coordinated working relationship among patients, their nurses or care managers, and their physicians.
- ◆ Patients are taught to better manage their own health care with intensive education aimed at increasing their understanding of their chronic diseases.

Studies of the efficacy of disease management programs have found that monitoring chronic conditions and improving the coordination of care can reduce the number of emergency visits or hospital stays of patients. These studies indicate that health care costs related to chronic conditions could be reduced by as much as 50 percent. These savings would be partly offset by the cost of disease management services, but in a number of cases the implementation of a

disease management approach has resulted in a significant net reduction in health program costs.

- 1) A 1998 study of a program that involved the interactive home monitoring of Medicaid patients who had previously been treated for congestive heart failure found that it significantly reduced their returns to the hospital for additional medical assistance. The program resulted in a 44 percent decrease in the readmissions of patients to hospitals and, despite the intensive nature of the disease management interventions, resulted in net savings of \$460 on average for each patient involved in the program.
- 2) Another study of heart failure patients in 1999 found that patients enrolled in an intervention program incurred overall health costs that were significantly less than for comparable patients who were not enrolled in the program.
- 3) There is evidence that disease management can also reduce the costs of other types of medical conditions besides heart problems. A 1999 study found that Virginia's disease management program for asthma patients enrolled in Medicaid reduced their collective number of emergency visits by about 41 percent.

If disease management programs are not carefully designed and implemented, the evidence indicates that they will not necessarily prove successful. Florida's first efforts a few years ago at implementation of a disease management strategy in its Medicaid program did not achieve the projected savings of \$113 million over four years, and may have actually cost the state more money than the program saved. Florida's failure to achieve the projected level of savings has been attributed to two main factors: an initial inability to correctly estimate the potential savings from the program, and specific problems in its approach to disease management.

In regard to the second factor, Florida's implementation approach was to contract with a number of disease management vendors, with each one hired to focus its efforts on one particular type of disease. This approach proved unsuccessful primarily because patients often have a combination of chronic conditions. Treating one disease at a time instead of implementing a comprehensive approach to a patient's entire set of chronic conditions appears to have been inadequate to improve patients' health care.

Although Florida's disease management program as a whole did not achieve savings, some of its individual efforts were successful. For example, the chronic health failure program, which has operated for more than two years in a fee-for-service medical system, has achieved 16 percent gross savings in the first year (net savings). The program achieved a 40 percent reduction in the utilization of medical services compared to another group of patients who for testing purposes did not receive such services.

Some disease management programs have effectively involved pharmacists in ensuring that patients take their prescription drugs in compliance with doctors' orders. A program for patients suffering from high cholesterol levels – a condition related to heart and other health problems – has demonstrated a positive effect on patients. One study found that, after one year, about 70 percent of patients continue taking their medicine compared to 30 percent nationally and about 85 percent of the same patients have healthy cholesterol levels compared to 45 percent nationally. Ensuring that patients take their medications properly can reduce health care costs by decreasing the number of unnecessary emergency room and hospital visits.

Not surprisingly, the implementation of disease management programs that focus on prescription drugs can result in an increase in drug utilization and expenditures for those medications. In this case, however, this is a desirable result because of the much larger and

offsetting savings associated with a reduction in the number of hospitalizations from keeping patients with chronic conditions healthy.

One state is taking an approach that guarantees that it will achieve savings, at least initially, from integrating disease management practices into its Medicaid program. Florida has contracted with a drug manufacturer that has guaranteed the state savings of \$15 million in the first year and \$18 million in the second year. The state has also contracted with another drug manufacturer for expected further savings of \$16 million.

The expansion of disease management programs is now a national trend. A number of states plan to implement disease management programs this year in an attempt to achieve savings in their Medicaid programs. The California Public Employment Retirement System is moving to implement disease management. Missouri will implement disease management programs for asthma, congestive heart failure, diabetes, and chronic obstructive pulmonary disease. Mississippi plans to implement such programs for asthma, diabetes, and hypertension. Iowa intends to enhance its existing programs, while the State of Washington recently signed agreements with three disease management companies providing the state a 5 percent guarantee of net savings (after disease management program costs have been taken into account) for Medicaid patients suffering from asthma, diabetes, congestive heart failure, and kidney disease.

Moving California Toward Disease Management

- 1) The LAO recommends the enactment of legislation to guide the implementation and evaluation of disease management pilot projects for the aged, blind, and disabled patients enrolled in fee-for-service Medi-Cal. Such pilot projects would enable the Legislature to identify the most cost-effective disease management programs for the Medi-Cal population. We estimate that the implementation of a full-scale disease management program for the aged, blind, and disabled could result in future net savings to the General Fund of up to several hundreds of millions of dollars annually.
- 2) ***Aged, Blind, and Disabled Could Benefit the Most.*** A growing body of scientific studies and the experiences of other states indicate that the effective implementation of disease management programs could reduce the state's health care costs and improve care for the more than 1 million aged, blind, and disabled Medi-Cal patients currently enrolled in Medi-Cal's fee-for-service health care delivery system. The older Medi-Cal beneficiaries are the most likely to fully benefit from a disease management program as they generally consume the most health care dollars. They are about 24 percent of the Medi-Cal population, but 64 percent of Medi-Cal program costs and they are living longer with multiple chronic conditions.

The fee-for-service system is a fragmented and uncoordinated approach to the delivery of care often not well suited for the care of individuals suffering from chronic medical conditions. For example, physicians participating in Medi-Cal are not required to communicate with one another about the care that they might be providing to the same patient. That could make it very difficult for a patient with significant health care needs to follow multiple treatment plans that include monitoring themselves, taking medication, and making other lifestyle changes.

General Fund Savings Could Be Significant. The LAO, on the basis of other states' experiences, estimates that the gross savings to the General Fund could range from \$387 million to \$601 million annually. The estimate assumes that 440,000 aged, blind and disabled patients with one chronic disease are managed. The total Medi-Cal costs to these patients in

2001 was \$5.3 billion (\$2.7 billion General Fund). The annual cost per patient was \$12,000 with the range being \$6,000 to \$76,000.

The cost of providing disease management services, using data from other states, ranged from \$900 to \$2,400 per person annually with the average being about \$1,650 per person and a total cost of \$360 million General Fund for serving the aged, blind, and disabled population. However, management of some diseases is more costly than for others. For example, the average annual cost of providing disease management services for someone with diabetes can cost as much as \$9,600 annually. Programs that focus on pharmaceutical use and that directly reimburse pharmacists for providing such services could cost much less.

Savings Levels Could Be Guaranteed. Using the same general approach as is now being implemented in Florida and Washington, the LAO believes a disease management program could be structured in California in a way that would guarantee savings to the state, or at least ensure that such a program would result in no additional costs to the state if it were unsuccessful. This could be accomplished by contracting for such services in a way that places the disease management contractor's fees at risk depending upon the contractor's ability to achieve an agreed-upon level of savings. If the contractor were unable to achieve that savings level, its fee payments from the state would be reduced or eliminated altogether.

The LAO recommends the Legislature budget the necessary funds and adopt statutory language directing the Department of Health Services to conduct a few small pilot projects in disease management for three years.

- 1) The projects would be designed to improve treatment of a variety of chronic conditions such as diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease and hypertension.
- 2) The cost of such pilot projects that focus on a portion of the chronic conditions would be about \$650,000, with a state General Fund appropriation of \$323,000 needed in the 2003-04 fiscal year to get such a project under way. (This amount could be higher or lower depending on the scope of the pilot program.)
- 3) The pilot projects would achieve a small amount of savings initially that could grow to reduce or eliminate the cost to the state of the projects in the future.
- 4) Funding from nonprofit organizations may be available to conduct an evaluation that could lower the state's financial commitment or expand the scope of the pilot projects. Legislation [AB 1949 (Baca)] to initiate a disease management program in Medi-Cal was proposed but not enacted during the 1997-98 legislative session.
- 5) The statutory language adopted for the pilot projects should include the following provisions:
 - a) A requirement that the pilot projects include statistically significant samples of the Medi-Cal aged, blind, and disabled population with the random assignment of an approximately equal number of patients with similar conditions both to a disease management program and to a "control group" that does not receive disease management services.
 - b) A requirement that the Department of Health Services test more than one type of disease management strategy, including at least one pilot project focused on intervention strategies and one focused on involving pharmacists in ensuring patient compliance with their drug prescriptions. If feasible, the Department of Health Services should also consider establishing a pilot project in which a contractor guarantees savings to the state and bears some financial risk for achieving savings from their implementation of disease management services.

- c) A requirement that the Department of Health Services evaluate the impact on the quality of care and fiscal effects of the disease management pilot projects and report the results of these pilot projects to the Legislature by December 1, 2006.
- d) Provisions authorizing the receipt and expenditure of grants from non-profit organizations to help offset the costs of such a study.

The LAO believes this approach would provide the Legislature with a scientifically valid and relatively low-cost approach to evaluating the potential benefits of disease management for the Medi-Cal program. Depending on the success of the pilot projects, the disease management services could be expanded to additional Medi-Cal patients in the future when the state may be better able to afford the substantial investment of funds needed to expand such programs. The LAO notes one important consideration for the Legislature is that any net savings from implementation of a disease management program in 2003-04 would probably not be realized until 2004-05.

COMMENTS:

Legislative Analyst's Office, please provide the Subcommittee with an overview of disease management and its applicability to Medi-Cal. What is the LAO estimate for potential savings from instituting disease management in California's Medi-Cal program?

Department of Health Services, please provide the Subcommittee with an assessment of disease management and its relevance to the Medi-Cal program.

Department of Health Services, what has been the experience with disease management in the Medi-Cal program? What promise does it hold for improved health outcomes and cost control? Has a broad scale pilot study been conducted to test its merits?

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL**ISSUE 8: CONTROLS ON SELECTED SERVICES****BACKGROUND:**

The Governor's January Budget proposal would implement new utilization and payment controls in the Medi-Cal program for savings of \$76 million total funds, \$38 million General Fund. See handout for trailer bill language.

The four proposals are as follows:

- Reduction of Medi-Cal rates to 80 percent of Medicare Level for Laboratory Services for an estimated savings of \$20 million in total funds, \$10 million General Fund. An across-the-board rate reduction of the Medi-Cal rate to 80 percent or less than the current federal Medicare rate is being proposed. Authority was provided to the Department of Health Services to contract out for laboratory services in the omnibus health trailer bill for the 2002-2003 Fiscal Year. Contracting for clinical lab services, however, takes time and has not yet been implemented. Therefore, to achieve the immediate savings needed the budget proposes a statutory change to limit the reimbursement to 80 percent of Medicare rates.

The Department notes that contracting will be implemented in three stages:

- a) Clinical laboratories not affiliated with either hospitals or clinics that perform moderate and/or high complexity tests;
 - b) Physician and physician groups;
 - c) Clinical laboratories that are affiliated with clinics that perform moderate and/or high complexity tests; and
 - d) Hospital outpatient laboratories will not be included in the contracting because of the Orthopaedic Hospital lawsuit agreement.
- Linking Reimbursement to Net Purchase Price of Products for an estimated savings of \$5 million total funds, \$2.5 million General Fund. The Department requires Medi-Cal billings by providers for medical supplies, incontinence supplies, durable medical equipment and prosthetic and orthotic appliances be based on the net purchase price of these products, not the estimated acquisition cost or the weighted average cost of the negotiated contract price, which both presume operation of market conditions. The Department reimburses providers at 23 percent above net purchase price. Savings would be generated by the proposal through auditing of claims data.
 - Rate Review and Adjustments for an estimated savings of \$35 million total funds, \$17.5 million General Fund. The Department proposes to research and eliminate obsolete Medi-Cal codes that are currently reimbursed. These codes may be obsolete due to medical advances such as medications, products, or equipment that is no longer manufactured, or physician procedures that are no longer in practice. For example, the elimination of payment for services not medically justified such as elastic stockings as a Medi-Cal benefit.
 - Procedure Code Restriction for an estimated \$16 million total funds, \$8 million General Fund. The Department proposes to reduce a provider's ability to cause secondarily referred

services to be billed by a physician, pharmacy, laboratory, or durable medical equipment provider. The Department's Audits and Investigations unit has observed cases where a non-Medi-Cal provider has been administratively sanctioned or banned from the Medi-Cal program yet is still causing the downstream occurrence of a large amount of paid claims through deferrals, prescriptions, or requisitions. Current sanctions do not limit a provider's ability to refer patients to other non-sanctioned providers. As a result, direct payments to the providers in question may cease, but payments made on behalf of their actions (i.e., referrals to other providers) may continue or actually increase.

COMMENTS:

Department of Health Services, please describe each component of the proposal and the necessity for it.

ITEM 4260 DEPARTMENT OF HEALTH SERVICES – MEDI-CAL**ISSUE 9: LONG TERM CARE INTEGRATION****BACKGROUND:**

In 1995, legislation was enacted to authorize and implement the Long Term Care Integration (LTCI) Pilot Program to integrate the financing and administration of long-term care services. A project could be either a public or non-profit entity, however all the applicants have been counties. LTCI gives each county the ability to pool the Medi-Cal institutional care, personal care and in-home supportive services funds that historically flow to it and manage those dollars in new ways. Care management was to be the centerpiece of the new way of managing the funds. Care management includes assessment of client needs; development of a service plan based on those needs, and authorization and arrangement for purchase of services or linkages with appropriate medical and social support services. It was envisioned that capitation would achieve a savings that could be used by counties to enhance service capacity. The projects are required to be budget neutral.

Slightly more than half of California's total long-term care funds are expended on 5 percent of the long-term care population in skilled nursing facilities. The LAO projects that long-term care caseload will almost double in the next 10 years. A significant percentage of those needing long-term care are admitted to nursing homes when it would be possible for them to remain in their homes.

Figure 1 State Funded Long-Term Care Services Fiscal Years 2000-01 and 2010-11		
<i>(Dollars in Millions)</i>		
	Funding	
	State	Total
2000-01 ^a		
Institutional Care	\$2,479	\$4,450
Community-Based Care	1,710	2,637
In-Home Care	777	2,019
Totals	\$4,966	\$9,106
Projected 2010-11		
Institutional Care	\$3,588	\$6,183
Community-Based Care	4,821	7,708
In-Home Care	2,869	7,517
Totals	\$11,278	\$21,408

^a Estimated, as displayed in the Analysis of the 2001-02 Budget Bill.

While California has developed an array of lower cost alternatives to nursing home placement, there are no incentives for gatekeepers – physicians and hospital discharge planners – to utilize these alternatives. In order to align incentives, a single entity must have control over utilization of long-term care funding. Several mechanisms could be used to integrate funding. LTCI

authorizing legislation proposes setting a capitation rate and utilizing case management (care coordination) to ensure the most effective utilization of resources. The goal of long-term care integration is to rationalize spending – so that the least costly alternatives are utilized first.

The road to development and implementation has been challenging. However, several counties have demonstrated sustained commitment to achieving an integrated service delivery system. Contra Costa, Marin, San Mateo, San Diego, Santa Cruz and Monterey counties and Cal Optima (Orange County) have made incremental steps toward integration and with support could move forward to fully integrated systems in the near future. In total, 17 counties have explored either coordinated, integrated or capitated approaches long-term care service delivery.

LTCI represents a cost-effective approach to enhancing service delivery while maintaining overall budget neutrality for long-term care services. Some states have experienced cost savings with the implementation of LTCI. However, implementing LTCI will require an initial expenditure of state funds for the development of a waiver and for technical assistance with initial implementation. In addition, there will be a need for ongoing monitoring. However, it is expected that such expenditures will prove cost effective over the long run.

COMMENTS:

Department of Health Services, please provide an overview of the history of developing the Long Term Care Integration projects. Can LTCI save the state money? Will LTCI improve the quality of services and care provided to aging, vulnerable and chronically ill individuals?

Department of Health Services, please provide the Subcommittee with an overview of what has been the policy and financial history of LTCI projects in other states?

Department of Health Services, what impediments have the state experienced in the development of the pilot projects?

Department of Health Services, what remains to be done to implement LTCI in the state?