



Medi-Cal 1115 Demonstration Waiver

**Stakeholder Advisory Committee
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What is an 1115 waiver?



- Authorized by Section 1115 of the federal Social Security Act
- Can make small changes or can include large portions of program
- Some provisions cannot be waived under any circumstances
- Often used to advance federal priorities



Key Features of an 1115 Waiver



- Budget neutrality
 - Costs under waiver are less than costs would have been without the waiver
- Opportunity for funding for costs not otherwise matchable
 - Ability to provide medical coverage to individuals who may not otherwise be eligible; and/or
 - Provide services that may not otherwise be allowed under the regular Medicaid rules



Essential Waiver Ingredients



- Compelling reform concept
 - Worthwhile reform
 - Prospect for real savings
 - Match with federal priorities
 - Reasonable implementation timeframe
- Note: Any additional federal funds that the waiver makes available require a nonfederal match



Historical Context for Our Current Waiver



- End to 10 years of indigent care funding in Los Angeles County
- Federal concerns about intergovernmental transfer (IGT) funding



Existing 1115 Waiver



- Allowed restructuring of hospital financing
- Provides continuation of federal funding for indigent care
 - Support for public hospital costs for providing indigent care
 - Support for more organized care for uninsured individuals through health care coverage initiatives
 - Provides some General Fund relief
- Contained essential features, but was narrowly focused



Drivers for a Comprehensive Waiver Approach



- Long-term budget challenges
- Financial challenges in safety net system
- Opportunity for real reform
 - Well-recognized problems
 - Stimulate the creative process
 - Constructive stakeholder engagement
- Potential to capture federal savings to support reforms



Key Question



- How can California maximize these federal resources under budget neutrality?
 - Propose meaningful reforms
 - Improve the delivery of services to our beneficiaries
 - Make a strong case for program savings
 - Make effective use of available federal resources



Key Reform Elements Proposed for Our Waiver



- Expand enrollment in organized systems of care
- Improve the delivery of care for children with special needs
- Better integrate care for dual eligibles
- Better integrate care for persons with behavioral health needs
- Build on safety net financing approaches established in the current waiver
- Expand on value-based purchasing



Expand Enrollment in Organized Systems of Care



- Opportunities to offer better care coordination for those most at risk
 - Seniors and persons with disabilities
 - Families who live where managed care is not offered
- Offers the prospect of:
 - Greater use of preventive care
 - Better overall outcomes
 - Lower cost



Seniors and Persons With Disabilities



- Monthly average of 1.5 m Medi-Cal beneficiaries, of whom 650,000 are Medi-Cal only
- Medi-Cal only disabled adults number about 360,000 and
 - Overall annual average cost of \$8,700
 - The most expensive 10% cost an annual average of \$50,600
- 25% of all seniors and persons with disabilities in managed care counties are served by managed care plans including
 - 296,000 in County Organized Health Systems
 - 35,000 in counties with Geographic Managed Care
 - 157,000 in counties with the Two-Plan Model



Improve the Delivery of Care for Children with Special Needs



- Opportunity to rethink our care coordination model for children
 - Complex system
 - Expensive care
 - Multiple coordination responsibilities



2008-09 CCS Experience



	Enrollment	Expenditures
Medi-Cal	76%	88%
Healthy Families	14%	9%
CCS Only	10%	3%
	178,000	\$1.9 b



Additional CCS Program Elements



- Administrative Expenditures
 - \$160 m
- Medical Therapy Program
 - \$110 m
- About 60% of CCS-Medi-Cal children are also enrolled in a Medi-Cal managed care health plan.



Better Integrate Care for Dual Eligibles



- Includes most seniors and many persons with disabilities
- Barriers to coordination arise from separate funding streams
- Many beneficiaries with high needs



Medicare/Medi-Cal Eligibles



- In California
 - 1.1 million individuals were dually eligible in 2007
 - Accounted for \$8.6 b in Medi-Cal expenditures
 - Including \$3.2 b in long term care costs (75% of Medi-Cal's total LTC expense)
- In the US
 - Dual eligibles account for 24% of Medicare costs and 35% of Medicaid costs
 - 40% of dual eligibles have either a cognitive or mental impairment



Medicare/Medi-Cal Eligibles



- 77,000 dual eligibles are enrolled in managed care plans
- Plan capitation payments account for 8% of all Medi-Cal dual eligibles' expenditures
- Of Medi-Cal Duals, 51% are under the “Aged” eligibility aid code, 40% are under “Disabled,” and 6% are under “LTC”
- Duals under the “Disabled” aid code, annual average cost was \$24,841 per person



Integration of Care for Persons with Behavioral Health Needs



- Bifurcated system of care
 - Care settings, finance, administration
- Beneficiaries with complex care needs
- Potential to improve outcomes



Medi-Cal Beneficiaries with Behavioral Health Needs



- In CY 2006, 500,000 Medi-Cal beneficiaries were treated for psychiatric diagnoses.
 - Medi-Cal costs for these beneficiaries totaled \$5.3 b
- 80% were in Medi-Cal for full 12 months, of whom:
 - 12.5% were dual eligibles;
 - 30% were in managed care plans
 - 45% were in FFS
- 131,000 seniors and person with disabilities on Medi-Cal have serious mental illness
- Medi-Cal beneficiaries with serious mental illness have 23% more non-psychiatric hospital admissions compared to Medi-Cal beneficiaries without serious mental illness



Build on Safety Net Financing



- Coverage initiatives shows promise
- Safety net providers have yet to fully participate in providing organized care
- Infrastructure needed to support expanded delivery of care under health reform



Current Safety Net Support



- Coverage Initiative programs in ten counties
 - Safety Net Care Pool payments for health care services costs to 160,558 eligible individuals enrolled in: \$116 m (excluding a pending payment to LA County of \$54 m)
- FY 2008-09 supplemental payments to safety net hospitals and counties to help cover their uncompensated costs
 - Disproportionate Share Hospital payments to private and public hospitals: \$1.61 b
 - Supplemental payments to public and private hospitals: \$239 m
 - Safety Net Care Pool payments to designated public hospitals for uninsured care costs: \$367 m



Expand on Value-Based Purchasing



- Better monitoring of care
- Simplification of payment systems
- Payments approaches to encourage the desired outcomes
- Better alignment of payment to the cost of providing quality care



Questions

*“Preserve and Improve the Health
Status of all Californians”*