ADPI

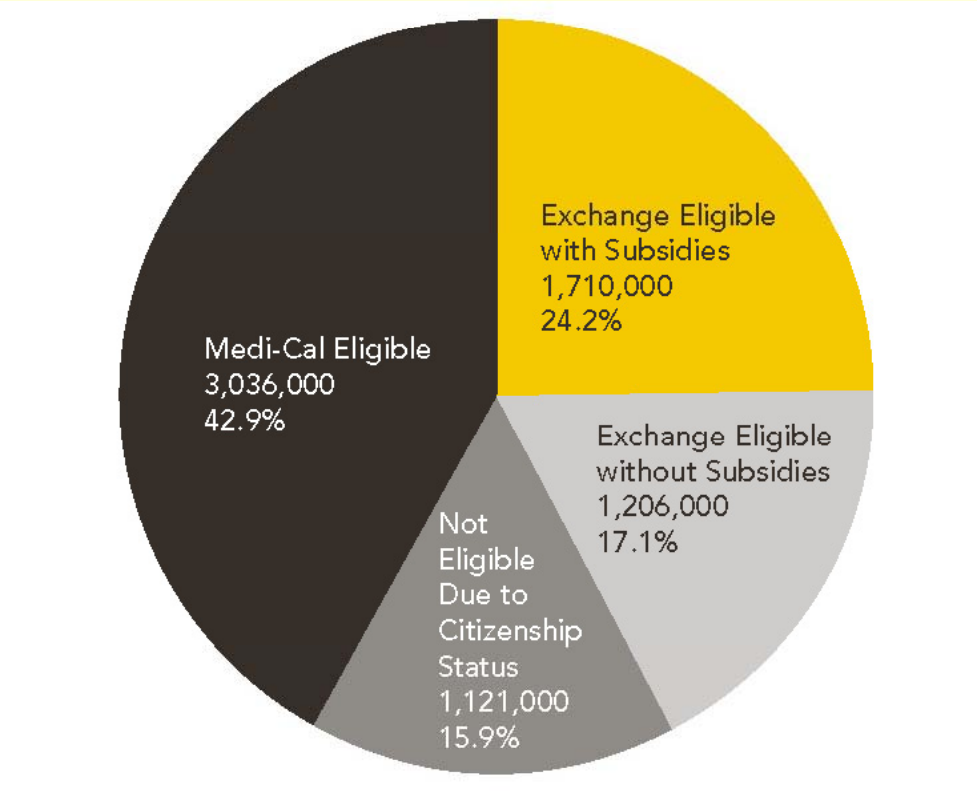
The Medi-Cal Eligibility Expansion and Substance Use Disorder Treatment Services in Los Angeles County

National Expansion of Medi-Cal

- On 1 January 2014, Medicaid will expand to cover an estimated 17.1 uninsured Americans.

- Eligibility rules will change –
  - Income ceiling rises to 138% of FPL.
  - Program linkages (CalWorks) are no longer necessary.

Who will be gain coverage in 2014

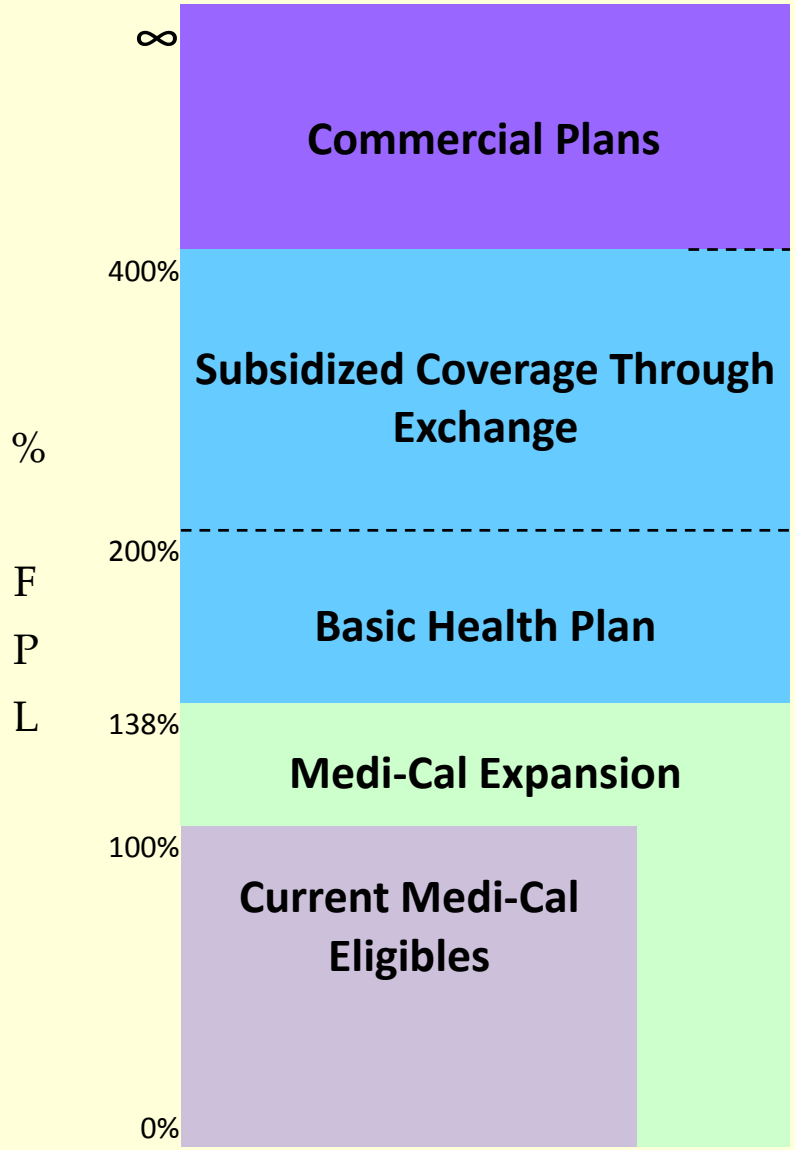


Total Uninsured All or Part Year: 7,072,000

Source: UCLA Center for Health Policy Research. 2009 California Health Interview Survey.

ADPI

Categories of Coverage in the ACA



ADPI

In California . . .

- In California, this means health care coverage for between 1.7 to 2.3 Million new Medi-Cal beneficiaries.

- In the uninsured population, about 25% have coverage at some point in the year, indicating movement across plans.

California Estimates

- Four counties will have nearly 50% of the total statewide expansion population.
  - LA (32%), San Bernardino, Orange & San Diego.
  - LA = 544,00 to 736,000

- The top 10 counties will have 74% of the expansion population.
  - Top 4 + Riverside, Sacramento, Fresno, Santa Clara, Alameda & Kern.

SUD Caseload Estimates

- Demographics of persons needing SUD treatment within the expansion population are projected to be generally similar to the overall population.

- SUD cohort estimate is between 113,000 to 151,000. CalOMS admits for FY 10-11 were 181,000.

Source: TAC/HSRI. (2012) California Mental Health and Substance Use System Needs Assessment

California Estimates

- The current representation of Latinos and Asian/Pacific Islanders in the current Medi-Cal population is lower than the predicted proportions of these groups in the expansion population.

- There will be a proportionately larger gap for these groups.

SUD Caseload Estimates

	Current MC %	Expansion %	Current SUD Tx %
African-American	11%	8%	15.2%
Asian-Pac. Islander	3%	10%	.3%
Latino	21%	41%	35%

- 23% of expansion population do not speak English well or do not speak English at all.
- Demographic changes in the expansion cohort needing or seeking SUD treatment will drive changes in outreach and engagement strategies.
- A culturally competent workforce will be essential.

SUD Caseload Estimates

- Current penetration rate is 7.9% for Medi-Cal SUD services, lower than the 10% national benchmark.

- 2010 national survey data indicate that 45% of persons who needed SUD treatment did not seek it because of a lack of coverage.

SUD Caseload Estimates

- In FY 10-11, 63% of SUD treatment admits (N=118,266) reported they were not Medi-Cal eligible.
- Of those who did report eligibility, not all were in programs that billed Drug Medi-Cal (DMC).

Increased Demand

- Coverage expansion will result in large increases in demand for mental health and substance use services:
  - 21-28% increase in mental health demand
  - 33-44% increase in substance use demand

Source: Jarvis & Freeman. Briefing Paper 2: Implications of Coverage Expansion Examining Increased Demand for Mental Health and Substance Use Services. June 2012.

Increased Funding

- This will result in additional mental health and substance use service spending of **$251-$678 million per year** for the safety net expansion population.
- SUD share between $94 - $254 Million.
  - LA County share between $31 - $85 million.

Source: Jarvis & Freeman. Briefing Paper 2: Implications of Coverage Expansion Examining Increased Demand for Mental Health and Substance Use Services. June 2012.

Increased Competition

- Clients will have choices.
  - Providers will need to adapt.
- Is that $251 - $678 Million guaranteed to Counties?
  - Counties won't be the only players.
  - Providers will need to build relationships with new funders.

Impact on Business Infrastructure

Ramping up to serve the Medi-Cal expansion population will place an extraordinary strain on organizations providing SUD treatment in California.

- Staffing
- Coverage-Related Service Changes
- Business Practices
- IT

Impact on Caseload Growth

- Due to large numbers of potentially eligible clients currently in SUD treatment, overall caseload growth, at least in the short term, may be less than current estimates would suggest.

- However, the proportion of clients with coverage will increase dramatically.

Impact on Primary Care Integration

- Under proposed eligibility procedures, SUD staff may be able to assist clients in enrolling for Medi-Cal.
- SUD programs will be more involved in their clients' health and health care.
- The health care system will experience demands for care from a caseload it has had little experience with.

Impact on Mental Health Service Integration

- With appropriate staffing, SUD treatment programs will be able to better address the MH treatment needs of non-SMI clients.

- Perhaps this nexus of where SUD and non-SMI MH meet is where our two systems find common ground.

Impact on Offender Treatment

A resurgence of offender treatment is likely as coverage becomes available to childless adults.

- Medical necessity and covered services will change the dynamic somewhat.
- AB 109 Realignment modifies opportunities to mandate offenders to treatment.

Impact of Realignment

- There has been an increase in provider interest in DMC certification.
- However, counties are reluctant to bring on new providers.
  - Realignment 2011 places counties at risk.
- We may enter 2014 with too few providers certified to bill Medi-Cal.

Impact on the Block Grant

- Uncertain future of the Federal Substance Abuse Prevention and Treatment Block Grant.
- If everything we do is covered under Medi-Cal, is the block grant still needed to pay for treatment services?

More Block Grant

"Beginning in 2014, Block Grant dollars should be used to pay for:

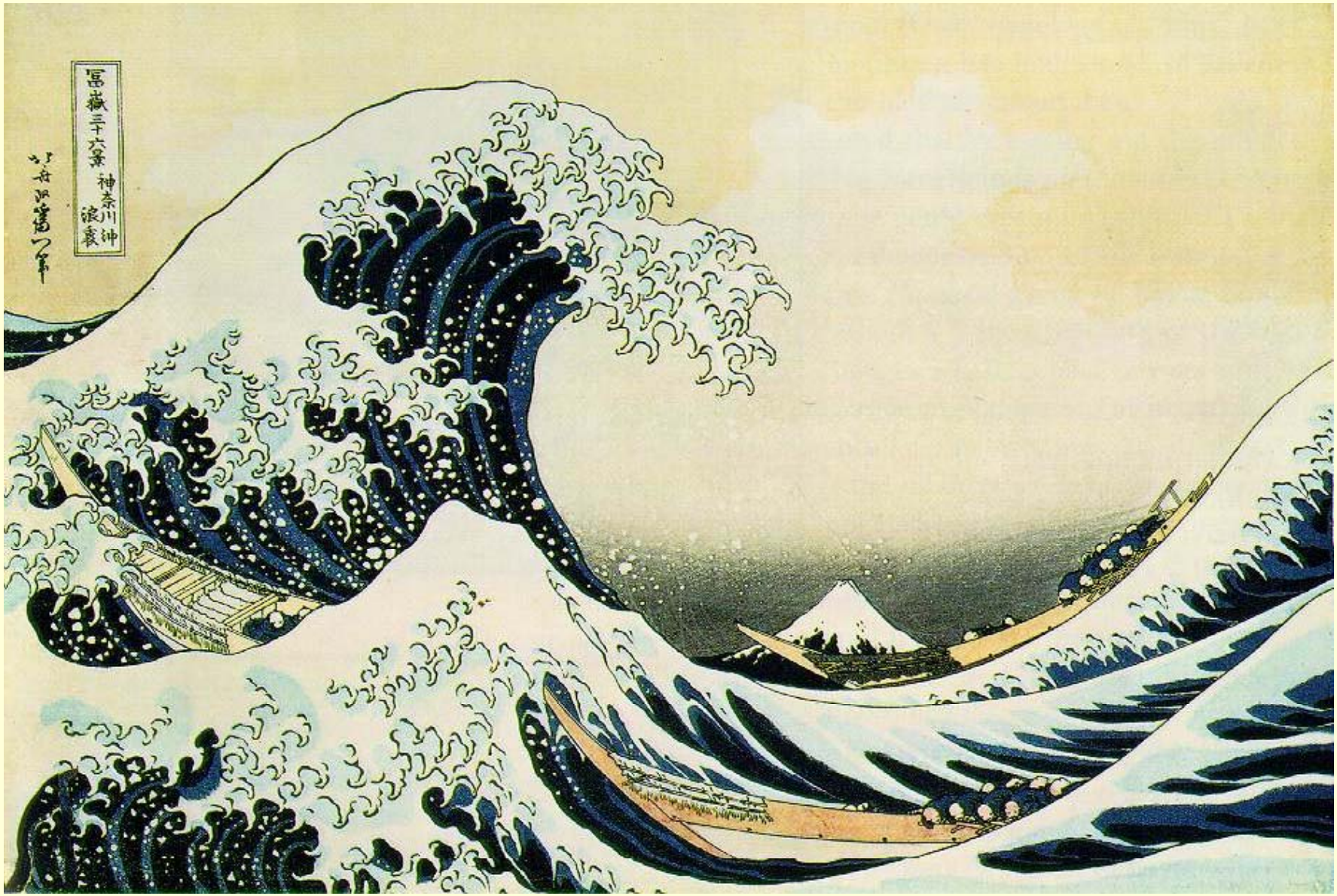
1) people who are uninsured, and

2) services that are not covered by insurance and Medicaid."

ADPI

Source: DHHS/SAMHSA. Proposed FY 2014-2015 Block Grant Application. 07-17-12

Questions?



ADPI

Strategy Development

Four main areas of focus –

- Financial Management
- Treatment Services
- Marketing Strategies
- Partnerships/Networks

Adjusting Business Strategies to Address New Market Forces

ADPI

Source: Lucking, Thomas. (2002). Aligning business strategies with purchasing methods in behavioral health care.

What do Most Businesses Do?

1. Nothing. What we've done in the past will continue to be successful.

2. Hire a consultant. We need a new strategic plan.

3. Start a new line of business. We should become an FQHC.

What Happens?

- Provide services below cost to attract business. True cost not precisely known.
- Continue same line of business. Provide services funded by a single purchaser.
- Subsidize one program with 'profit' from another.
- Look to private and public sources for continued funding.

Specific Business Strategies that are Counterproductive.

Providing Services at Rates Below Provider Cost

1. Other funding helps to subsidize services.
   - Often obscured by a collection of incremental solutions.
2. Can't turn clients away. The grant ends but demand does not.
3. Preservation of administrative infrastructure.

Providing Services Funded by a Single Purchaser

- Possibly volatile utilization.
- Most publicly funded SUD programs have only one purchaser.
- Who carries risk?
  - Purchaser - Cost Reimbursement
  - Provider - Fee for Service
- Who controls access to services?

Program Continuation is the Primary Measure of Success

- Your agency is not its mission. Ultimately, your agency is what you can market.
- Are your services really essential components of the community safety net?
- Cost reimbursement funds your mission.
- Fee for service funds your work.
- Case rates fund your successes.

Subsidizing Unprofitable Services with Profitable Ones.

- Keep your cash cows healthy. Don't weaken them to support unprofitable programs.
- Cross-subsidizing can delay the day of reckoning for weak programs until it's too late.
- What about the administrative overhead contributed by weak programs?

Underestimating the Costs / Losses From Some Services

- Exacerbated by cross-subsidization.
- On what basis are administrative costs allocated? Actual utilization may exceed estimates.

Looking to Public and Private Funding Sources

- An earlier generation of non-profits was based on a revenue model relying on fundraising, donations & foundation support.
- Non-profits created in the 60's and 70's tend to rely more on public funding.
- In either case public purchasers do not see their responsibility as guaranteeing the fiscal health of CBO's.

Taking Stock:

Do You Know . . .

- The implications of changes in public purchasing practices for your cashflow and bottom line.
- The costs and sources of revenue for each program or service. This includes administration and other overhead.
- The impact of different contracts, payer mixes, and your overall program portfolio on your organization's financial health.

Taking Stock:

Do You Know . . .

- The community benefit of subsidized services and contracts when purchasers are already obligated to provide access to specific Medi-Cal reimbursed services.

- The full costs at the global and service unit levels of maintaining current services and the community benefits of maintaining these services.

- The impact that particular services have on the fiscal health of other services, including reduced quality, compensation, and stability.

Taking Stock:

Do You Know . . .

- Do you know what your planned vs. actual unit costs are?
  - In near real time?
- Planned cost is derived from what you put in the contract.
- Actual cost reflects what really happens.
  - Is it a result of true cost increases, low productivity, staff time spent in low performing programs, client no-shows, or what?

Adaptation Strategies

Source: State of Washington Outpatient Services Extended Rate Study. 2006.

What Do Nonprofits Do In Times of Financial Challenge?

- Ask for cash advances from funders
- Borrow money (long-term)
- Borrow money (short-term lines of credit)
- Change mix of staff (using less expensive)
- Close satellite offices
- Consolidate programs (or services)
- Convert investments into cash for operations
- Cut administrative costs
- Defer maintenance costs
- Delay payments on accounts payable
- Diversify mix of services
- Across-the-board cost cuts
- Selective cost cuts
- Drawn down cash reserves
- Sell or factor accounts receivable
- Furlough employees
- Increase Staff Workload
- Lease instead of buying
- Merge with another agency
- Obtain gifts
- Obtain grants
- Offer client transportation
- Offer non-monetary offsets (e.g., training)
- Offset the cost of one program with another
- Outsource services
- Reduce broken client appointments
- Reduce number of personnel
- Reduce quality of services
- Refer clients to another service or agency
- Replace personnel with less expensive staff
- Sell off long-lived assets
- Share facility with another agency
- Use group purchasing

Preferred Approaches

Strategy	Prefer	Oppose	Use Often	Use Seldom
Reduce broken client appointments	84	6	61	17
Obtain grants	76	6	39	29
Selective cost cuts	74	10	62	30
Offer non-monetary offsets (e.g., training)	61	15	36	33
Offer client transportation	61	13	34	28
Diversify mix of services	60	10	54	20
Use group purchasing	56	8	42	12
Obtain gifts	55	11	25	16
Cut administrative costs	48	30	50	34
Consolidate programs (or services)	42	20	31	41
Offset the cost of one program with another	36	42	65	19
Refer clients to another service or agency	35	35	41	43
Increase staff workload	28	56	64	31
Change mix of staff (using less expensive)	22	59	21	38
Share facility with another agency	22	56	12	10
Lease instead of buying	22	23	28	31

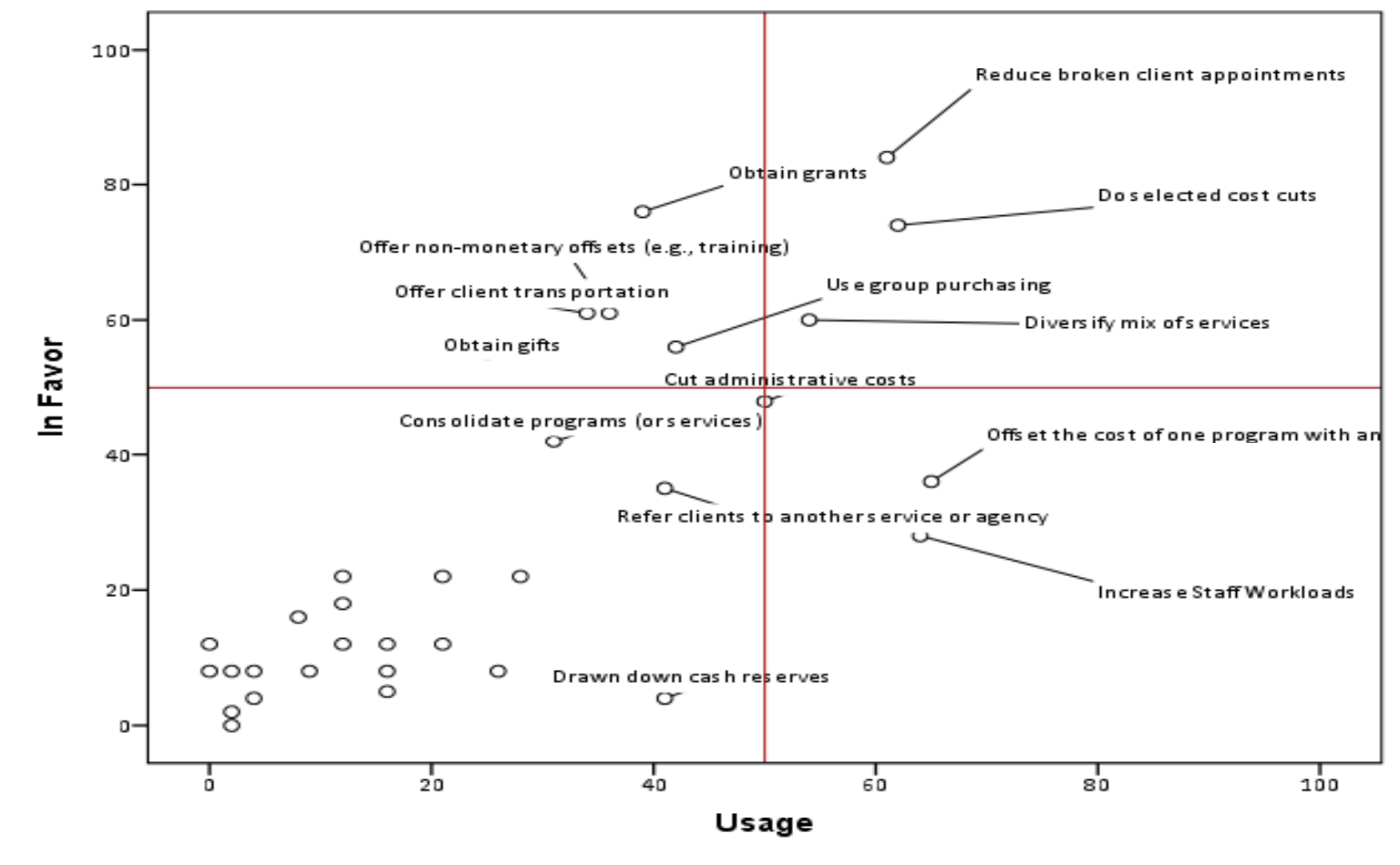
Least Preferred Approaches

Strategy	Prefer	Oppose	Use Often	Use Seldom
Reduce quality of services	0	90	2	16
Replace personnel with less expensive staff	12	73	21	38
Delay payments on accounts payable	5	73	16	29
Do across-the-board cost cuts	8	70	16	58
Drawn down cash reserves	4	66	41	31
Defer maintenance costs	8	66	26	45
Reduce number of personnel	18	66	12	66
Ask for cash advances from funders	4	66	4	14
Borrow money (long-term)	8	62	4	29
Change mix of staff (using less expensive)	22	59	21	38
Furlough employees	12	58	0	29
Increase Staff Workloads	28	56	64	31
Share facility with another agency	22	56	12	10
Outsource services	16	56	8	28
Merge with another agency	8	56	0	5
Borrow money (short-term lines of credit)	12	50	16	26
Convert investments into cash	8	50	9	29

Most Frequently Used Choices

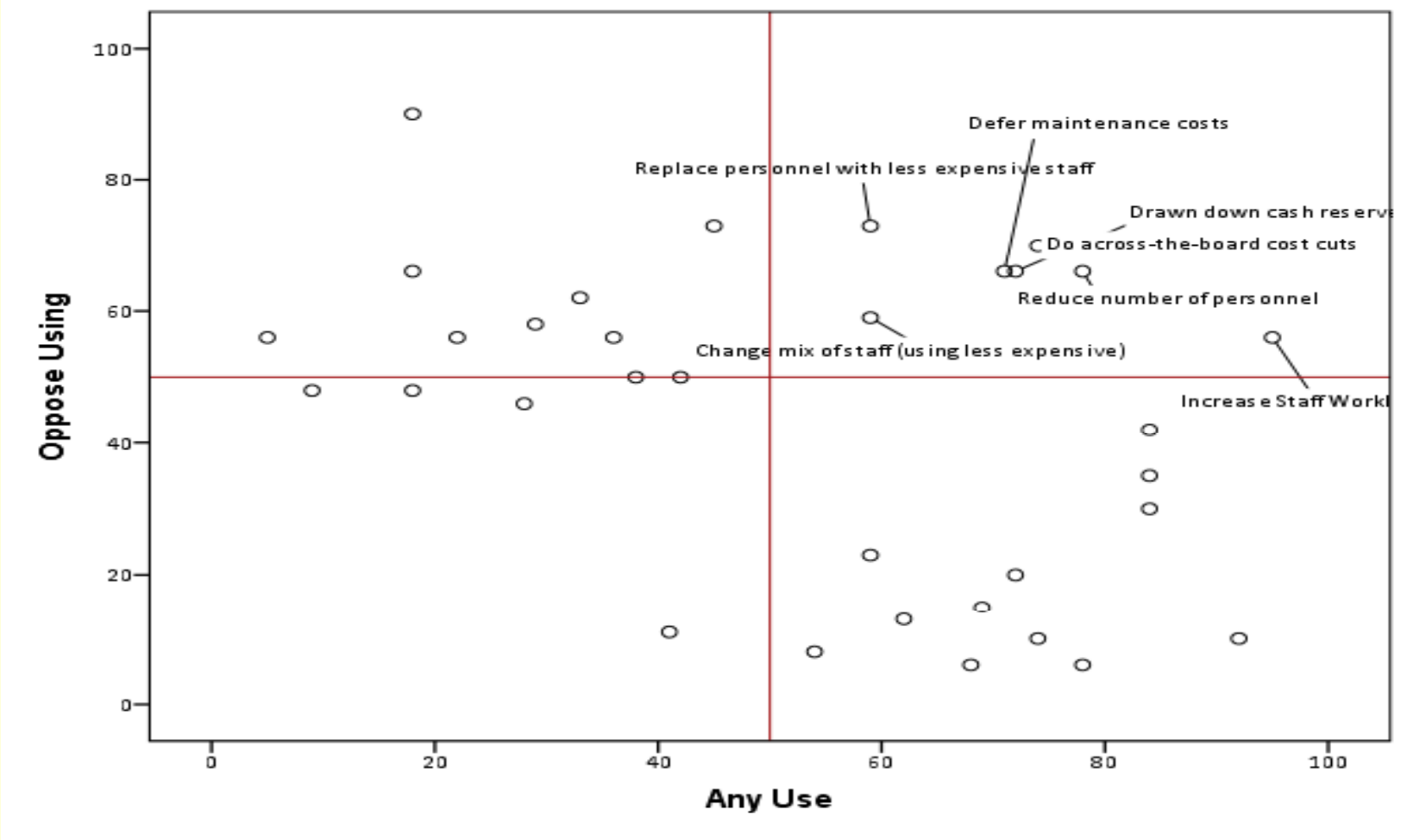
Strategy	Prefer	Oppose	Use Often	Use Seldom
Offset the cost of one program with another	36	42	65	19
Increase Staff Workloads	28	56	64	31
Selective cost cuts	74	10	62	30
Reduce broken client appointments	84	6	61	17
Diversify mix of services	60	10	54	20
Cut administrative costs	48	30	50	34
Use group purchasing	56	8	42	12
Drawn down cash reserves	4	66	41	31
Refer clients to another service or agency	35	35	41	43
Obtain grants	76	6	39	29

What is Preferred?



ADPI

What Actually Happens



ADPI

ADPI

ADPI

ADPI

Questions?

For More Information

vkogler@aodpolicy.org

916-623-5415

ADPI