Medi-Cal

BUDGET AND COST DRIVERS

January 2006

California HealthCare Foundation

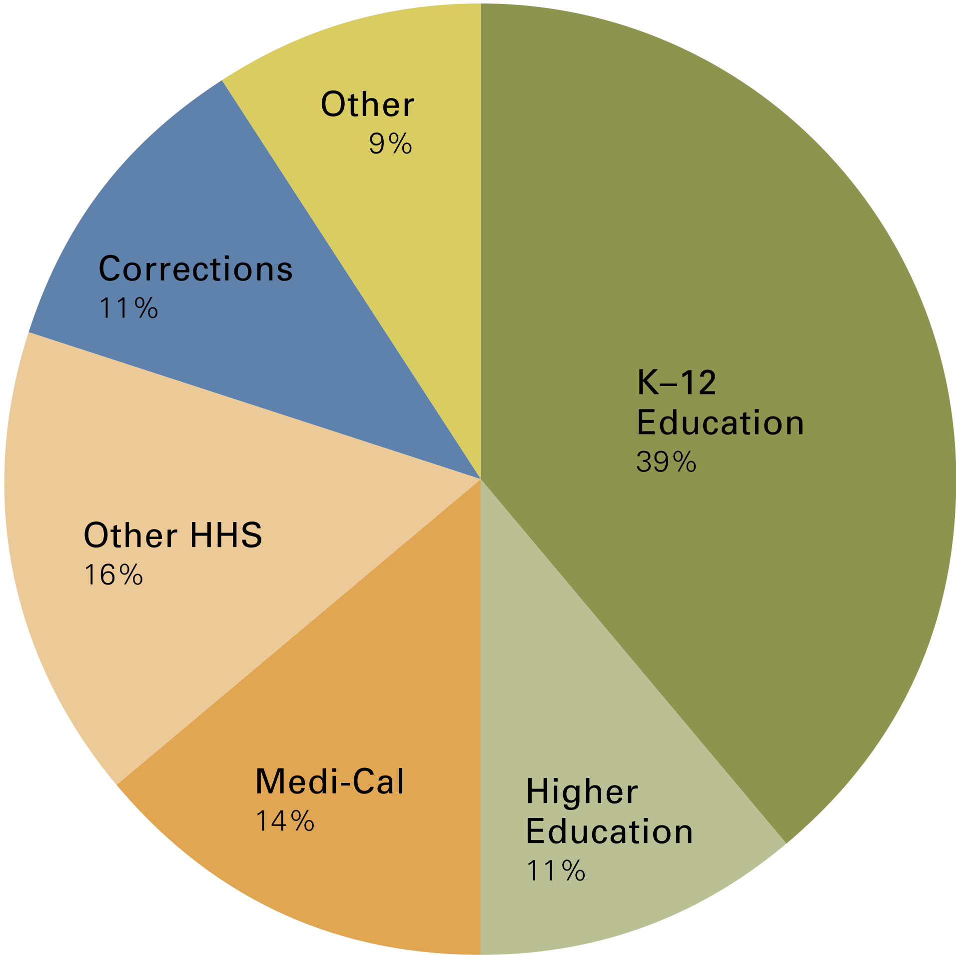
Introduction

Medi-Cal (Medicaid) is the main source of health care coverage for six-and- a-half million people, over one in six Californians. It draws nearly $19 billion in federal funds into the state's health care system and accounts for more than 14 percent of General Fund spending in FY2005–06. Medi-Cal is a complex program that pays providers for essential acute and long-term care services delivered to a wide range of beneficiaries. Although many people associate Medi-Cal with welfare, more than half of funds pay for medical and long-term care for the elderly and adults with disabilities. Medi-Cal also provides essential support to California's safety net providers. This document provides important information about the Medi-Cal budget and spending trends and highlights key factors that are influencing these trends.

Medi-Cal is the main source of health care coverage for 6.5 million people — more than one in six Californians.

State Budget Distribution

Projected General Fund Spending: $90 billion



Notes: HHS is Health and Human Services.

Source: Legislative Analyst's Office, *California Spending Plan 2005–06: The Budget Act and Related Legislation,* September 2005.

Medi-Cal
Budget and Characteristics

Medi-Cal accounts for the third-largest share of the state's General Fund behind K–14 Education and all other HHS programs combined.

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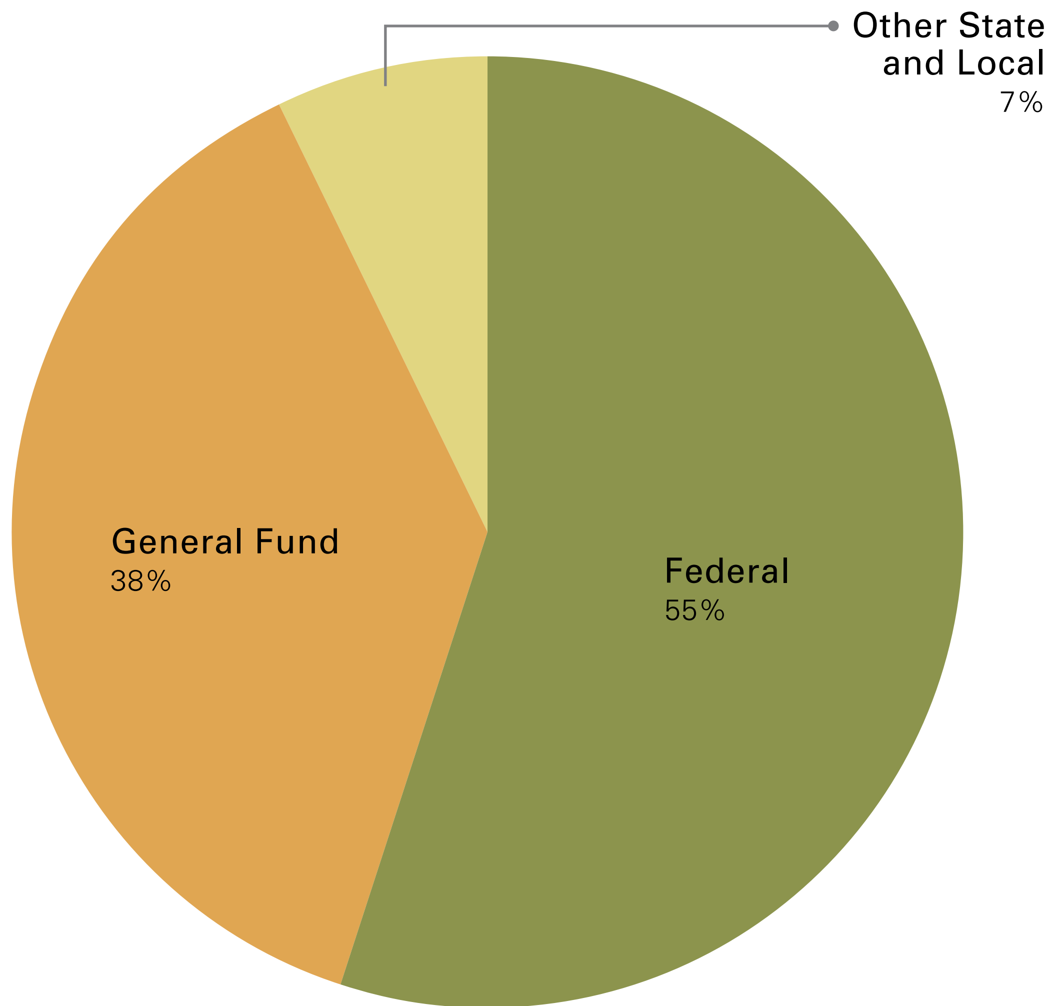
Funding Sources

Medi-Cal Budget: $34.4 billion



Source: Legislative Analyst's Office, *Analysis of the 2005–06 Budget Bill,* February 2005; Governor's Budget FY2005–06.

Medi-Cal
Budget and Characteristics

California generally receives one dollar in federal matching funds for every dollar the state spends. Medi-Cal is expected to draw $19 billion in federal funding in 2005–06.

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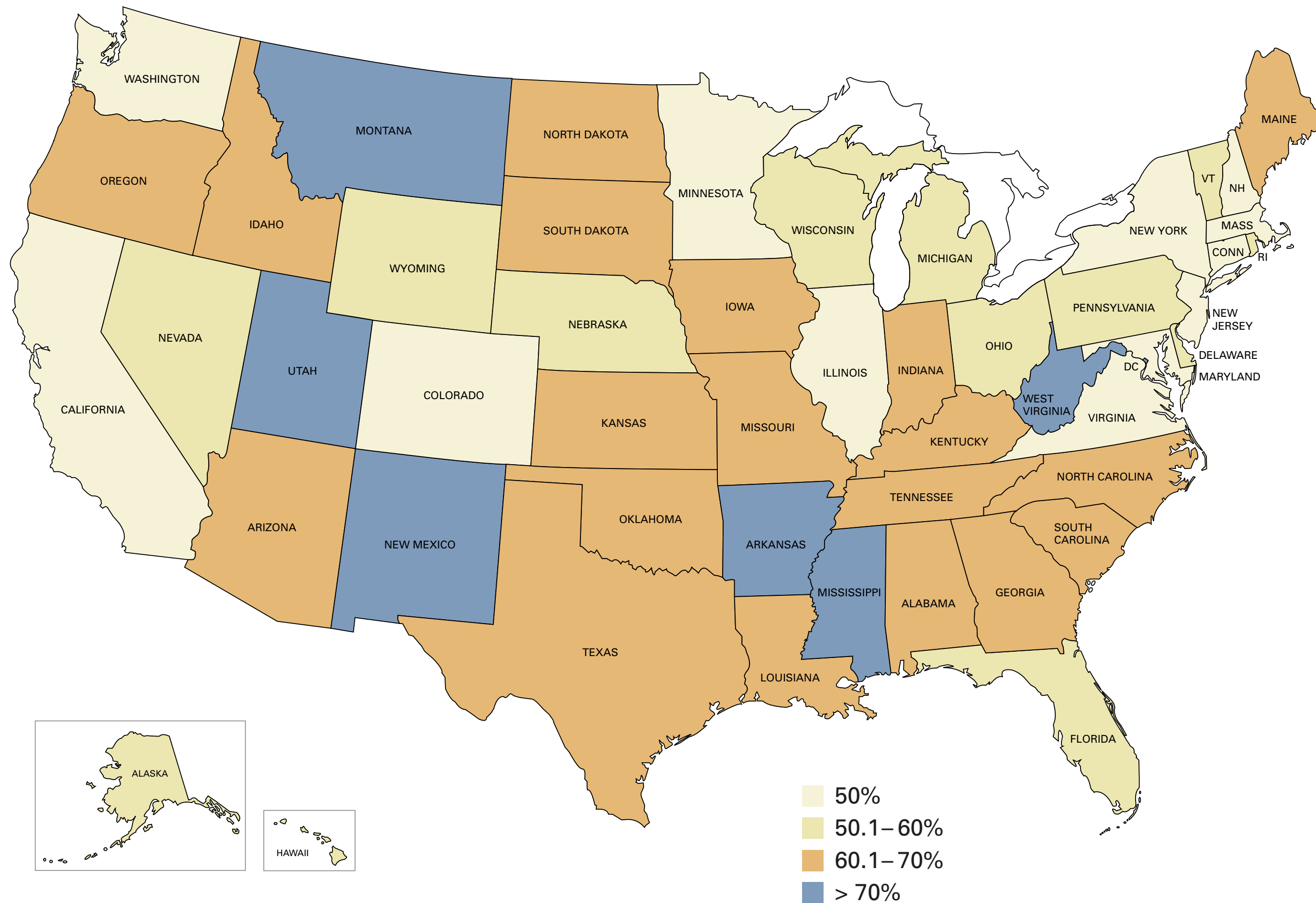
Federal Matching Rates
Medical Assistance Percentage



Source: Kaiser Family Foundation (www.statehealthfactsonline.org), 2006 data.

Medi-Cal
Budget and Characteristics

For every dollar California spends on Medi-Cal, the federal government contributes 50 cents.

The federal matching rate takes into account a state's resources to fund Medicaid (per capita income), but not a state's need (percent of population below poverty).

According to the GAO,* this formula is unfavorable to states like California that have a high percentage of population below the poverty level relative to the national average.

*GAO is the U.S. Government Accountability Office.

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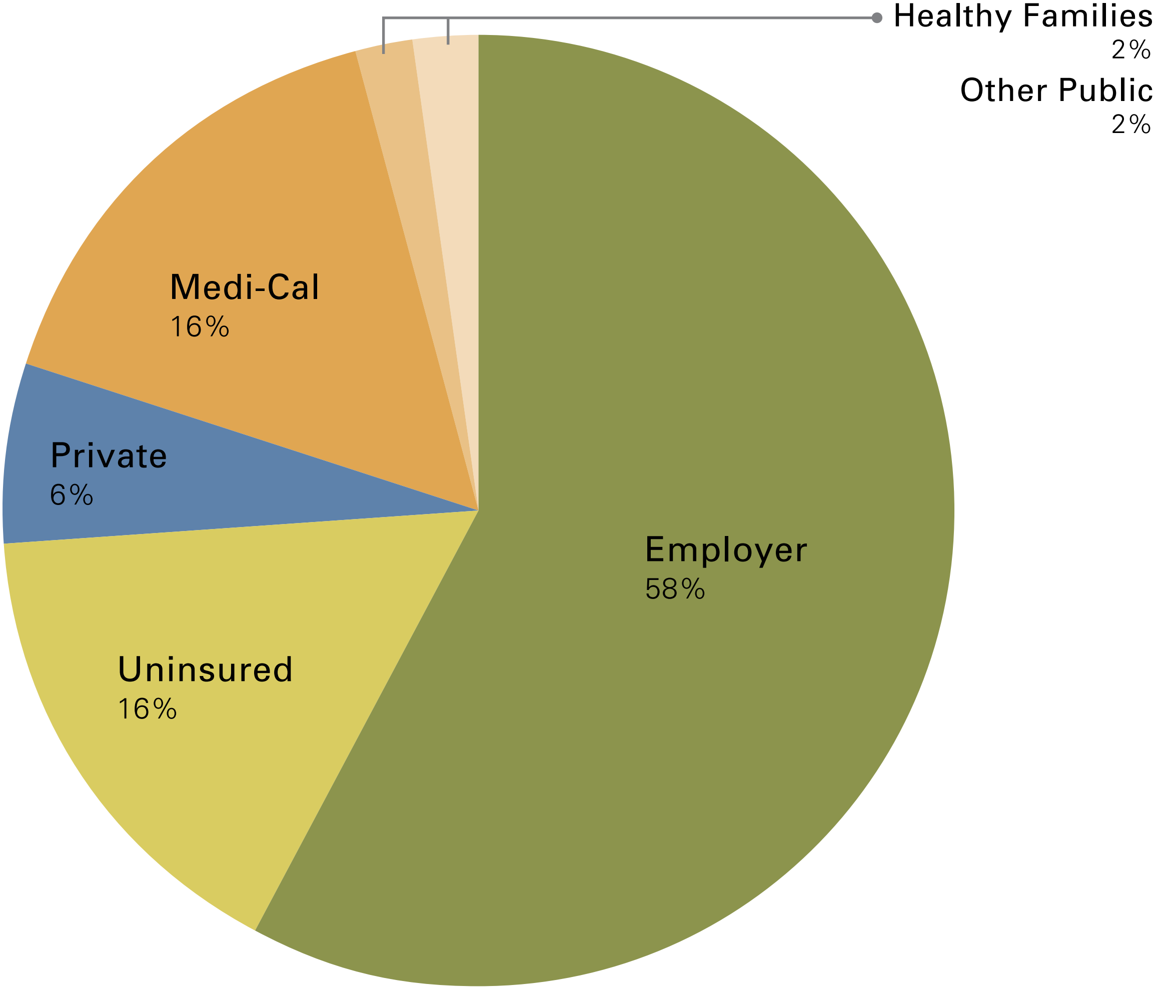
Non-Elderly Coverage

California Population Age 65 and Under: 31.3 million



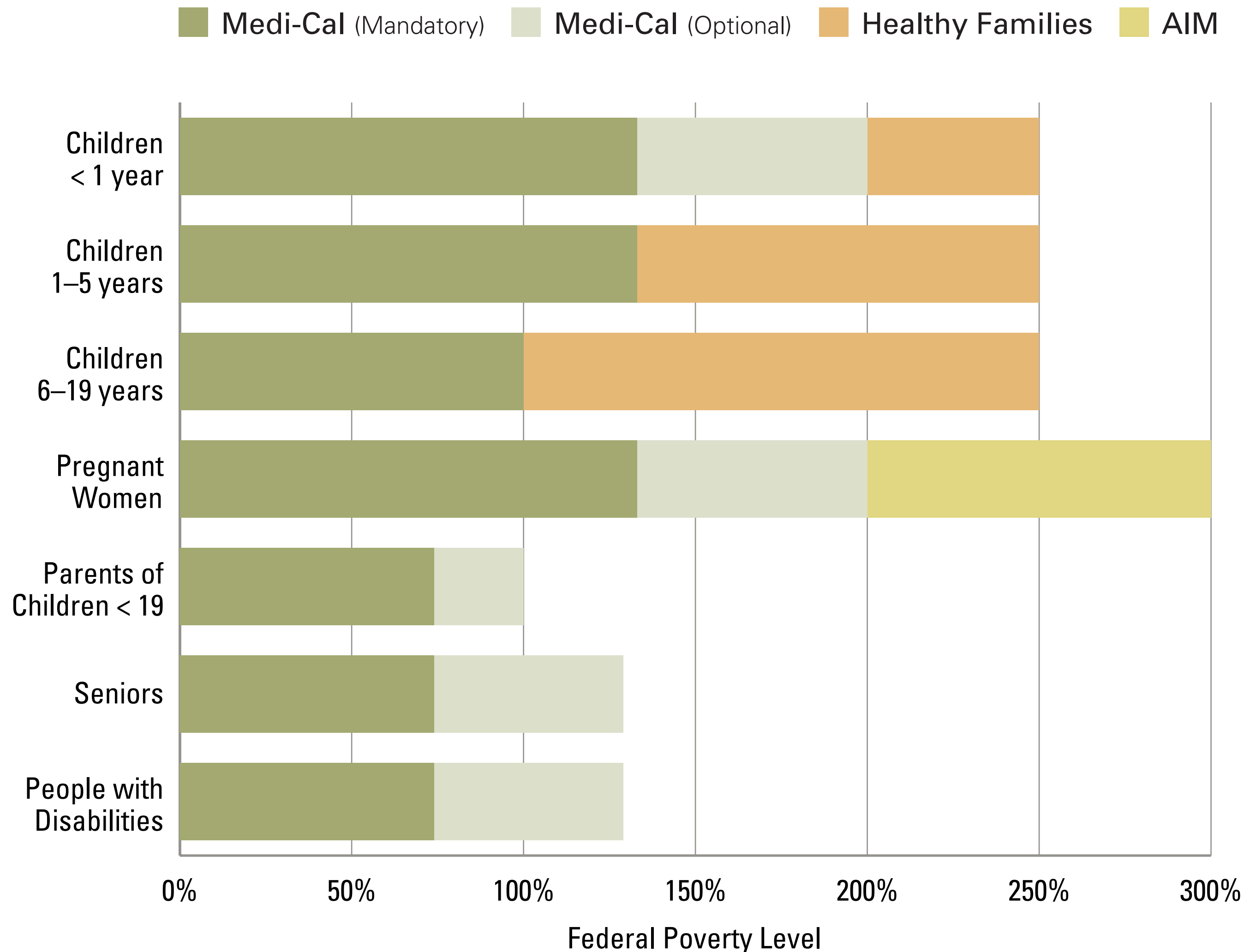
Source: California Health Interview Survey (2003 data).

Medi-Cal
Budget and Characteristics

One in six individuals under age 65 is covered by Medi-Cal.

Income Limits

Medi-Cal income limits vary by population.



Notes: AIM is Access for Infants and Mothers. Reflects Full-scope Medi-Cal only. Excludes Medically Needy and the 250 Percent Working Disabled Program. Federal poverty level (FPL) for a family of three is $16,090 through March 2006. Individuals must also meet other eligibility requirements (e.g., assets, deprivation, residency, immigration status); California is required to cover pregnant women and children up to 185 percent FPL. Medi-Cal provides coverage to seniors and people with disabilities with monthly incomes up to 100 percent FPL plus $230 (for an individual).

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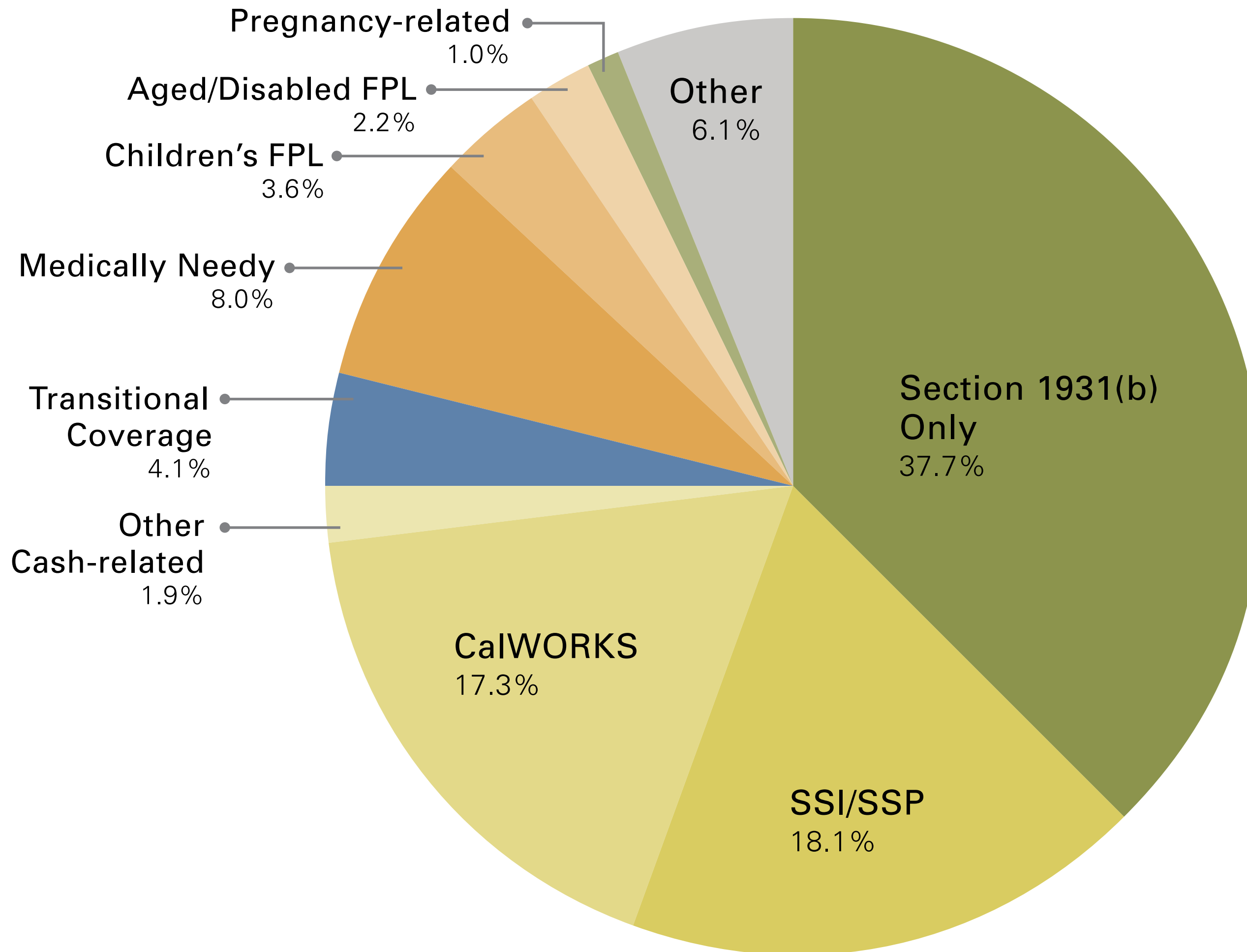
Enrollment by Program

Total Enrollment: 6.5 million



Note: Cash-related programs include people who receive cash assistance through programs such as CalWORKs, SSI/SSP, Foster Care, Adoption Assistance, In-Home Supportive Services, or Entrant and Refugee Cash Assistance. Section 1931(b) Only includes parents and children with incomes below the AFDC threshold in July 1996.

Source: Medstat analysis of Medi-Cal MIS/DSS data updated through August 2005 (May 2005 data).

Cash-related programs and Section 1931(b) account for 75 percent of Medi-Cal beneficiaries.

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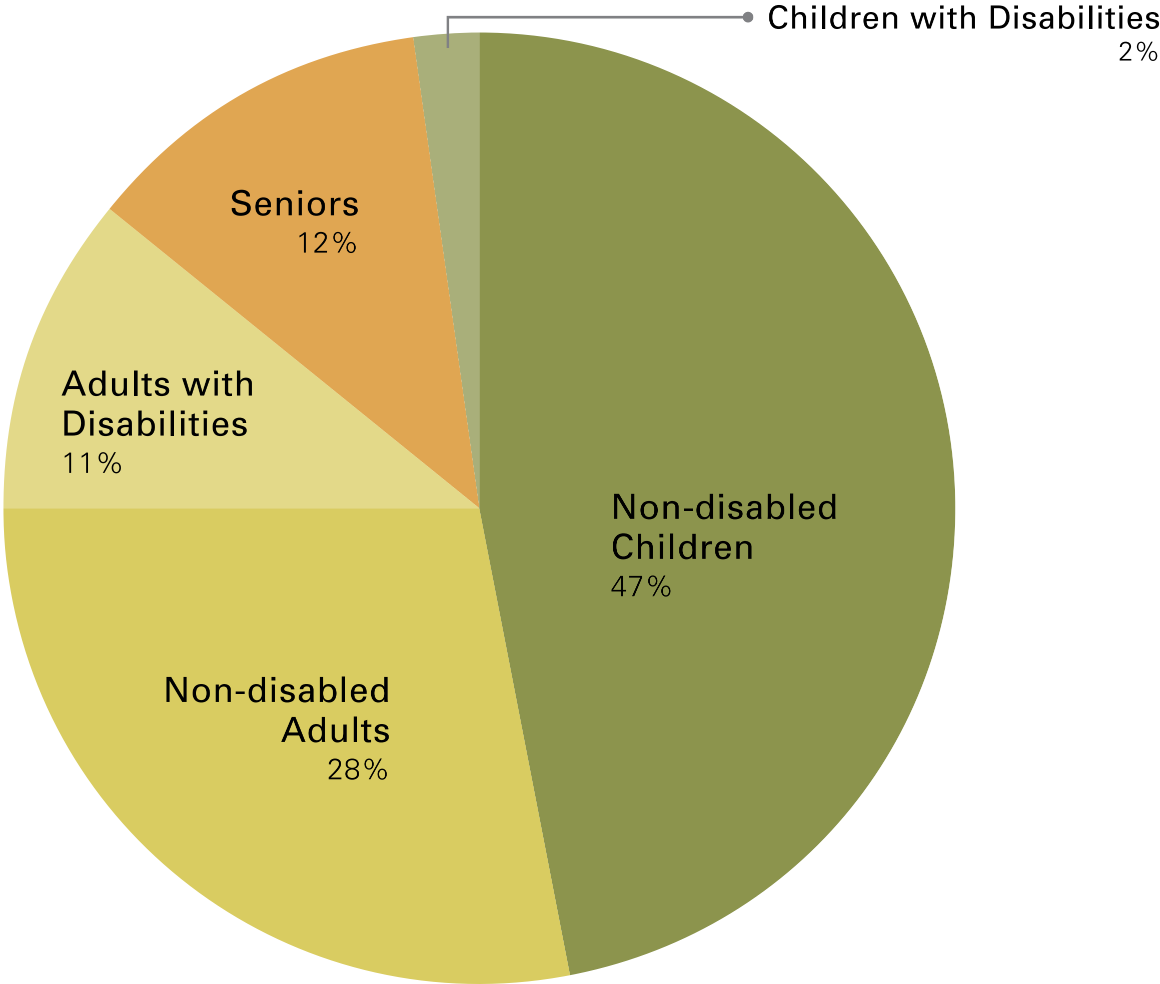
Enrollment by Major Population

Total Enrollment: 6.5 million



Children account for nearly one-half of Medi-Cal beneficiaries.

Seniors and adults with disabilities constitute 23 percent.

Source: Medstat analysis of Medi-Cal MIS/DSS updated through August, 2005 (May 2005 data).

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Medi-Cal Benefits

Required Services*

- In/outpatient hospital
- Physician visits
- Lab tests and x-rays
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children under 21
- Family planning and supplies
- Clinic in Federally Qualified Health Centers (FQHC)
- Certified midwife
- Certified nurse practitioner
- Nursing home care for adults over 21

Optional Services*

- Prescription drugs
- Vision services and eyeglasses
- Dental care and dentures
- Medical equipment and supplies
- Targeted case management
- Adult day health
- Personal care services
- Physical therapy
- Intermediate Care Facilities for Mentally Retarded (ICF-MR)
- Inpatient psychiatric for children under 21
- Rehabilitation for mental health and substance abuse
- Home health care
- Hospice
- Occupational therapy
- Chiropractic

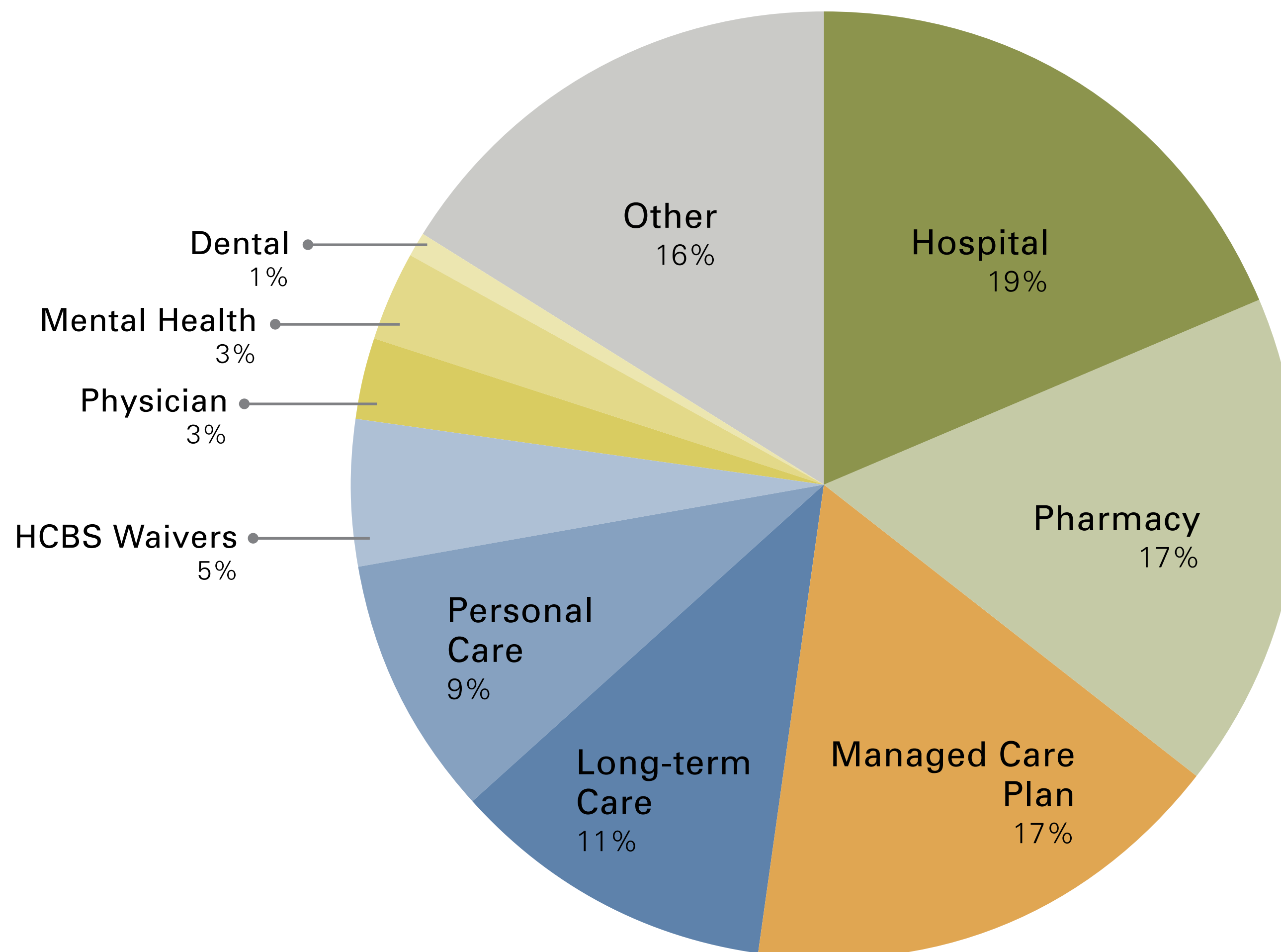
All states are federally required to provide certain benefits. California offers a number of additional benefits. Partial lists of both are shown here.

*Partial lists.

Source: Department of Health Services, 2003.

Distribution of Expenditures

Medi-Cal Service Expenditures: $28 billion



Payments to hospitals, pharmacies, and managed care plans account for the largest share of Medi-Cal expenditures.

Note: Hospitals includes inpatient and outpatient services. HCBS is Home and Community-Based Services.

Source: Medstat analysis of Medi-Cal MIS/DSS data updated through August 2005. Expenditures include only claims and capitation payments for Medi-Cal beneficiaries (e.g., exclude administrative expenses and DSH payments).

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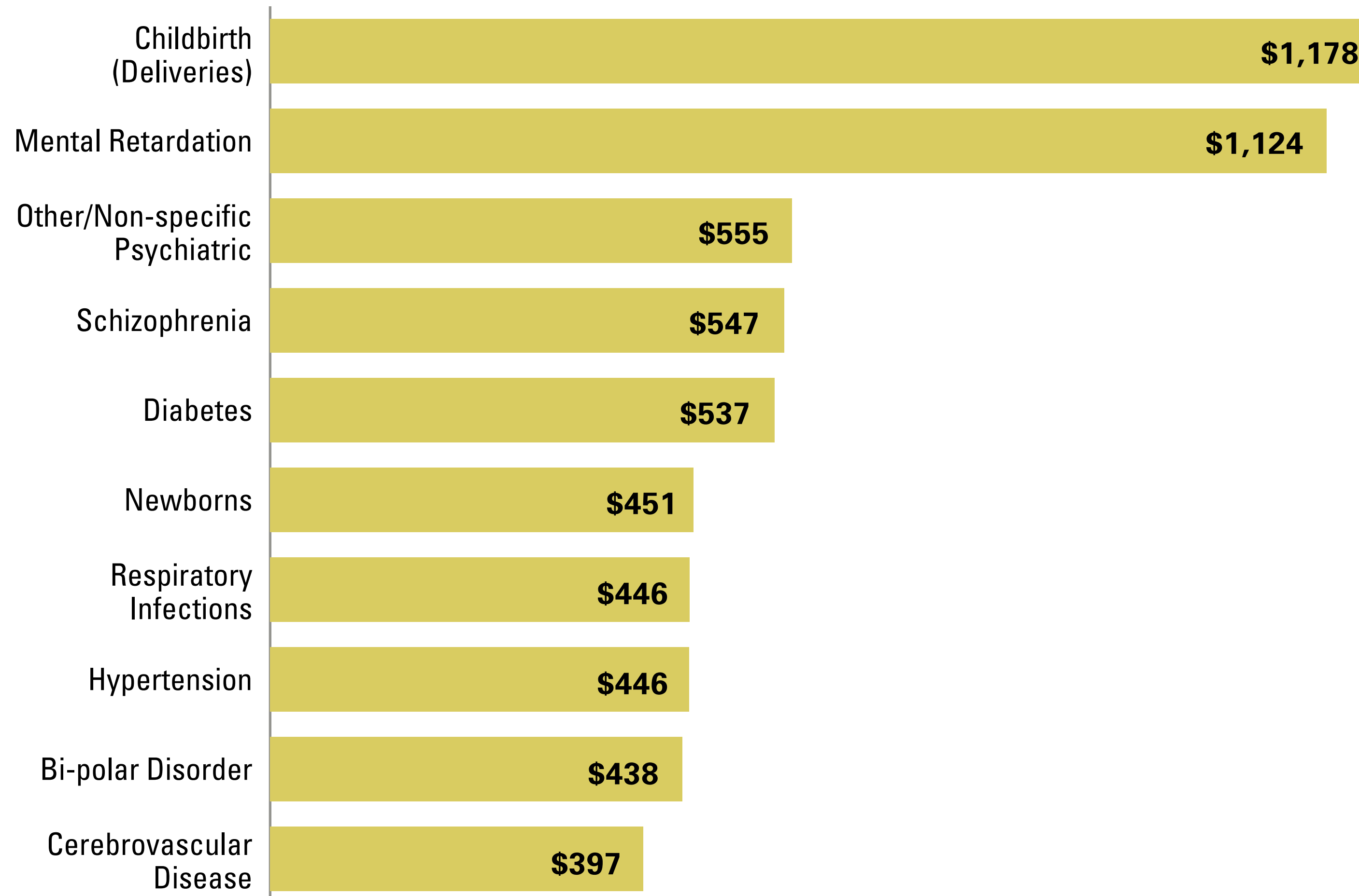
Most Expensive Conditions

Fee-for-Service Payments (millions)



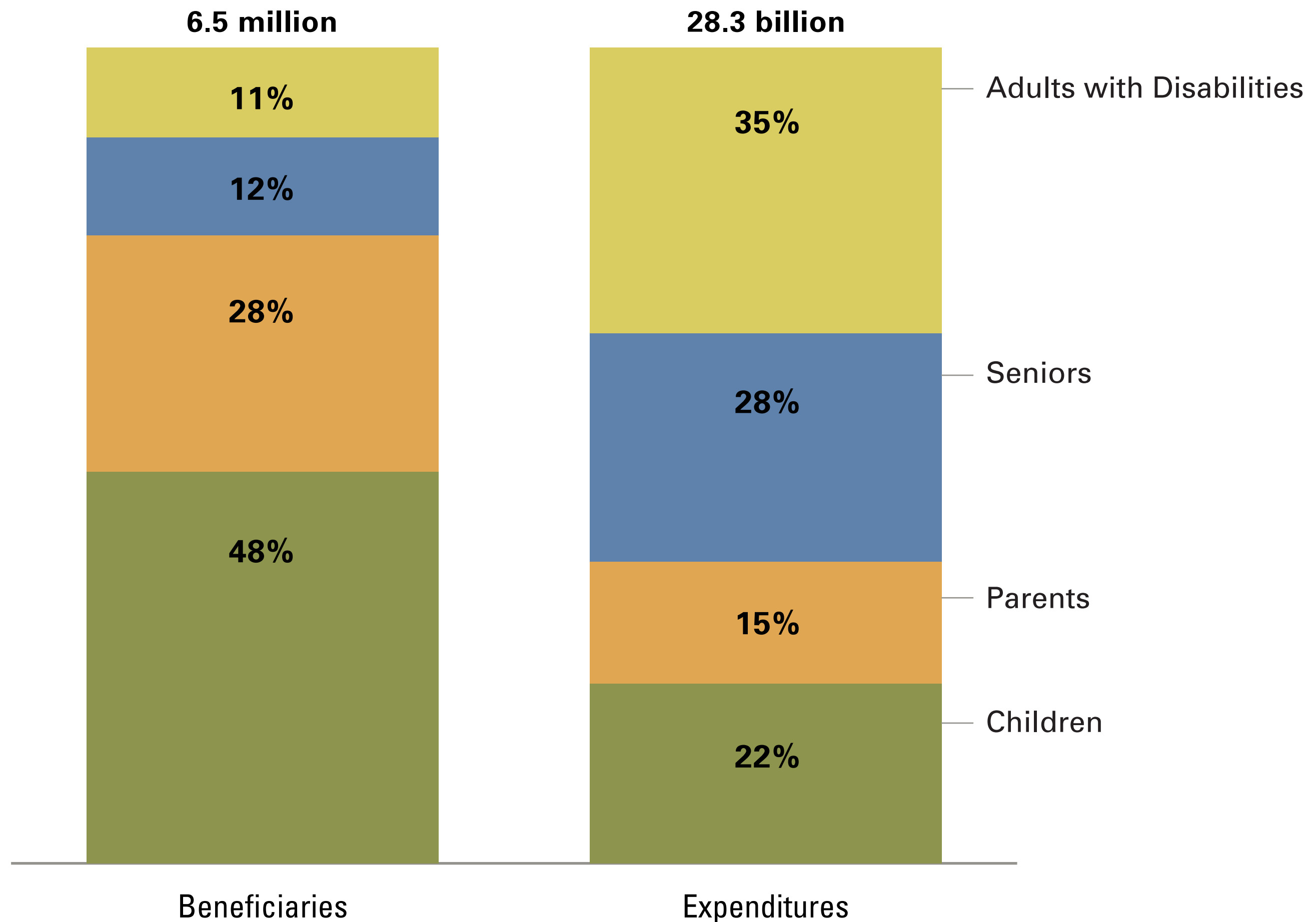
Among fee-for-service payments, Medi-Cal spends more on childbirth and mental retardation than on any other condition.

Notes: Reflects ten most costly episode of care categories among over 200 total categories. Based on fee-for-service payments for episodes of care initiated in 2004; episodes and payments may continue beyond 2004. Deliveries includes vaginal deliveries and C-sections; Other/Non-specific Psychiatric does not include depression or anxiety disorders. Payments for all episodes of care totaled $13.3 billion.

Source: Medstat analysis of Medi-Cal MIS/DSS data updated through September 2005

Beneficiaries and Cost

Seniors and adults with disabilities account for one-fourth of enrollees, but nearly two-thirds of Medi-Cal expenditures.



Source: Medstat analysis of Medi-Cal MIS/DSS data updated through August 2005; these expenditures include only claims and capitation payments for Medi-Cal patients (e.g., exclude administrative expenses and DSH payments).

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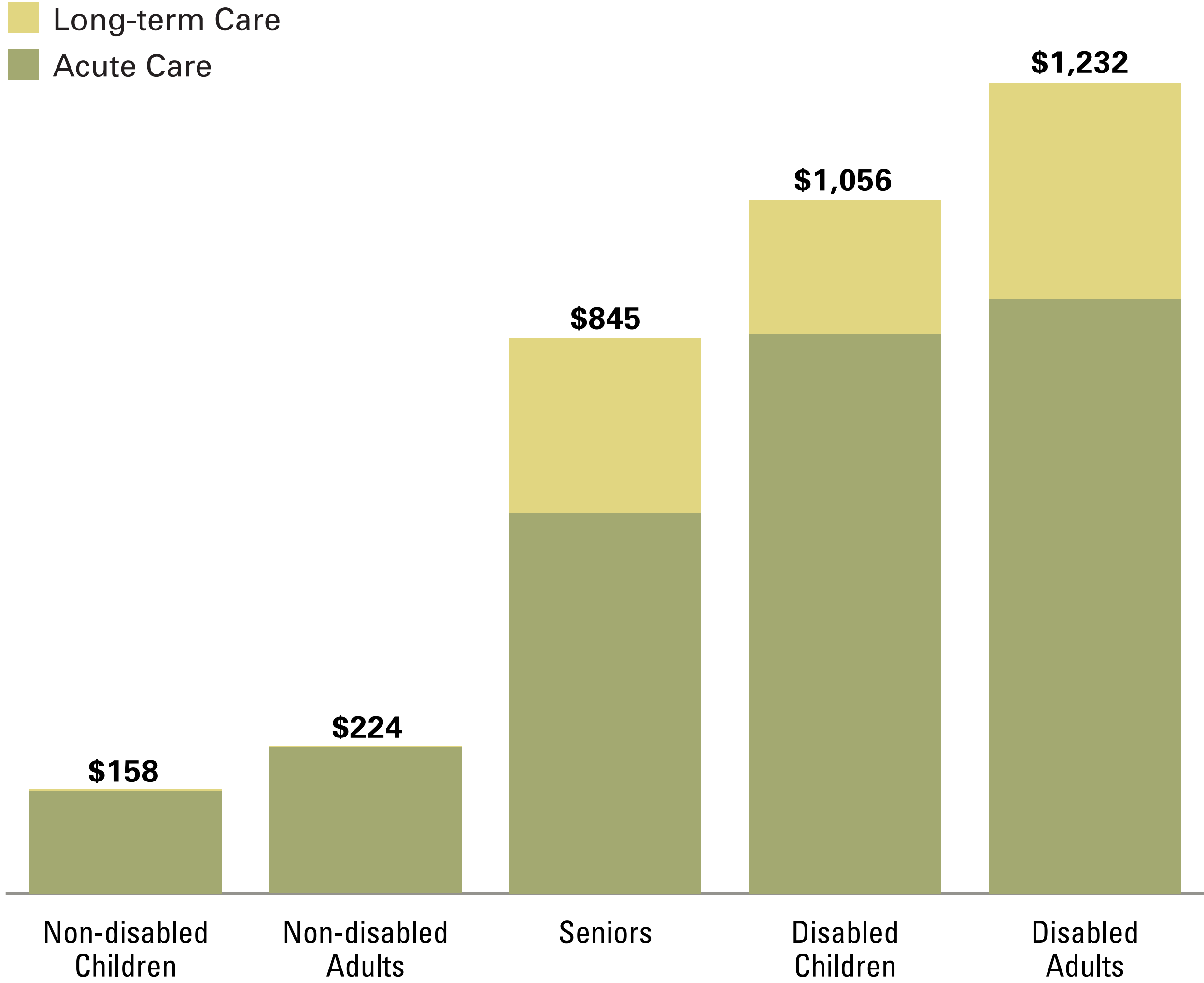
Monthly Cost per Beneficiary

Children and adults with disabilities are five to seven times more expensive than those without disabilities.



Source: Medstat analysis of Medi-Cal MIS/DSS data updated through October 2005. Fee-for-service payments and eligibles only. Long-term care (LTC) includes nursing facilities, home and community-based waiver service and intermediate care facilities.

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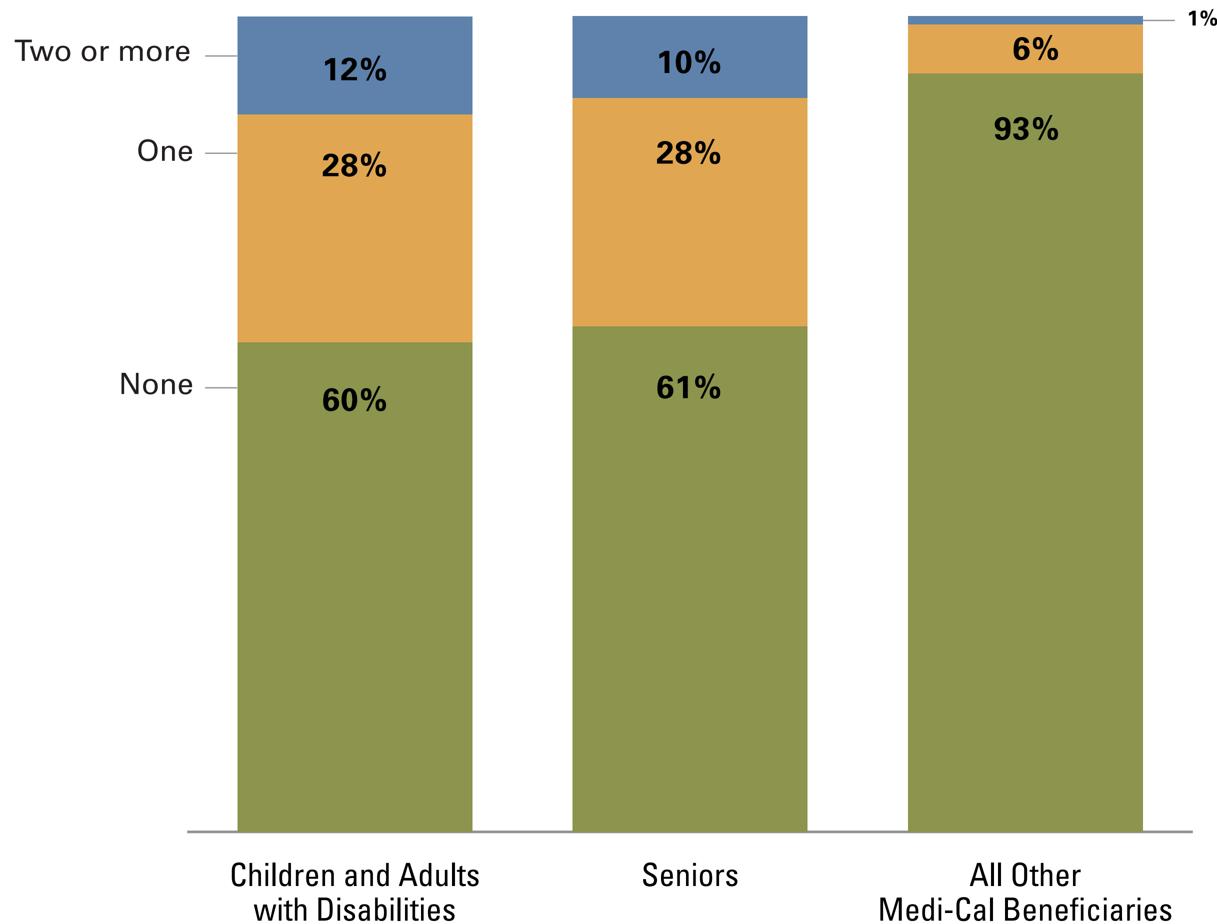
Prevalence of Chronic Conditions

Number of Chronic Conditions



Seniors and people with disabilities are nearly six times more likely than other Medi-Cal beneficiaries to have a chronic condition, and ten times more likely to have multiple chronic conditions.

Notes: Includes fee-for-service patients only. Among episodes of care initiated in 2004.

Source: Medstat analysis of Medi-Cal MIS/DSS, CY2004.

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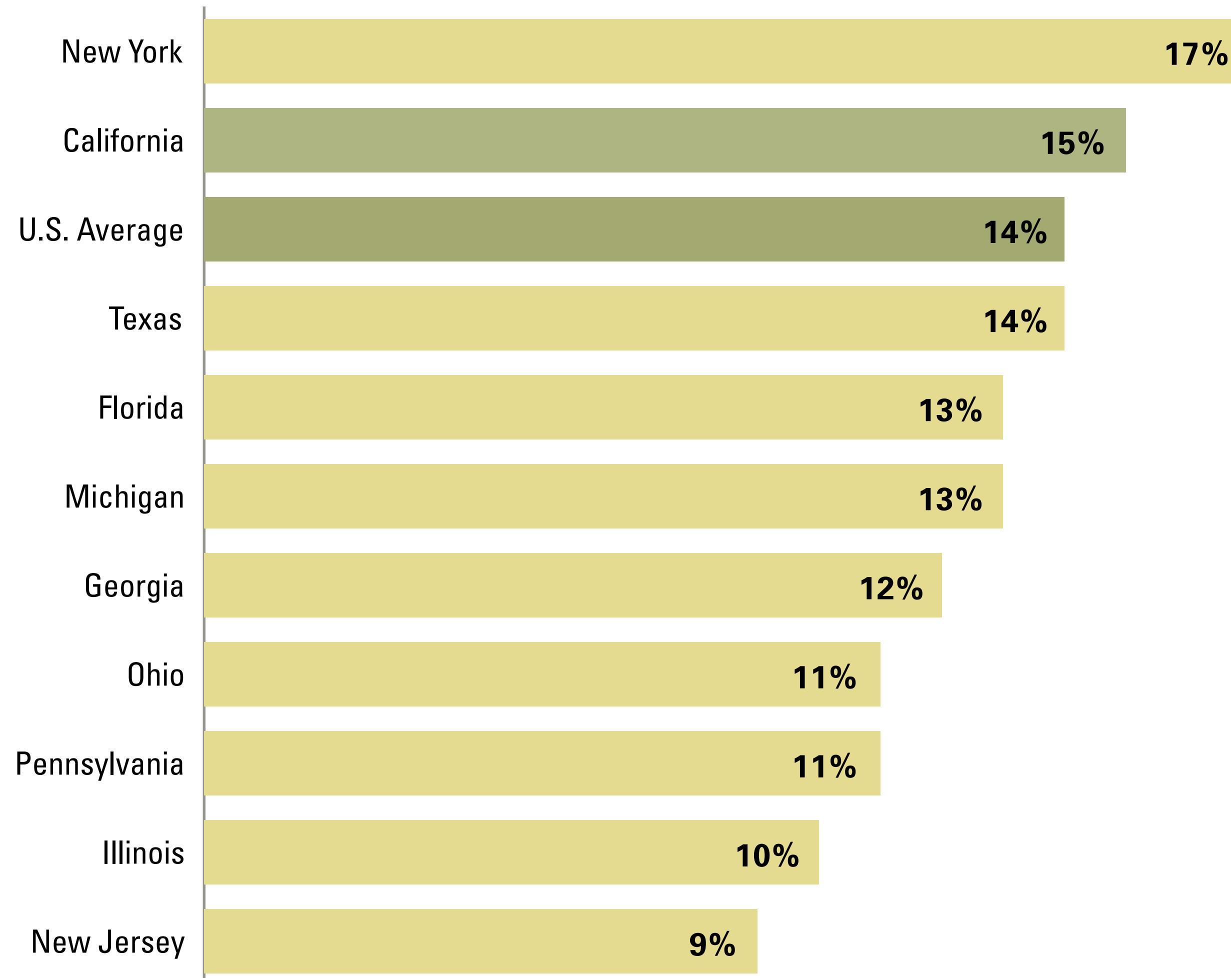
Enrollment

Non-elderly Population Covered by Medicaid



Note: The ten most populous states are represented along with the national average.

Source: Kaiser Family Foundation (www.statehealthfactsonline.org), 2003 data.

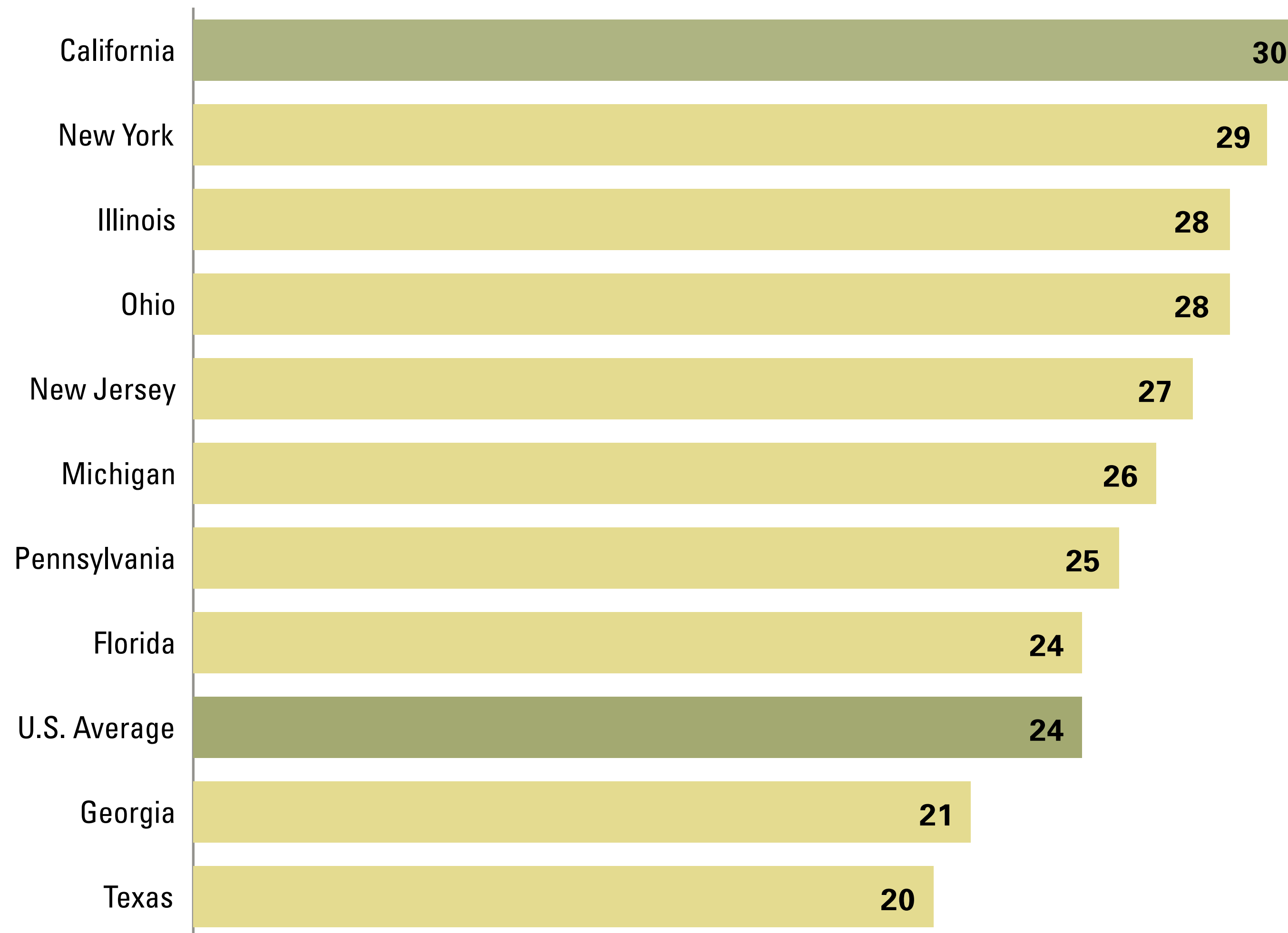
Medi-Cal
State Comparison

California covers a slightly higher proportion of the non-elderly population than the national average.

California also has a slightly higher proportion of its non-elderly residents with incomes below the FPL than the national average* (not shown).

*For example, percent of non-elderly adults with incomes below the poverty level is 16 percent for California and 17 percent for the U.S.

Optional Benefits Covered (of 31 total)



Medi-Cal
State Comparison

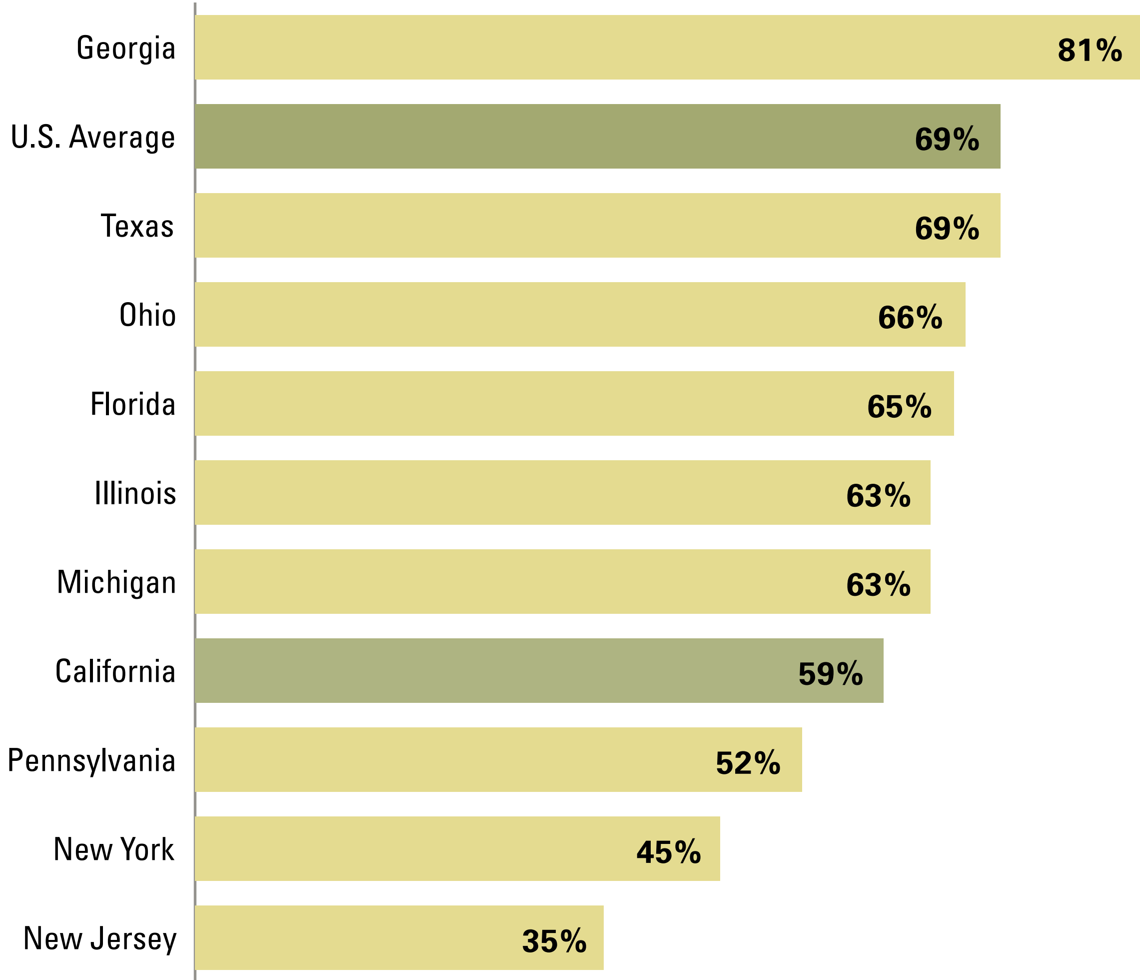
California covers more optional benefits than any large state. Among those services least likely to be covered by other states are: chiropractic, dental, dentures, hearing aids, occupational therapy, and physical therapy.

Notes: The ten most populous states are represented along with the national average. Of the 31 optional benefits examined, Medi-Cal does not cover direct billing for Private Duty Nursing.

Source: Kaiser Commission on Medicaid and the Uninsured Medicaid: An Overview of Spending on "Mandatory" vs. "Optional", Populations and Services June 2005 and Kaiser Commission on Medicaid and the Uninsured Medicaid: Medicaid Benefits Online Database.

Physician Payment Rates

as Share of Medicare Rates



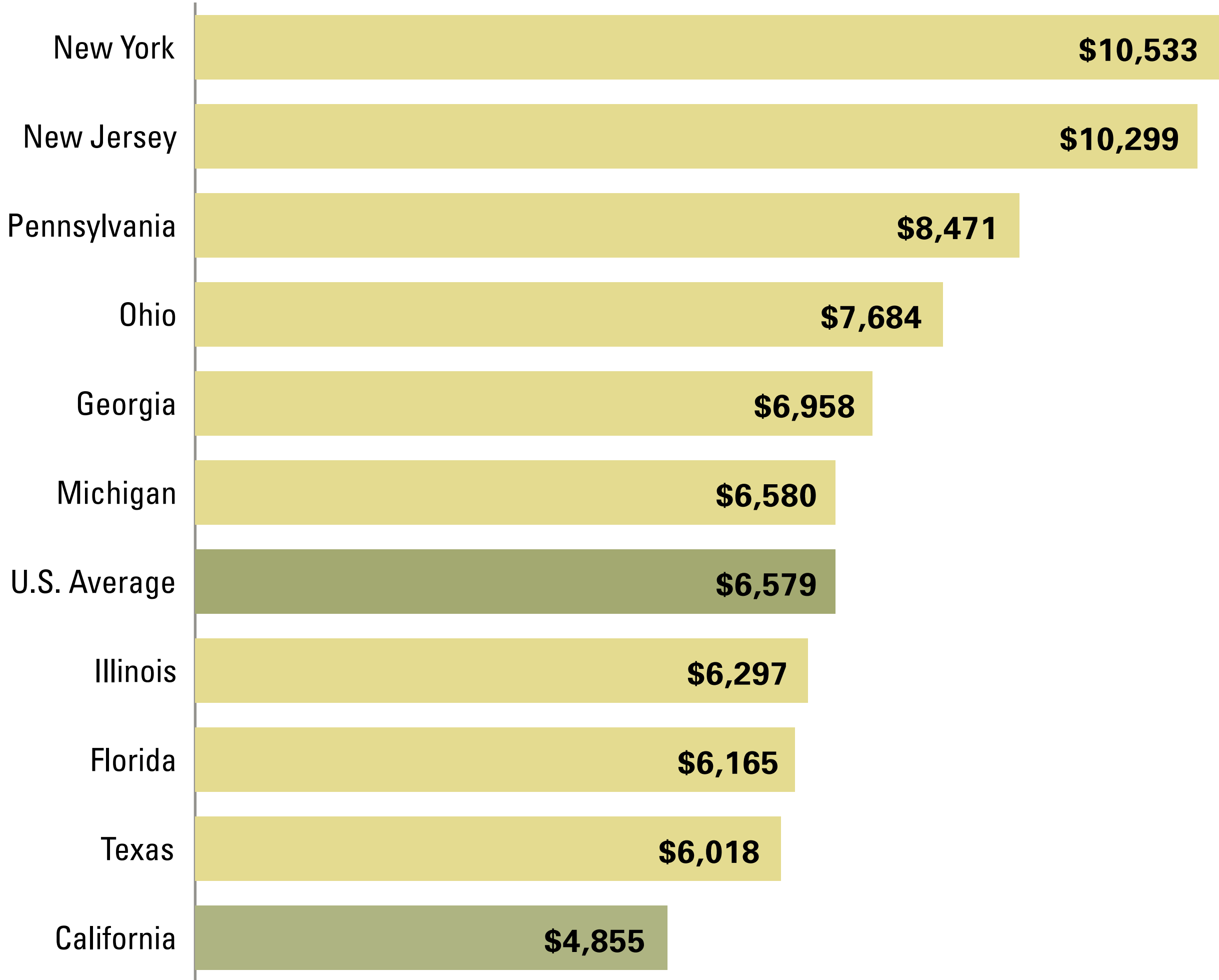
Notes: The ten most populous states are represented along with the national average. Medicaid physician reimbursement in each state reflects the unique characteristics of that state's delivery systems and may not be directly comparable to other states. In New York, for example, most physician payments flow through clinics and outpatient hospitals using higher, bundled per visit rates.

Source: Urban Institute / Health System Change 2003 Medicaid Physician Fee Survey.

Medi-Cal
State Comparison

Medi-Cal pays physicians 59 percent of Medicare rates. This is less than most other large states, and 10 percentage points below the national Medicaid average.

Spending per Beneficiary



California spends nearly 30 percent less per beneficiary than the national average and the least per beneficiary among the ten largest states.

Note: The ten most populous states are represented along with the national average.

Source: Kaiser State Health Facts. (Federal FY2004 expenditures; June 2004 enrollment).

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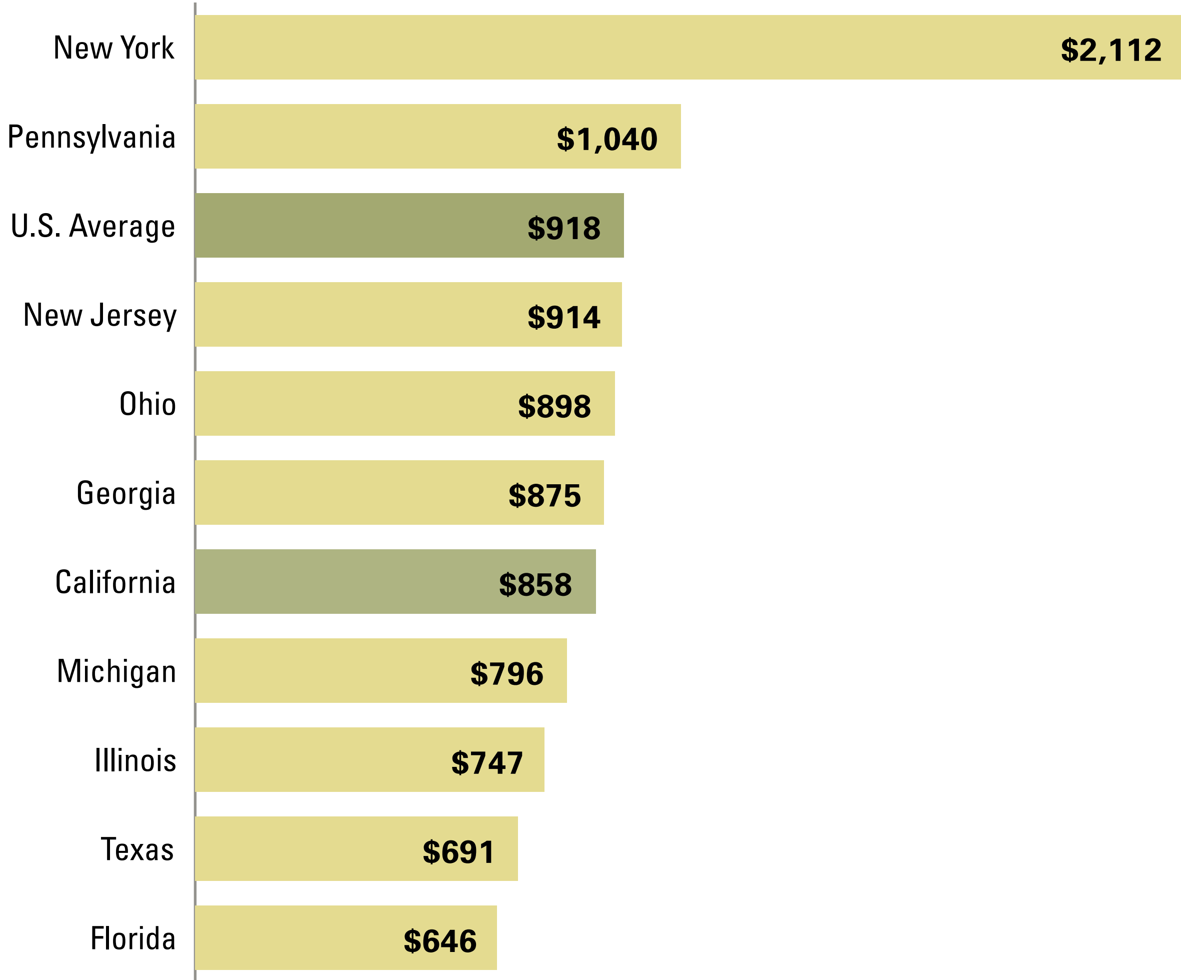
Spending per Resident

California spends 7 percent less per state resident on Medicaid than the national average.



Note: The ten most populous states are represented along with the national average.

Source: Kaiser, State Health Facts (Total Medicaid Spending, Federal FY2003) and U.S. Census Bureau, Table NST-EST2004-01 (State Population Estimates, July 1, 2003).

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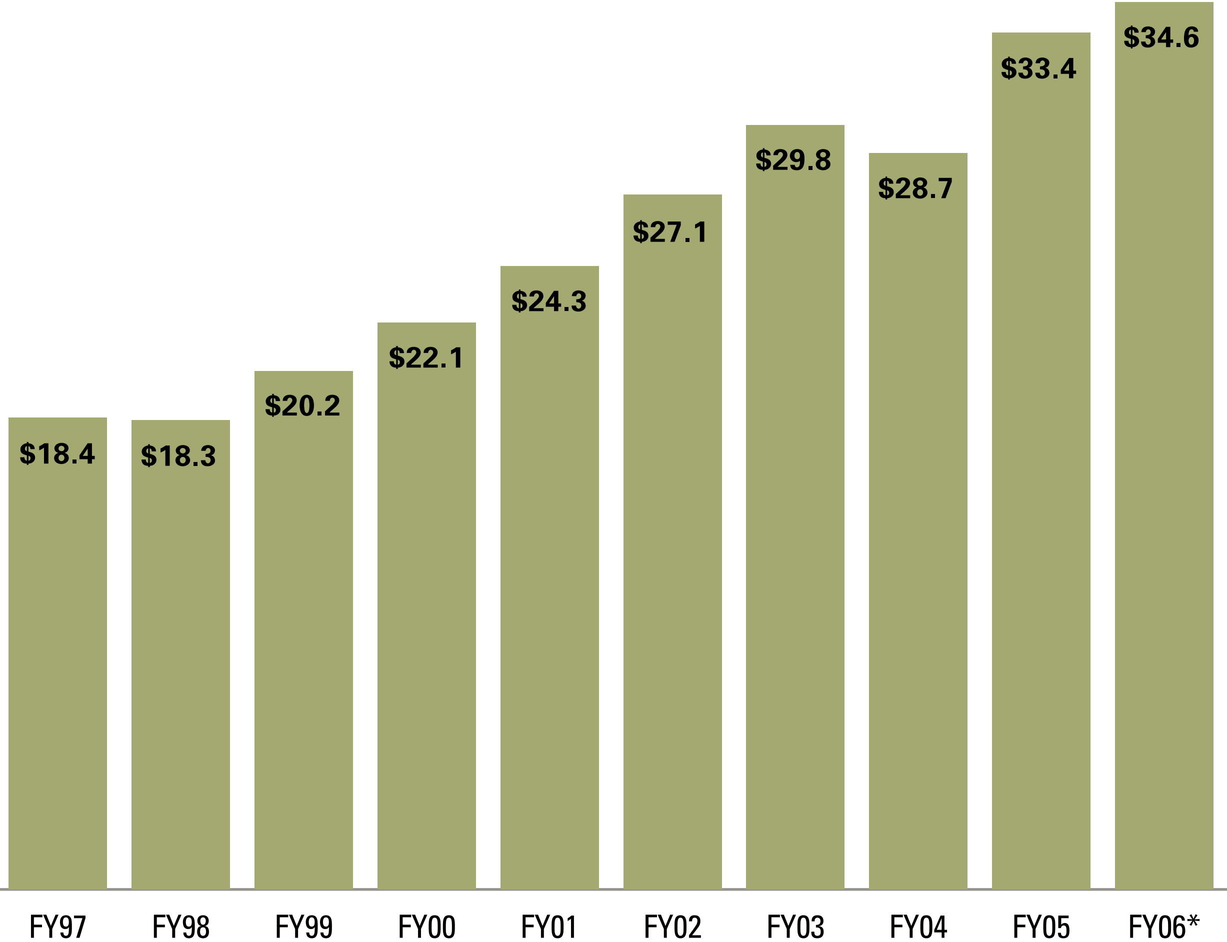
Medi-Cal Spending Trends

(billions)



*Estimate.

Source: Department of Health Services, Medical Care Statistics Section, May Medi-Cal Estimates, 1997 through 2005. Spending dip in FY04 is due to change from accrual to cash accounting.

Over the past 10 years, Medi-Cal expenditures grew at an average annual rate of 7 percent.

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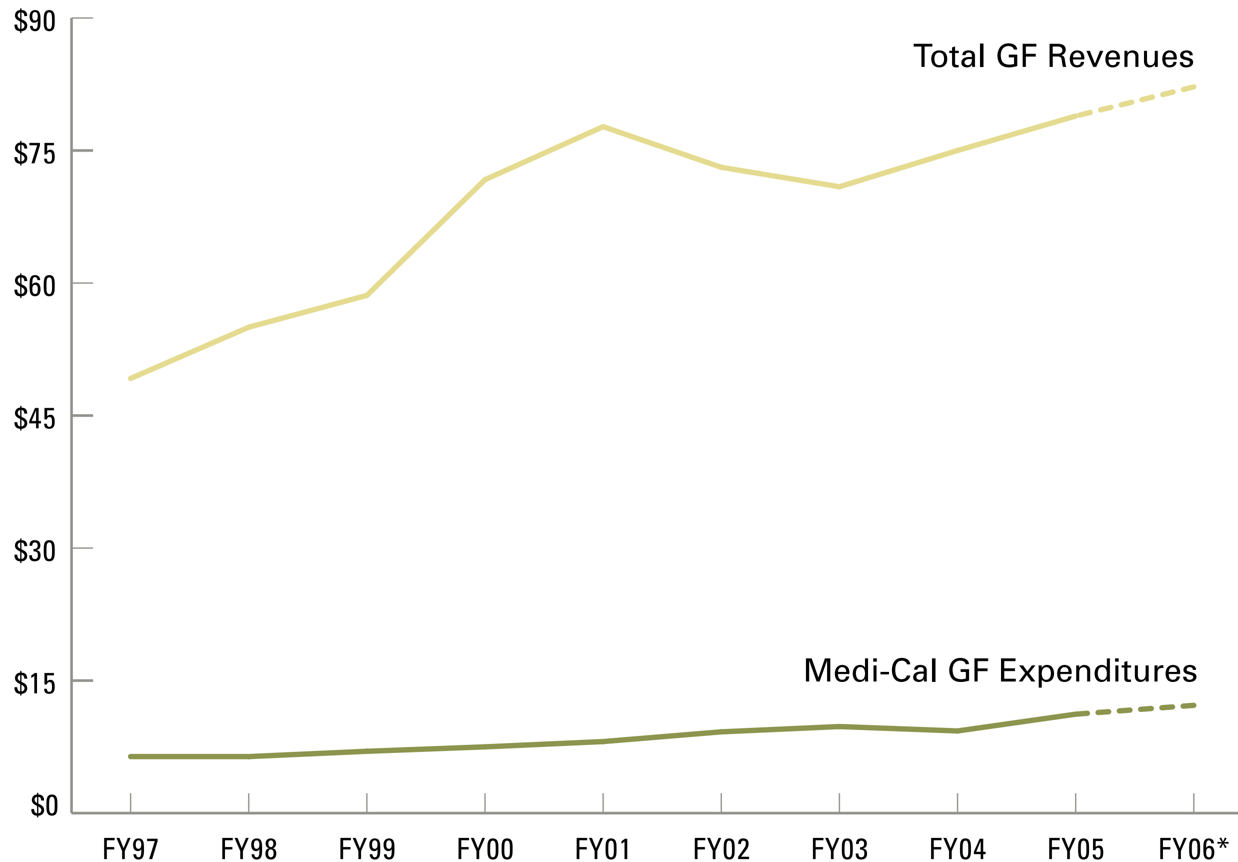
General Fund Trends



*Estimate.

Note: Medi-Cal spending dipped in FY04 due to change from accrual to cash accounting.

Source: Legislative Analyst's Office, *California's Fiscal Outlook* (through FY05).

Over the past decade, Medi-Cal expenditures have increased faster than General Fund revenues (7.2 and 6.1 percent, respectively).

Medi-Cal expenditures as a share of total General Fund revenues have grown from 13 percent to over 14 percent during this period.

Cost Driver Framework

Number of People Enrolled	×	Cost per Person
CONTRIBUTING FACTORS		CONTRIBUTING FACTORS
• Economy		• Service use
• Eligibility policies		• Beneficiary mix
• Enrollment practices		• Benefits covered
		• Provider payment rates
		• Beneficiary cost sharing
		• General and health care cost inflation

Medi-Cal spending is a factor of the number of enrollees and the cost per person. There are numerous contributors to each of these variables.

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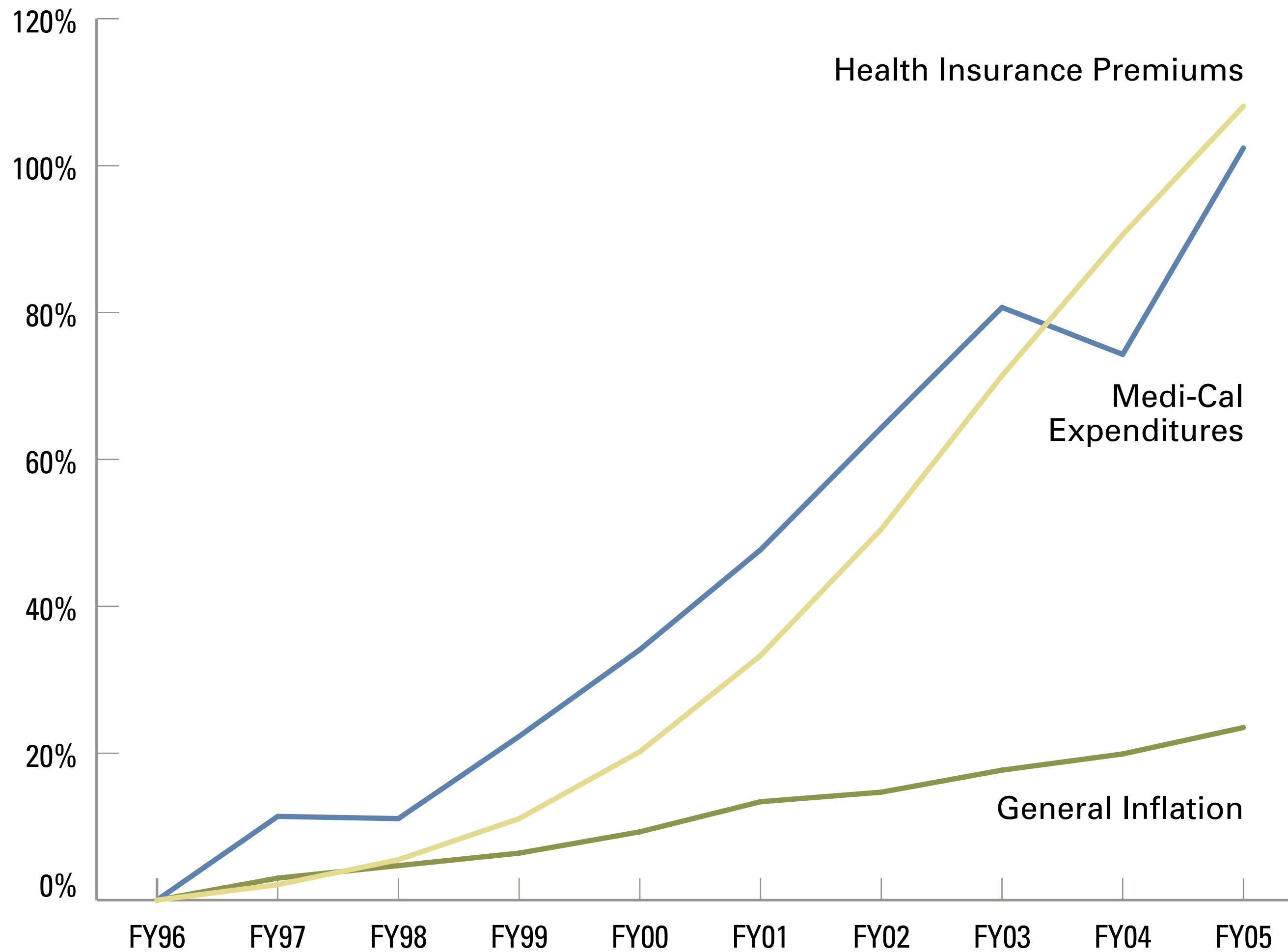
Health Care Inflation as a Cost Driver



Over the past decade, the cumulative growth of Medi-Cal spending is similar to the growth of private health insurance premiums. During this period, Medi-Cal spending and private health insurance premiums both grew at a pace more than four times that of the general inflation rate.

Sources: CHCF estimates of cumulative health insurance premium increases based on annual increases from Kaiser/HRET Employer Health Benefits 2005 Annual Survey (1996, 1999 – 2005), available at www.kff.org/insurance/7315/index.cfm and KPMG Survey of Employer-sponsored Health Benefits, (1996 – 1998), available at www.vahp.org/directory02/figure2.shtml. Medi-Cal data based on data from Department of Health Services, Medi-Cal May Estimates. General inflation data from U.S. Dept of Labor, Bureau of Labor Statistics, Consumer Price Index, All Urban Consumers ftp://ftp.bls.gov/pub/special.requests/cpi/cpiai.txt (January data for each year).

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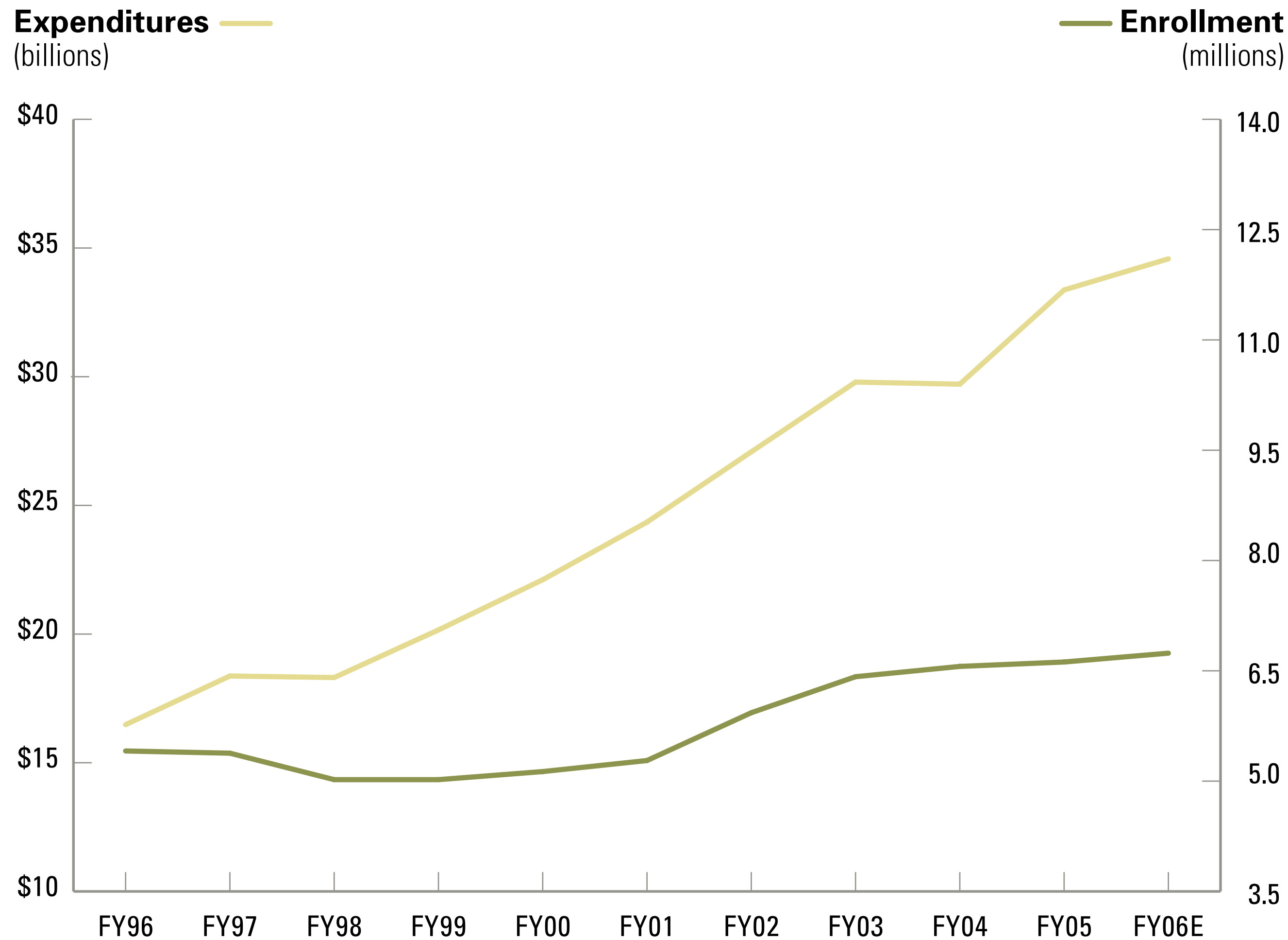
Enrollment as a Cost Driver



Sources: Department of Health Services, May Medi-Cal Estimates, 1976 through 2005; Legislative Analyst's Office, *Cal Facts: California's Budget and Economy in Perspective, 2004;* Medstat analysis of Medi-Cal MIS/DSS data updated through August 2005.

Enrollment growth has accounted for less than one-fifth of the growth in Med-Cal spending over the past decade.

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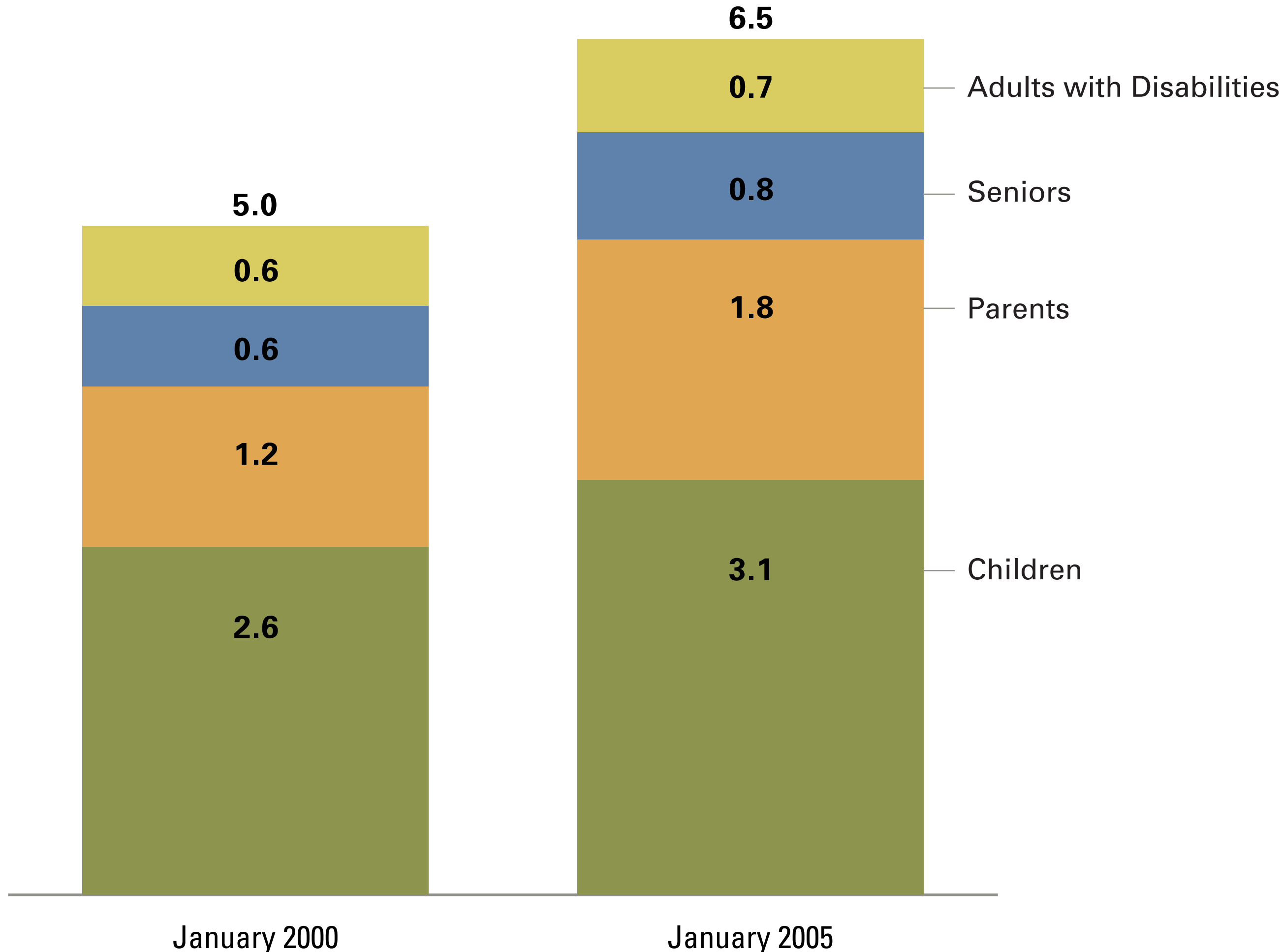
Enrollment Growth



Children and parents account for 80 percent of enrollment growth over the past 5 years. Enrollment growth during this period is largely a function of eligibility expansions in 2000 and 2001.

Source: Medstat analysis of Medi-Cal MIS/DSS data updated through August 2005.

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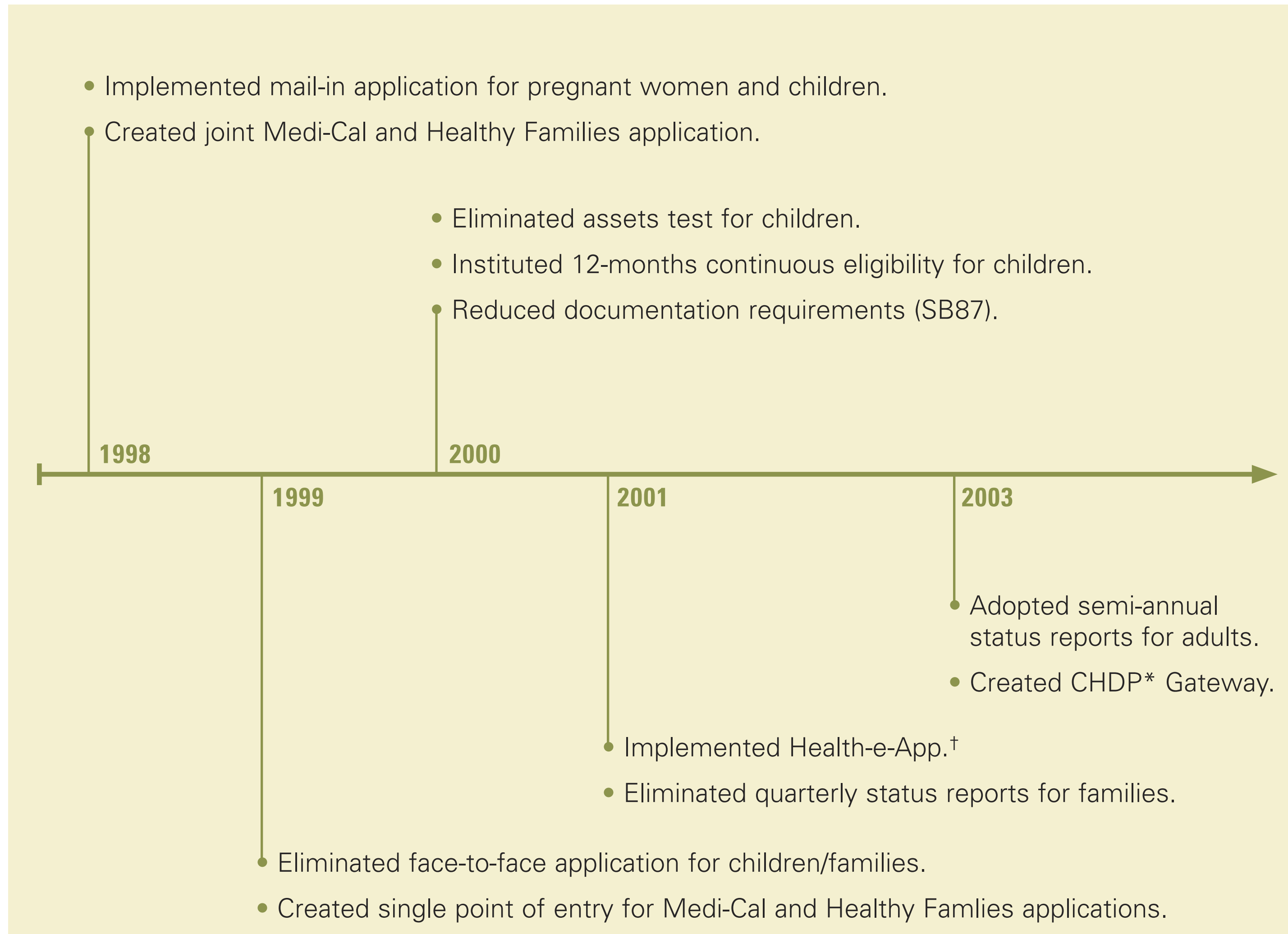
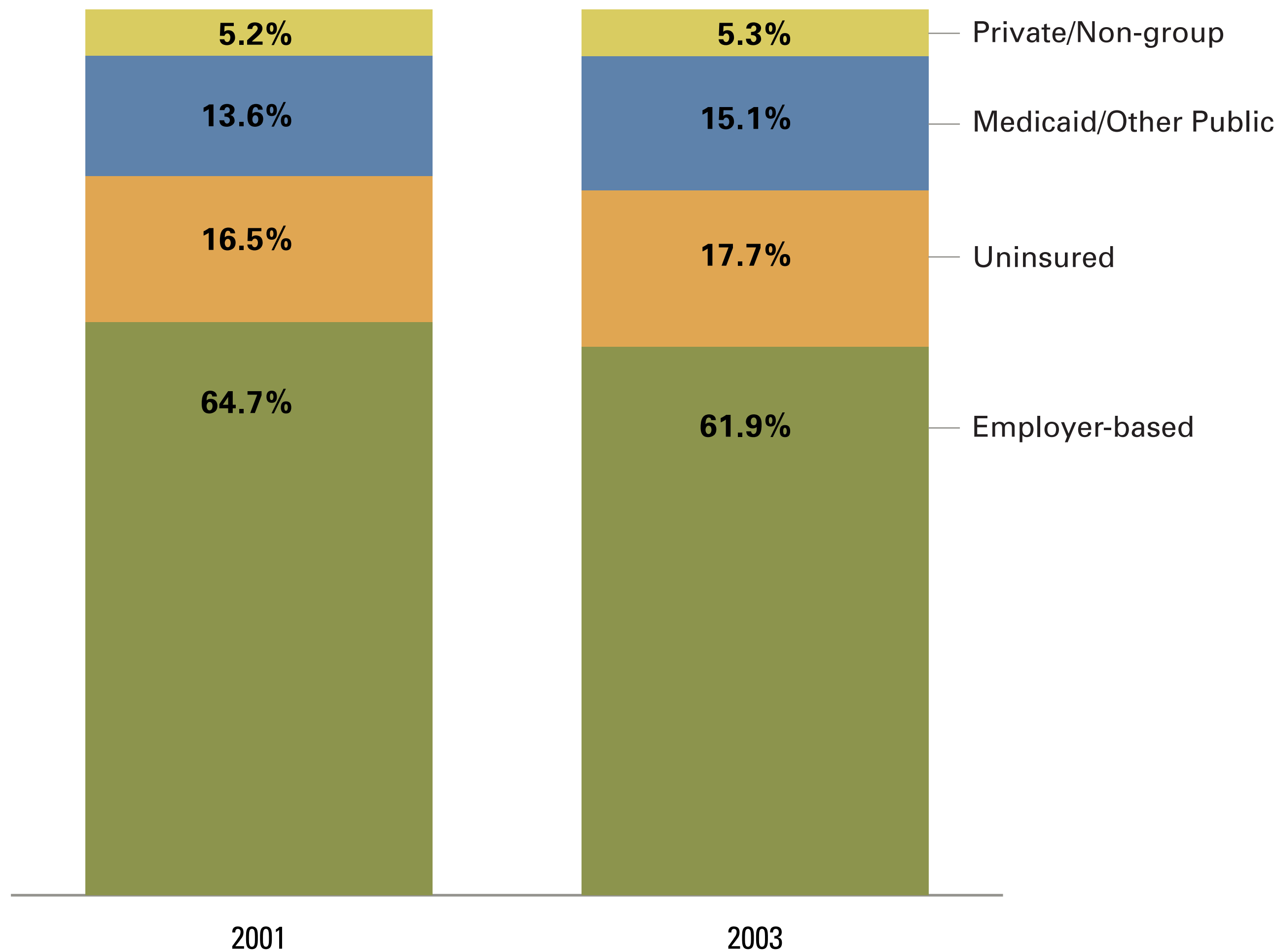
Eligibility and Enrollment Changes



The enrollment process has evolved significantly in recent years.

*Child Health and Disability Prevention program.
†Health-e-App is an electronic alternative to the paper Medi-Cal and Healthy Families application forms.
Source: The Lewin Group, 2003.

U.S. Health Insurance Trends



Source: Kaiser Commission on Medicaid and the Uninsured, 2003 Update.

About one-half of the decline in employer-based coverage between 2001 and 2003 was offset by increases in Medicaid and other public coverage.

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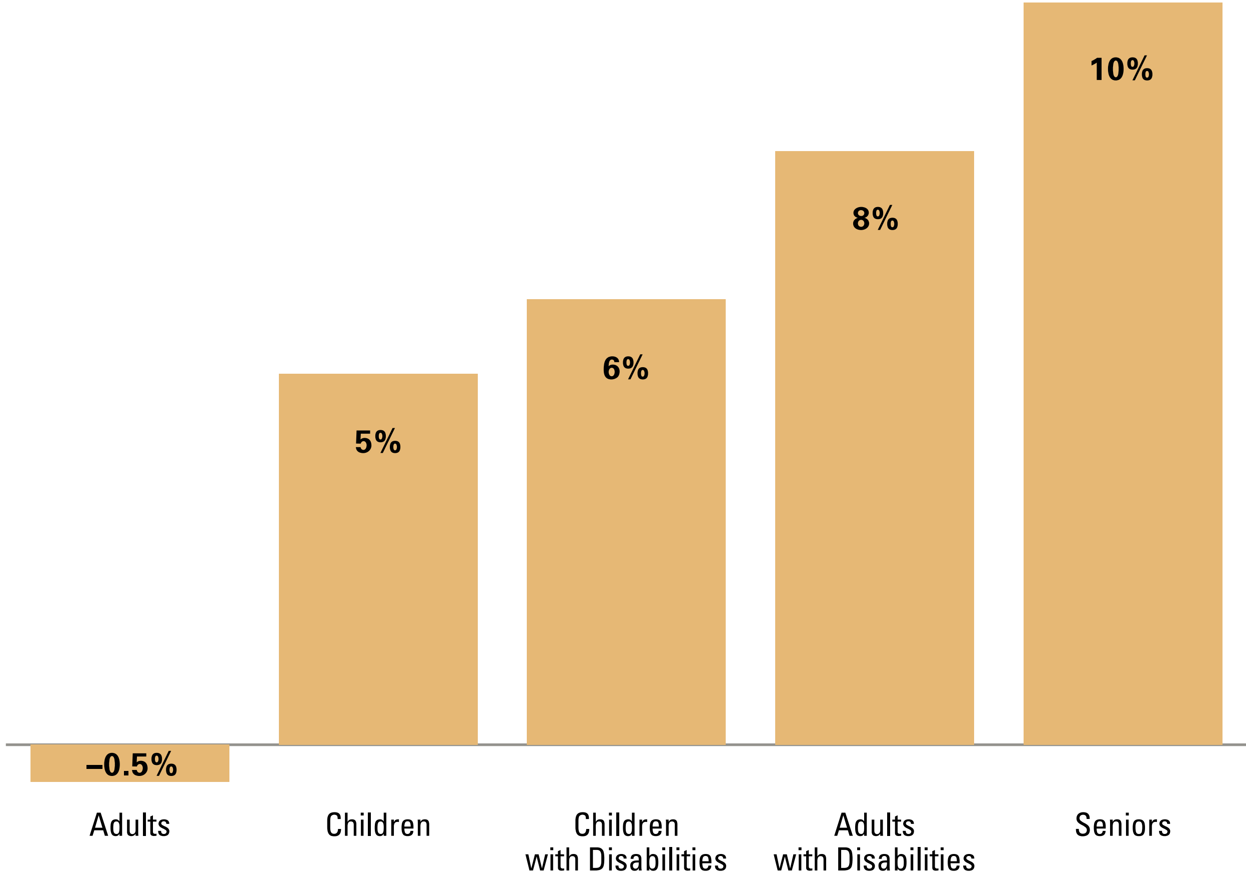
Per Person Costs as a Cost Driver

Medi-Cal spending grew fastest for adults with disabilities and the elderly. Annual spending for adults declined slightly.

CAGR* per Eligible Costs



*Compound annual growth rate.

Source: Medstat analysis of Medi-Cal MIS/DSS data updated through August 2005. Fee-for-service only. FY1999–00 and FY2004–05 data.

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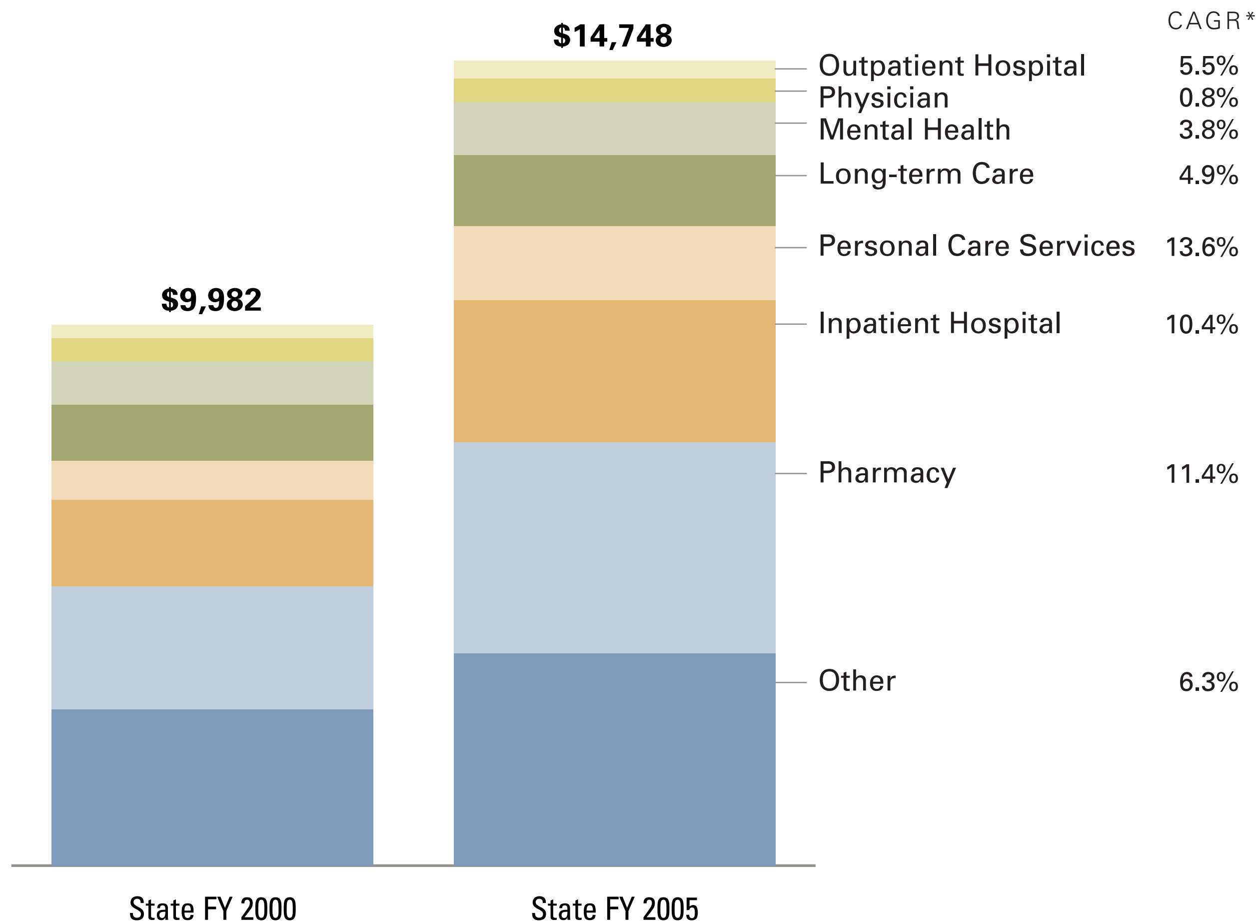
Spending Trends by Service

Monthly FFS Spending per Disabled Adult



*Compound annual growth rate.

Source: Medstat analysis of Medi-Cal MIS/DSS, updated through October 2005 (August 2005 data). Fee-for-service only.

Total overall spending increased by an average annual rate of 8 percent.

Prescription drugs accounted for one-third of the total spending increase.

Spending for personal care services, which grew at the fastest rate, accounted for 14 percent of the total spending increase.

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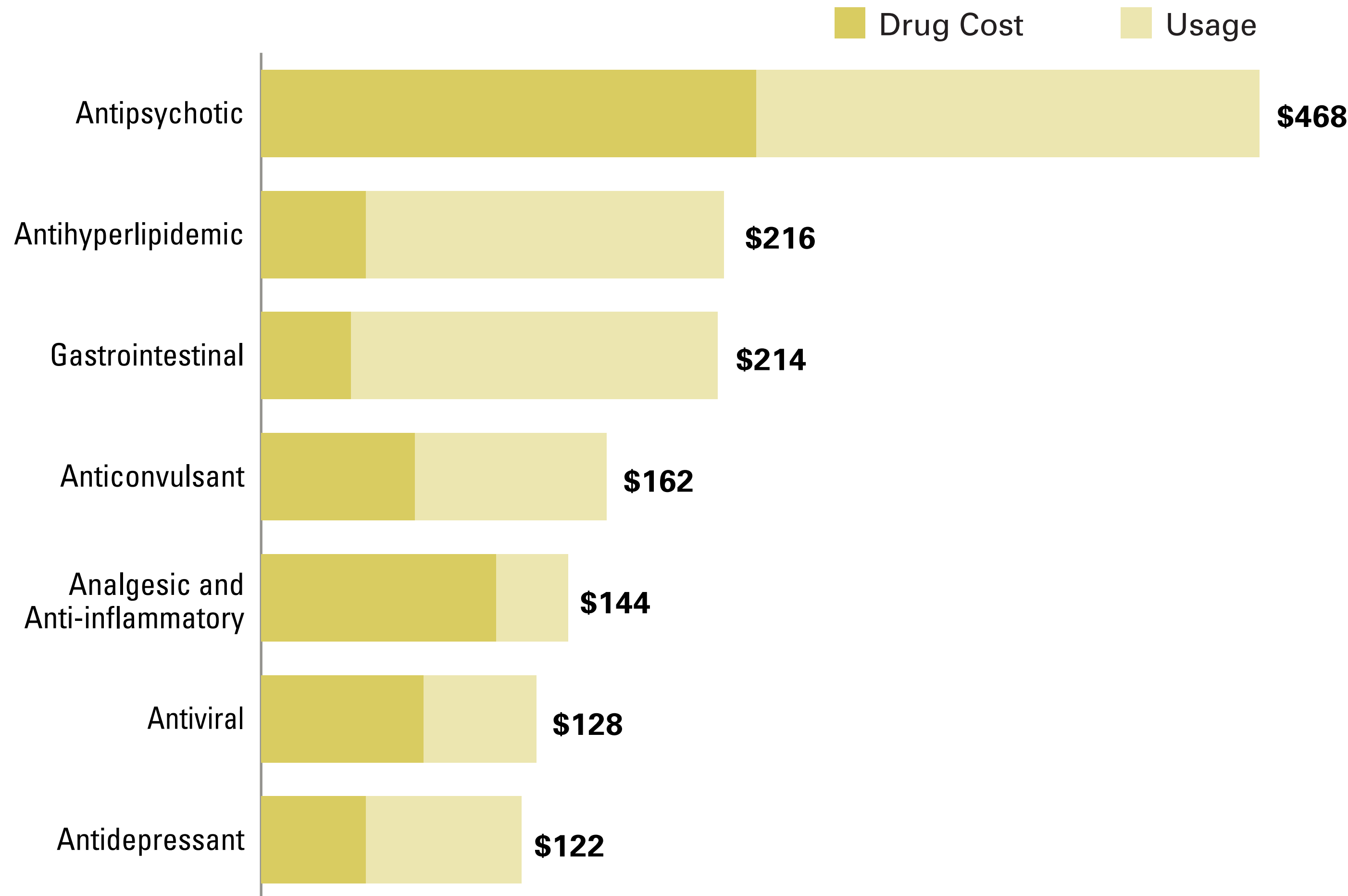
Prescription Drug Spending Drivers

Spending Increases Attributable to Therapeutic Class (millions)



Source: Medstat analysis of Medi-Cal MIS/DSS, May 2005. Excludes Pharmacy Rebates. 1999 to 2004 data.

Drug spending increases for antipsychotics were twice that of any other therapeutic class.

Drug spending increases among these theurapeutic classes were due to both increases in usage (57 percent) and drug costs (43 percent).

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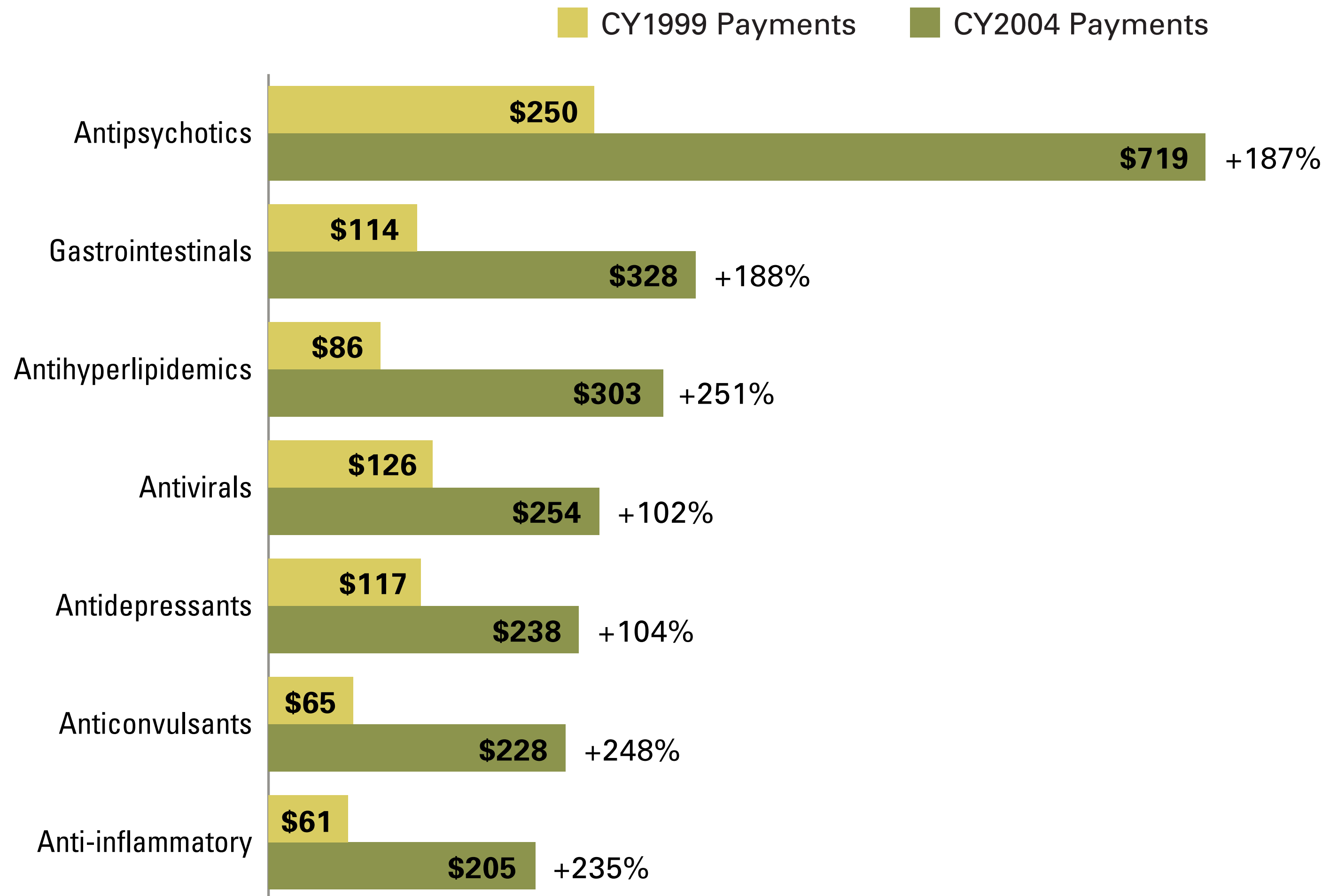
Prescription Drug Spending Trends

Top Drug Expenditures by Therapeutic Class (millions)



Source: Medstat analysis of Medi-Cal MIS/DSS data updated through August 2005. Excludes pharmacy rebates.

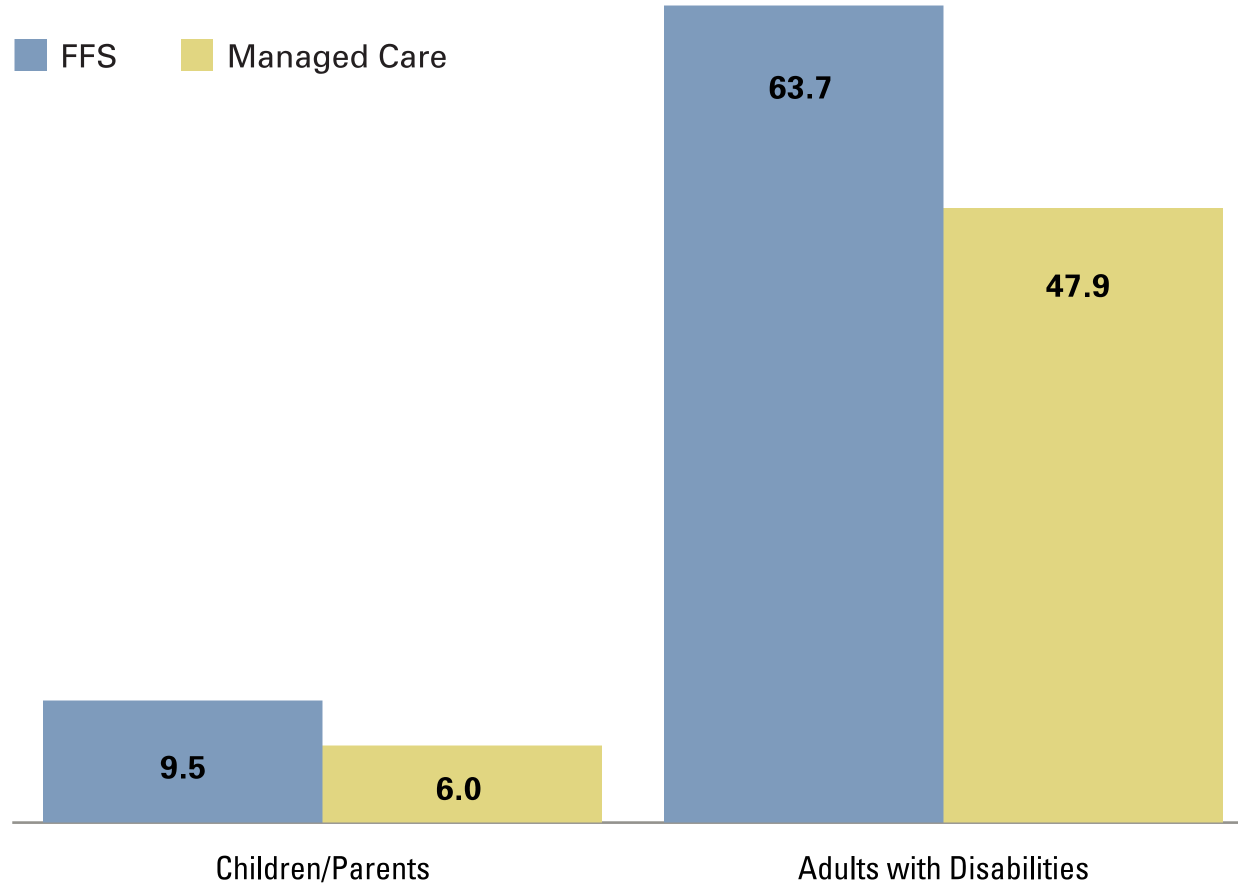
Medi-Cal spends more on antipsychotics than any other drug class.

Total payments for the ten most expensive drug classes nearly tripled, from $819 million to $2.3 billion, in five years.

Medi-Cal spending for antihyperlipidemics (cholesterol-reducing drugs) and anticonvulsants (to prevent seizures and treat depression) grew the fastest during this period.

Fee-for-Service vs. Managed Care

Preventable Hospitalizations, Admissions per 1,000 Enrollees



Note: Preventable hospitalizations are those which can often be avoided with proper care in an ambulatory setting for chronic conditions such as asthma, diabetes, hypertension and acute conditions include pneumonia, dehydration, and urinary tract infection.

Source: CHCF/UCSF, *Preventing Unnecessary Hospitalizations in Medi-Cal: Comparing Fee-for-Service with Managed Care.* 1994 to 1999 data.

Medicaid managed care has been a mechanism for states to reduce spending and provider greater budget predictability.

New evidence suggests Medi-Cal managed care also improves access to ambulatory care and health outcomes compared to FFS.

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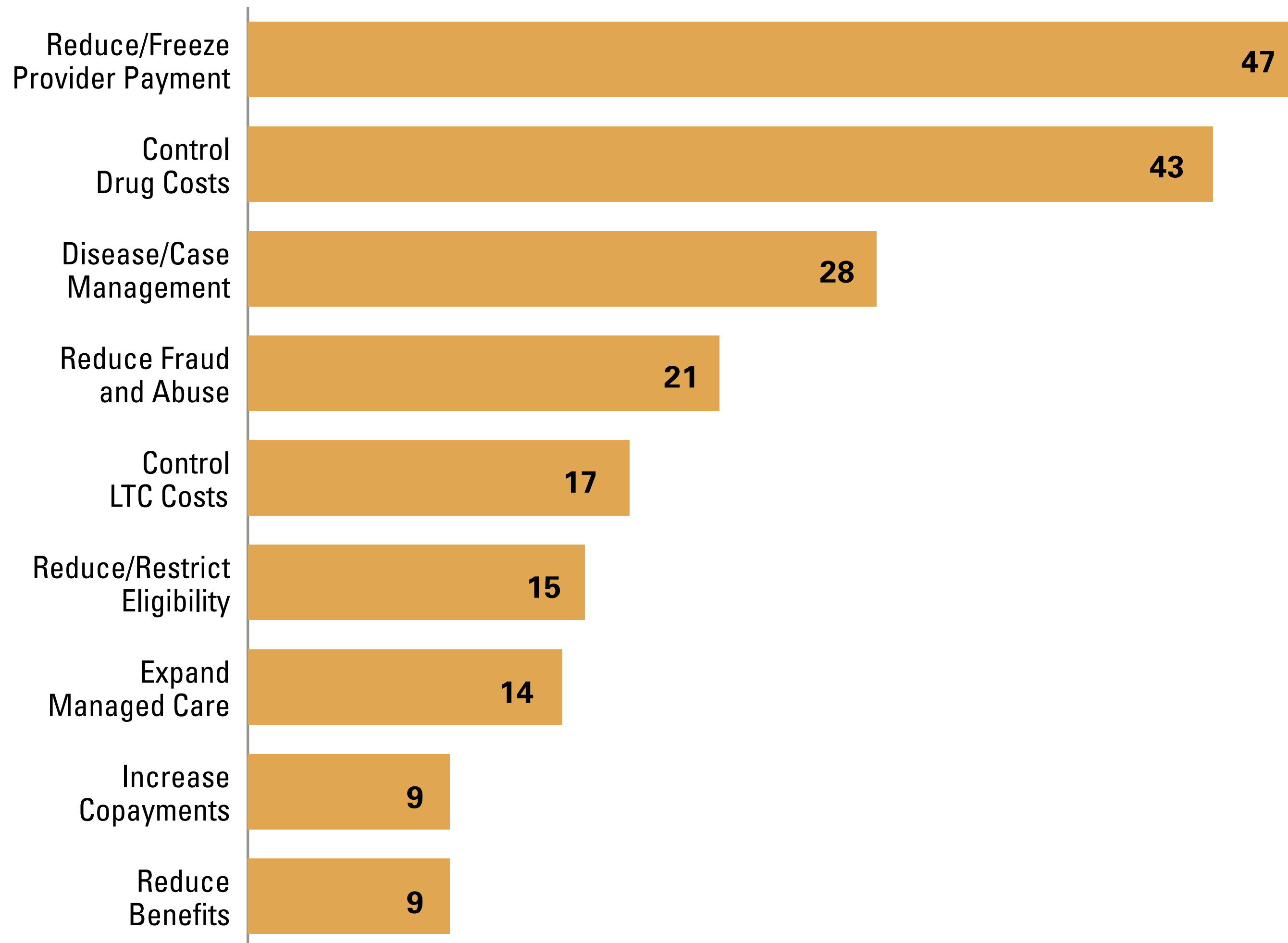
Cost Containment Strategies

Number of States Implementing Strategy Use



Source: Kaiser Family Foundation, *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005.*

Reducing or freezing provider payments and controlling drug costs are the most popular cost containment strategies. Increasing beneficiary copayments and reducing benefits are least popular.

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Summary

- **California spends slightly less per resident on Medicaid than most other large states and:**
  - Provides coverage to a higher proportion of low-income residents than most states.
  - Spends much less per beneficiary than the national average.
  - Is disadvantaged by an inequitable federal matching formula.
- **Recent growth of Medi-Cal expenditures is driven by two factors:**
  - Increases in enrollment: mostly among children and families, due to coverage expansions in 2000 and 2001 and the falling rate of employment-based coverage; and
  - Rising costs per beneficiary: largely due to rapidly increasing prescription drug spending among elderly and disabled beneficiaries.
- **The growth of Medi-Cal expenditures over the past decade is very similar to the growth of commercial health insurance premiums.**

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Acknowledgments

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California HealthCare Foundation
476 9th Street
Oakland, CA 94607
510.238.1040
www.chcf.org

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