CALIFORNIA

HEALTH CARE ALMANAC

California HealthCare Foundation

Medi-Cal Facts and Figures

SEPTEMBER 2009

Introduction

Medi-Cal, California's Medicaid program, is the main source of health care insurance for 6.8 million people, or one in six Californians. During the 2008–09 fiscal year, it drew $27 billion in federal funds into the state's health care system and accounted for 19 percent of General Fund spending. Medi-Cal is a complex program that pays providers for essential primary, acute, and long term care services delivered to a wide range of beneficiaries, including children, their parents, seniors and non-elderly adults with disabilities. Because it is the single largest source of health insurance coverage in the state and a major source of funding for safety-net providers, a thorough grasp of Medi-Cal is essential to understanding how health care is financed and delivered in California. For all its success, Medi-Cal faces numerous challenges, including enrollment barriers, low rates of participation among physicians, and rising health care costs.

Sources: California Department of Health Care Services (DHCS) *2008–09 Budget Act Highlights,* www.dhcs.ca.gov/Documents/Budget Act Highlights Dept of Health Care Services 2008-09.pdf. State of California, Department of Finance, E-1 Population Estimates for Cities, Counties and the State with Annual Percent Change — January 1, 2007 and 2008. Sacramento, California, May 2008. DHCS *Management Summary, Medi-Cal May 2009 Local Assistance Estimate for Fiscal Years 2008–09 and 2009–10,* www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/may_2009_estimate.aspx.

CONTENTS

About Medicaid

- Created by Title XIX of the Social Security Act that provides coverage for acute and long term care services to 59 million* Americans, including low-income children, parents, seniors and people with disabilities.
- State administered, governed by federal and state rules, and jointly funded with federal and state dollars.
- An entitlement program that requires federal and state governments to spend the funds necessary to provide mandatory benefits and services to specific populations.
- The nation's largest purchaser of health care services, collectively spending just over $336 billion in federal and state dollars from October 1, 2006 through September 30, 2007.
- A 43-year-old program that is continually evolving in terms of the populations it covers, the services for which it pays, and the manner in which care is delivered and financed.

Medicaid is a 43-year-old federal-state program that is now larger than Medicare.

*October 1, 2005 through September 30, 2006 (last year for which beneficiary data is available).

Source: Centers for Medicare and Medicaid Services (CMS), 2008. *Brief Summaries of Medicare and Medicaid: Title XVIII and Title XIX of The Social Security Act,* www.cms.hhs.gov/MedicareProgramRatesStats/Downloads/MedicareMedicaidSummaries2008.pdf.

About Medi-Cal

- Nation's largest Medicaid program, in terms of the number of people it serves, 6.8 million,[1] and is the second largest in terms of dollars spent, $47 billion.[2]
- Source of health care coverage for:
  - One in three California children;[3]
  - More than one in ten adults in the state under age 65; and[4]
  - The majority of people living with AIDS.[5]
- Pays for:
  - Forty-six percent of all births in the state;[6]
  - Care supplied to two-thirds of all nursing home residents; and[7]
  - Almost two-thirds of all net patient revenue in California's public hospitals.[8]
- Brings in $27 billion in federal funds to California's health care providers.[9]

Medi-Cal is the nation's largest Medicaid program.

Note: Includes Medi-Cal spending from other departments for FY2008–09, estimated at $6.304 billion.

Sources:
1. Kaiser Family Foundation (KFF) State Health Facts Total Medicaid Enrollment, FY2006, www.statehealthfacts.org/comparemaptable.jsp?ind=198&cat=4 and California Department of Health Care Services (DHCS) *2008–09 Budget Act Highlights,* www.dhcs.ca.gov/Documents/Budget Act Highlights Dept of Health Care Services 2008-09.pdf.
2. DHCS *Management Summary, Medi-Cal May 2009 Local Assistance Estimate for Fiscal Years 2008–09 and 2009–10,* www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/may_2009_estimate.aspx
3. U.S. Census Bureau: State and County QuickFacts, quickfacts.census.gov/qfd/states/06000.html.
4. Ibid.
5. California Department of Public Health (CDPH), Office of AIDS. HIV/AIDS Case Registry Section, data as of June 30, 2008, www.cdph.ca.gov/data/statistics/Documents/OA-2008-06HIVAIDSMerged.pdf.
6. CDPH, 2007 birth records, ww2.cdph.ca.gov/data/statistics/Documents/birthzip2007.pdf.
7. KFF State Health Facts. Total Number of Residents in Certified Nursing Facilities, 2007, www.statehealthfacts.org/comparemaptable.jsp?ind=408&cat=8.
8. California Office of Statewide Health Planning and Development (OSHPD) *Annual Hospital Financial Report, 2005.*
9. See Note 2.

Comparison to Medicare

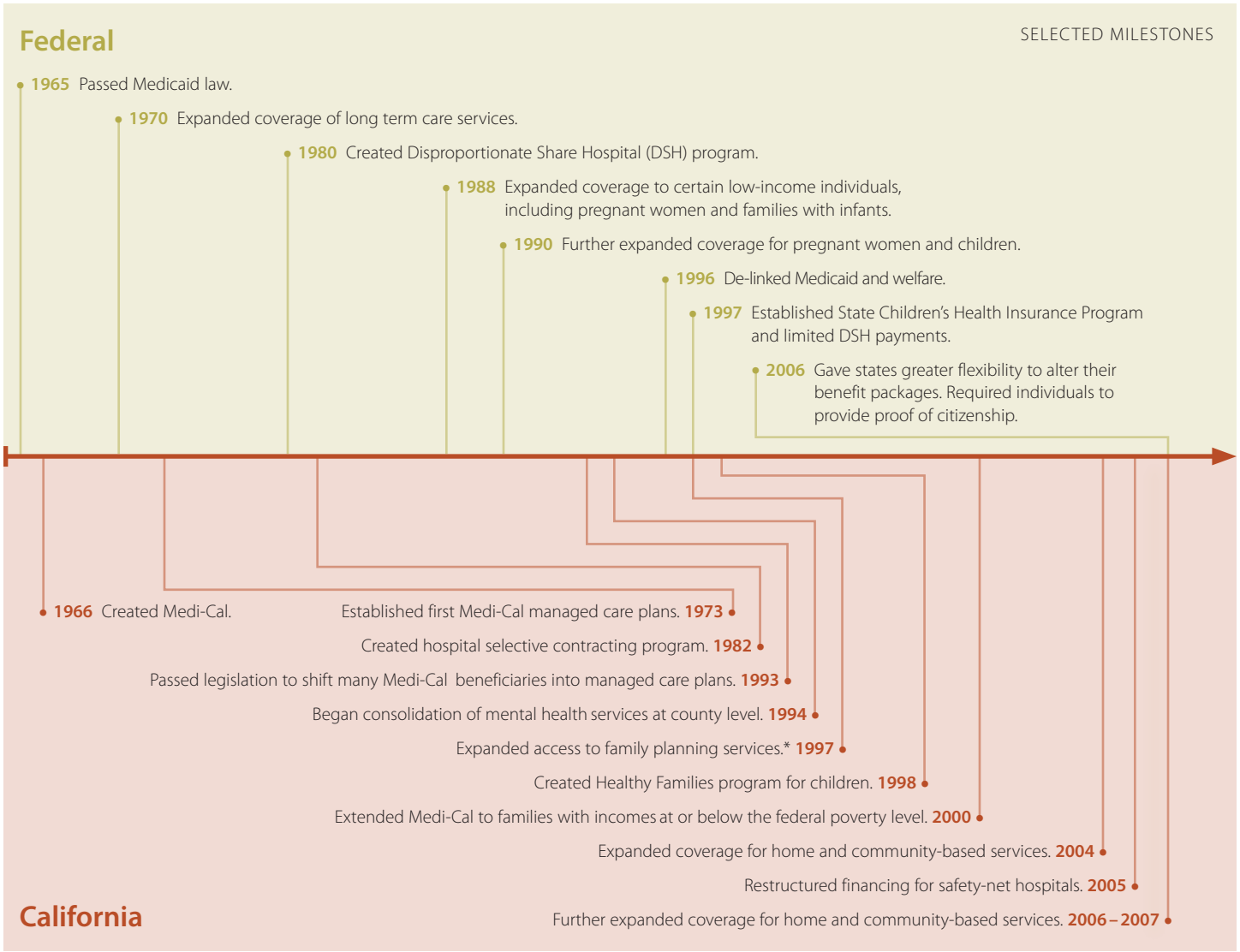
	MEDI-CAL	MEDICARE
Population	Low-income families and children, people with disabilities and seniors (65+)	Seniors (65+) or permanently disabled
Services Covered	Primary, acute, and long term care	Primary and acute care plus pharmacy under Medicare Part D
Cost Sharing	No premiums or copayments for lowest-income beneficiaries	Beneficiaries must pay premiums and deductibles
Funded by	Federal and California governments	Federal government and beneficiaries
Administered by	California with oversight by CMS	Federal government through CMS

There are over one million California seniors and people with disabilities who are eligible for both Medi-Cal and Medicare ("dual eligibles").

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008.

Legislative History

Medi-Cal has evolved over time in response to changing federal and state policies.



*Family Planning, Access, Care and Treatment (Family PACT) Program

Sources: Centers for Medicare and Medicaid Services (CMS), *Medicaid's Milestones,* www.cms.hhs.gov/History/Downloads/MedicaidMilestones.pdf. Committee on Budget & Fiscal Review, *Quick Summary: The Governor's Special Session Reduction Proposals and Proposed 2009–10 Budget,* January 6, 2009, www.sen.ca.gov/budget/QuickSummary0910Budget.pdf. California Department of Health Care Services (DHCS) *Description of Medi-Cal Waivers Chart,* August 1, 2008, www.dhcs.ca.gov/services/medi-cal/Documents/MediCalWaivers.pdf. DHCS, Medical Care Statistics Section, *Medi-Cal Program Highlights Calendar Year 1997,* December 1998, www.dhcs.ca.gov/dataandstats/statistics/Documents/highlights_1997.pdf.

Agencies Governing Medi-Cal

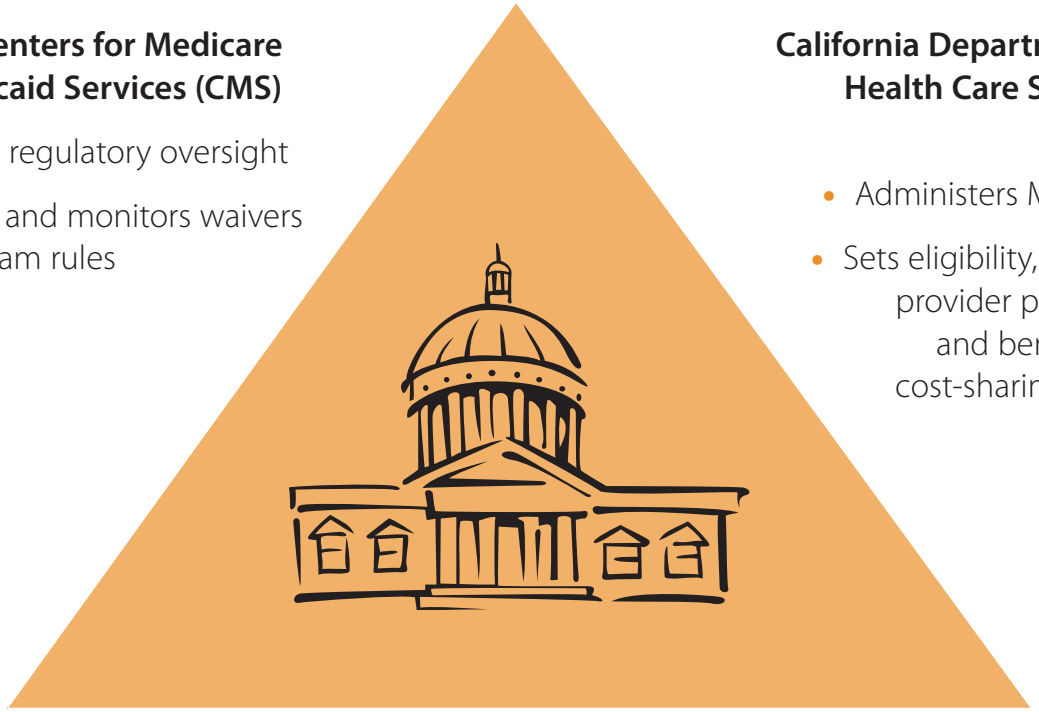
Medi-Cal is governed by the federal, state, and county agencies.

Federal Centers for Medicare and Medicaid Services (CMS)

- Provides regulatory oversight
- Reviews and monitors waivers to program rules

California Department of Health Care Services (DHCS)

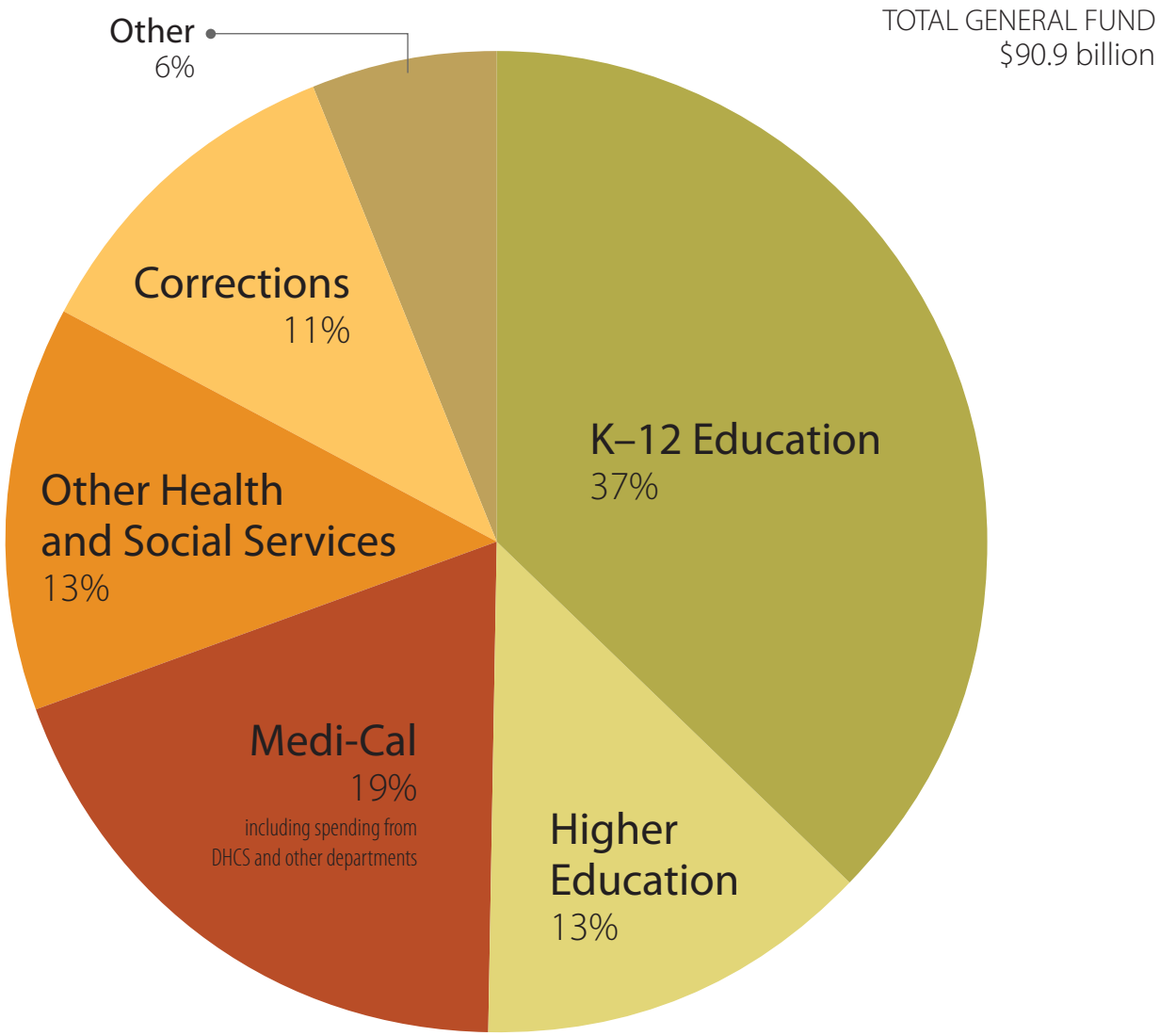
- Administers Medi-Cal
- Sets eligibility, benefit, provider payment, and beneficiary cost-sharing levels



County Health and Social Services Departments

- Conduct eligibility determination
- Oversee enrollment and recertification

State Budget Distribution, FY2008–2009



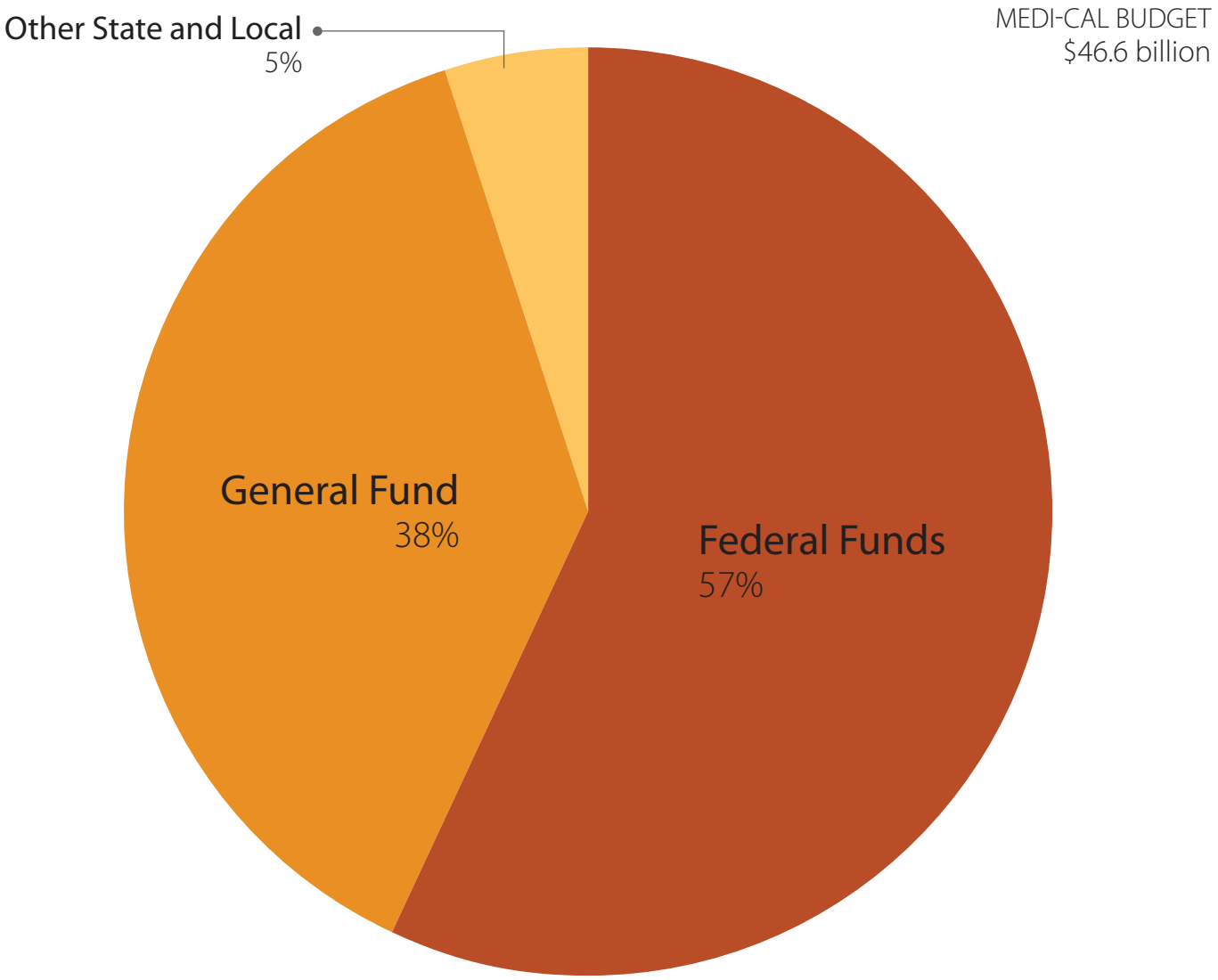
Note: Figures may not total 100 percent due to rounding.

Source: California Legislative Analyst's Office (LAO), Historical Expenditures and California Department of Health Care Services (DHCS), *Management Summary, Medi-Cal May 2009 Local Assistance Estimate for Fiscal Years 2008–09 and 2009–10,* www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/may_2009_estimate.aspx

Medi-Cal accounts for the second largest share of the state's General Fund, ranking behind only K-12 education.

Due in part to rising health costs and falling state revenue, Medi-Cal's share of the state budget increased from 17 percent to 19 percent in two years.

Funding Sources, FY2008–2009



Source: California Department of Health Care Services (DHCS) *Management Summary, Medi-Cal May 2009 Local Assistance Estimate for Fiscal Years 2008–09 and 2009–10*; includes DHCS estimate of Medi-Cal spending by other departments, www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/may_2009_estimate.aspx.

Federal funds account for more than half of Medi-Cal's budget.

Medicaid and the Federal Stimulus Bill

The Stimulus Bill:

- Establishes incentive payments to states to encourage the adoption and use of certified electronic health records (EHRs), including full reimbursement for state spending for payments to providers for adoption and operation of certified EHR technology, and 90 percent reimbursement for state costs in administering the EHR program.
- Establishes a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentages (FMAP)* for Medicaid payments between October 1, 2008 and September 30, 2011 for eligible states. States with high unemployment rates are eligible for additional increases.
- Requires that state Medicaid eligibility rules are no more restrictive than they were on July 1, 2008 to be eligible to receive additional federal funds.
- Prescribes a temporary increase in state allotments for payments to Medicaid DSH hospitals from October 1, 2008 through September 30, 2010.
- Provides states flexibility to expand certain other programs to help individuals preserve access to health care, including Transitional Medi-Cal.†

Under the Stimulus Bill, California's FMAP will increase from 50.0 to 61.6 percent between October 2008 and December 2010, for an estimated $10 to $11 billion in additional match funds.

California could receive more than $3 billion in federal funds allocated to health IT, and the state's public hospitals could receive up to $54 million in additional federal DSH payments.

*The Federal Medical Assistance Percentage (FMAP) is the percent of program expenditures paid by the federal government, commonly known as the matching rate. The formula for determining the rate is based on the state's per-capita income.

†The Transitional Medi-Cal program extends Medi-Cal coverage for up to one year for families who lose their eligibility for welfare payments due to new or increased earnings from employment.

Sources: H.R. 1 American Recovery and Reinvestment Act of 2009, passed on February 17, 2009, frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h1enr.txt.pdf.
California HealthCare Foundation, *What California Stands to Gain: The Impact of the Stimulus Package on Health Care,* March 2009, www.chcf.org/topics/view.cfm?itemid=133907.
California HealthCare Foundation, *An Unprecedented Opportunity: Using Federal Stimulus Funds to Advance Health IT in California,* February 2009, www.chcf.org/topics/view.cfm?itemID=133864.

Medicaid and the CHIP Reauthorization Act

The Children's Health Insurance Program Reauthorization Act (CHIPRA):

- Gives states the option to provide coverage under Medicaid and CHIP to legal immigrant children and pregnant women during their first five years in the country.
- Provides bonus funding for states that increase child enrollment in Medicaid above a specified baseline and implement certain eligibility simplifications.
- Allows states to comply with DRA citizenship documentation requirements through data matching with the Social Security Administration.

CHIPRA contains provisions that directly affect both Medi-Cal and Healthy Families. CHIPRA provides funding and authority for states to strengthen existing programs and expand coverage to additional low-income, uninsured children and pregnant women.

Sources: H.R. 2 Child Health Insurance Program Reauthorization Act of 2009, passed on February 4, 2009, frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h2enr.txt.pdf.
California HealthCare Foundation, *What California Stands to Gain: The Impact of the Stimulus Package on Health Care,* March 2009, www.chcf.org/topics/view.cfm?itemid=133907.
California HealthCare Foundation, *An Unprecedented Opportunity: Using Federal Stimulus Funds to Advance Health IT in California,* February 2009, www.chcf.org/topics/view.cfm?itemID=133864.

Eligibility Factors

- Eligibility for Other Public Assistance Programs (see page 13)
- Family Income (see page 14)
- Family Assets:
  - For most beneficiaries, the upper limit is $2,000 for one person and increases with family size.
  - Countable personal property includes but is not limited to savings, checking, stocks, bonds, and certain life insurance policies and annuities.
  - The home is usually not considered.
  - Personal assets are not considered for certain pregnant women and children who are under certain levels of federal poverty.
- U.S. Citizenship (see pages 15 and 16)
- California Residency (documented)
- Institutional Status
- Deprivation*

Medi-Cal eligibility is based on numerous factors, including income, assets, and immigration status.

*Deprivation exists when a parent is absent from the home, or is incapacitated, disabled, deceased, employed less than 100 hours per month, or has earnings that are below 100 percent of the Federal Poverty Level (currently set at $18,310 for a family of three).

Sources: California Health & Human Services Agency, *Medi-Cal General Property Limitations,* 2007, www.dhcs.ca.gov/formsandpubs/forms/Forms/MEB Info Notice/mc007info.pdf. United States Department of Health & Human Services, *The 2009 HHS Poverty Guidelines,* aspe.hhs.gov/poverty/09poverty.shtml.

Eligible Groups

MANDATORY	OPTIONAL
States MUST Cover:	**States MAY Cover:**
• Low-income families participating in CalWORKs, and those who meet financial standards for Aid to Families with Dependent Children (AFDC) that were in effect in July 1996.*	• Other pregnant women, children, seniors, and adults with disabilities, based on income levels and family size.
• Seniors and people with disabilities participating in the Supplemental Security Income (SSI) program.†	• Individuals who qualify for cash assistance except on the basis of income, and those eligible for cash assistance who choose not to participate, may qualify for Medicaid by "spending down" to specified levels (medically needy).
• Pregnant women and children with family incomes below specified levels.	• Pregnant women and children who do not meet medically needy deprivation requirements, and certain nursing facility residents, among others (medically indigent).
• Children receiving foster care and adoption assistance.	• Children and pregnant women, while eligibility is being determined (accelerated enrollment and presumptive eligibility).
• Certain low-income Medicare beneficiaries.	

Federal law requires that all state Medicaid programs cover certain (mandatory) groups, and allows states to receive federal matching funds for certain other (optional) groups.

Childless adults who are neither elderly nor disabled are generally not eligible for Medicaid, regardless of income.

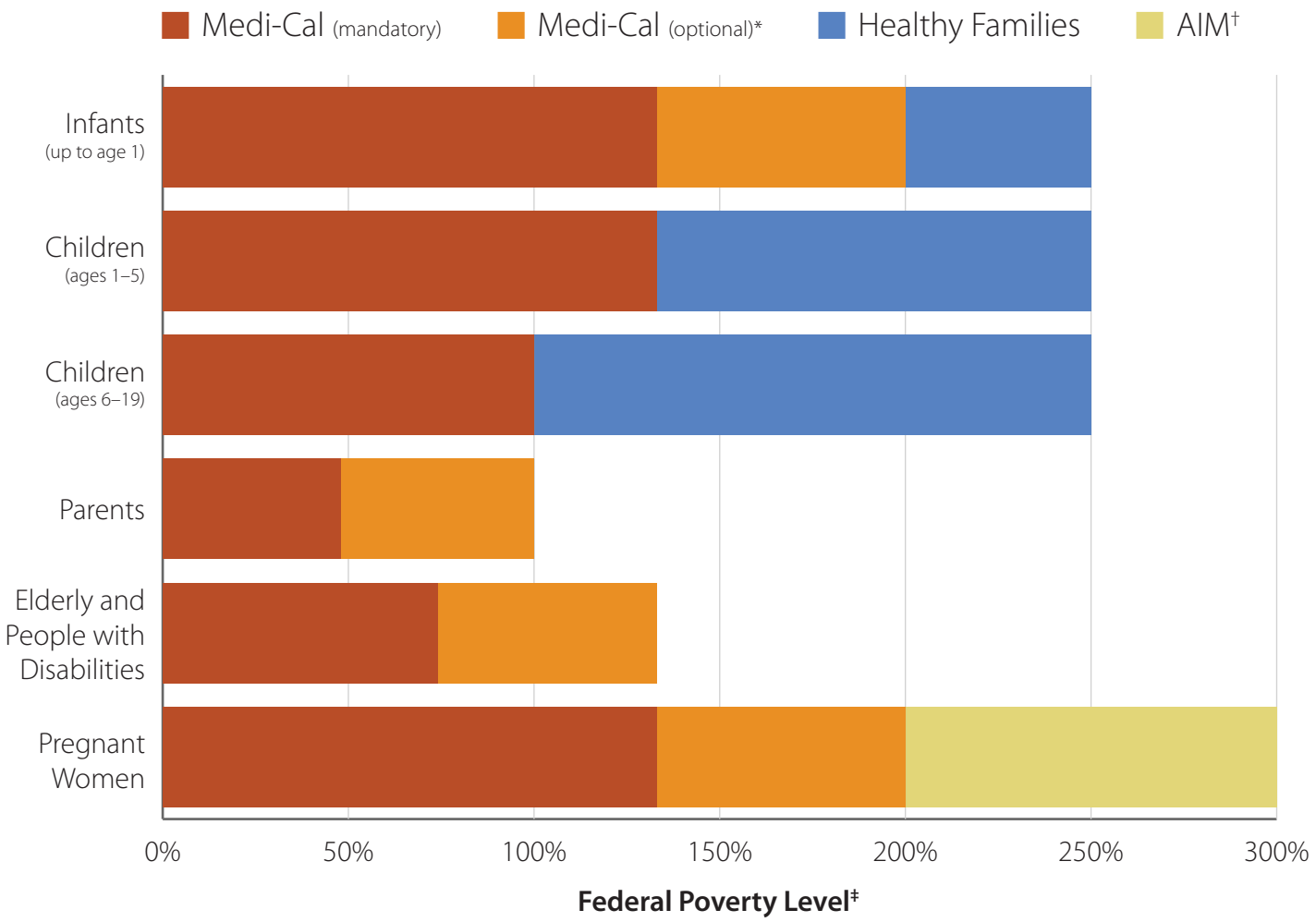
*1996 federal welfare reform legislation replaced Aid to Families with Dependent Children (AFDC) with Temporary Assistance for Needy Families (TANF), and granted states greater flexibility in designing their TANF programs. In order to ensure that states would not decrease families' access to Medicaid, a new category of Medicaid coverage, called 1931(b), was created. Under Section 1931(b) of the Social Security Act, states are required to grant Medicaid eligibility to anyone who would have been eligible under the AFDC requirements in place on July 16, 1996, primarily single women with young children. Additionally, 1931(b) criteria cannot be more restrictive than their TANF requirements. Subsequently, all TANF recipients remain automatically eligible for Medicaid through 1931(b).

†The Supplemental Security Income/State Supplementary Program (SSI/SSP) provides cash assistance to eligible aged, blind, and disabled people.

Notes: Not a comprehensive list. Multiple criteria have contributed to the creation of more than 160 eligibility categories or aid codes for beneficiaries. California Work Opportunity and Responsibility to Kids (CalWORKs) is California's welfare-to-work program established by the state Welfare-to-Work Act of 1997. The program, which replaced AFDC, makes welfare a temporary source of cash assistance.

Sources: Centers for Medicare and Medicaid Services Mandatory Eligibility Groups, www.cms.hhs.gov/medicaideligibility/03_mandatoryeligibilitygroups.asp. Kaiser Family Foundation. *Medicaid's Optional Populations: Coverage and Benefits,* February 2005, www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=51052.

Income Limits



Medi-Cal income limits vary among the groups eligible for coverage.

*Medi-Cal must provide coverage for parents and families with incomes below the state's July 1996 AFDC need standard, which was $730 per month for a family of three.

†Pregnant women not more than 30 weeks pregnant and their newborns up to age two with a total family income of 200 to 300 percent are eligible for Access for Infants and Mothers (AIM). Babies born to moms enrolled in AIM are eligible for enrollment in Healthy Families (CHIP).

‡Set at $18,310 for a family of three for the period beginning April 1, 2009 and ending March 31, 2010.

Sources: CMS Mandatory Eligibility Groups, www.cms.hhs.gov/MedicaidEligibility/03_MandatoryEligibilityGroups.asp. KFF State Health Facts, *Thresholds for Jobless and Working Parents Applying for Medicaid by Annual Income as a Percent of Federal Poverty Level (FPL), 2009,* www.statehealthfacts.org/comparetable.jsp?ind=205&cat=4. *Access for Infants and Mothers Application & Handbook,* February 2009, www.aim.ca.gov/Publications/AIM_handbook_en.pdf. DHCS Letter 09-08, New Limits and Disregards for the Aged and Disabled — Federal Poverty Level Program for 2009, February 24, 2009, www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/c09-08.pdf. NASMD, *Aged, Blind, and Disabled Medicaid Eligibility Survey,* www.nasmd.org/eligibility/optional.asp. HHS Office of the Assistant Secretary for Planning and Evaluation, *Aid to Families with Dependent Children: The Baseline,* June 1998, aspe.hhs.gov/HSP/AFDC/baseline/5benefits.pdf.

Immigrant Coverage

- Immigrants may be eligible for Medi-Cal if they meet the categorical, financial, and residency requirements.
- Full-scope Medi-Cal, with federal matching funds, is available to Lawful Permanent Residents, "green card holders," refugees, and immigrants granted asylum, among others.
- Full-scope Medi-Cal, with no federal match, is available to PRUCOL immigrants.*
- Restricted Medi-Cal, which primarily covers emergency and pregnancy-related services, is available to other immigrants.

Some immigrants are eligible for full-scope Medi-Cal, while others may be eligible for a limited set of Medi-Cal benefits.

*Permanent Resident Under Color of Law (PRUCOL) refers to people that the Department of Homeland Security knows are in the country and has no plans to depart or remove. See 42 CFR Section 435.408 for the federal definition and 22 CCR Section 50301.3 for the state definition. Restricted Medi-cal also covers breast and cervical cancer treatment, long term care, and kidney dialysis treatment.

Sources: Western Center on Law and Poverty, *Medi-Cal Eligibility Guide, How to Get and Keep Low-Income Health Coverage,* Spring 2005. H.R. 2 Child Health Insurance Program Reauthorization Act of 2009, passed on February 4, 2009, frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h2enr.txt.pdf. CMS State Health Official Letter 09-002, Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Overview, www.cms.hhs.gov/SMDL/downloads/SHO041709.pdf.

New Documentation Requirement

- Under the Federal Deficit Reduction Act (DRA) of 2005, people applying for, or renewing, coverage through Medi-Cal must present proof of citizenship (such as a birth certificate) and identity (such as a driver's license). This has increased the cost of determining eligibility for both the state and county agencies.
- To ease the application process, DHCS is conducting data matches to birth records to obtain proof of citizenship electronically.
- Prior to implementation of the DRA, Medicaid applicants were required to attest to their U.S. citizenship under penalty of perjury and without documentation.
- Under CHIPRA, the DRA Medicaid citizenship documentation requirement is extended to include CHIP, but allows states to comply with this requirement for both Medicaid and CHIP by using a data matching process with the Social Security Administration (SSA), rather than obtaining documentation from applicants.

The proof of citizenship requirement has raised the administrative cost of determining eligibility for state and local agencies.

Individual Application Process

- For those receiving Supplemental Security Income (SSI) or CalWORKs, Medi-Cal coverage is automatic.
- Other individuals may apply for Medi-Cal at their local county social services office or at hospitals and clinics where county eligibility workers are located.
- Doctors can request immediate temporary coverage for pregnant women and children while they apply for the program.
- Certain adults, as well as children and pregnant women, may also apply for Medi-Cal using a mail-in application.
- Medi-Cal applications can be submitted electronically using the Health-e-App* or One-e-App† internet-based systems, with the help of certified application assisters.

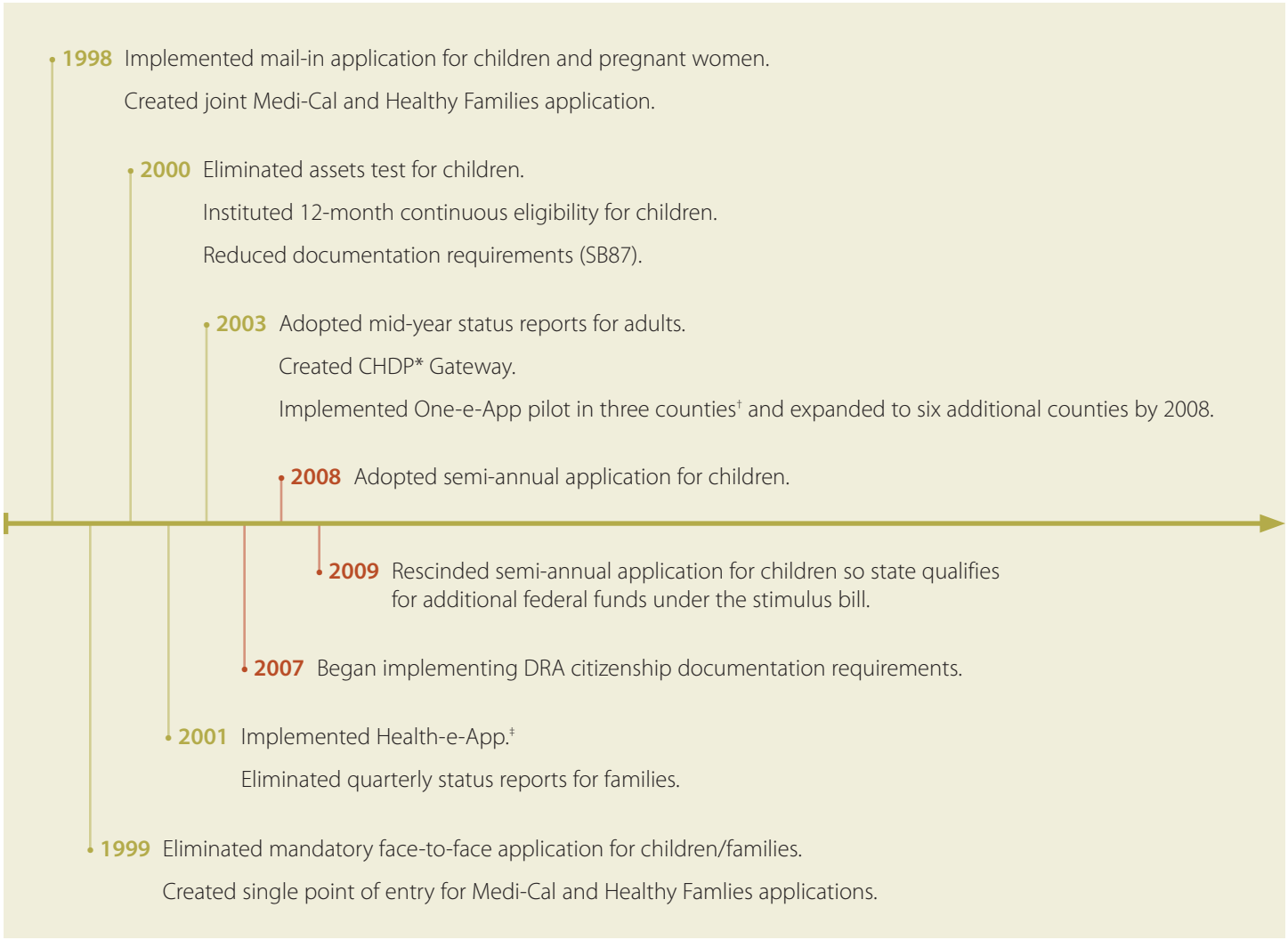
The application process varies in accordance with an individual's circumstances.

*Health-e-App is an electronic alternative to the paper Medi-Cal and Healthy Families application forms.

†One-e-App is an electronic application for enrollment in a range of public sector programs, including Medi-Cal; Healthy Families; Supplemental Nutrition for Women, Infants, and Children (WIC); Earned Income Tax Credit (EITC); and food stamps.

Recent Enrollment Process Changes

The enrollment process has evolved significantly over the last decade.



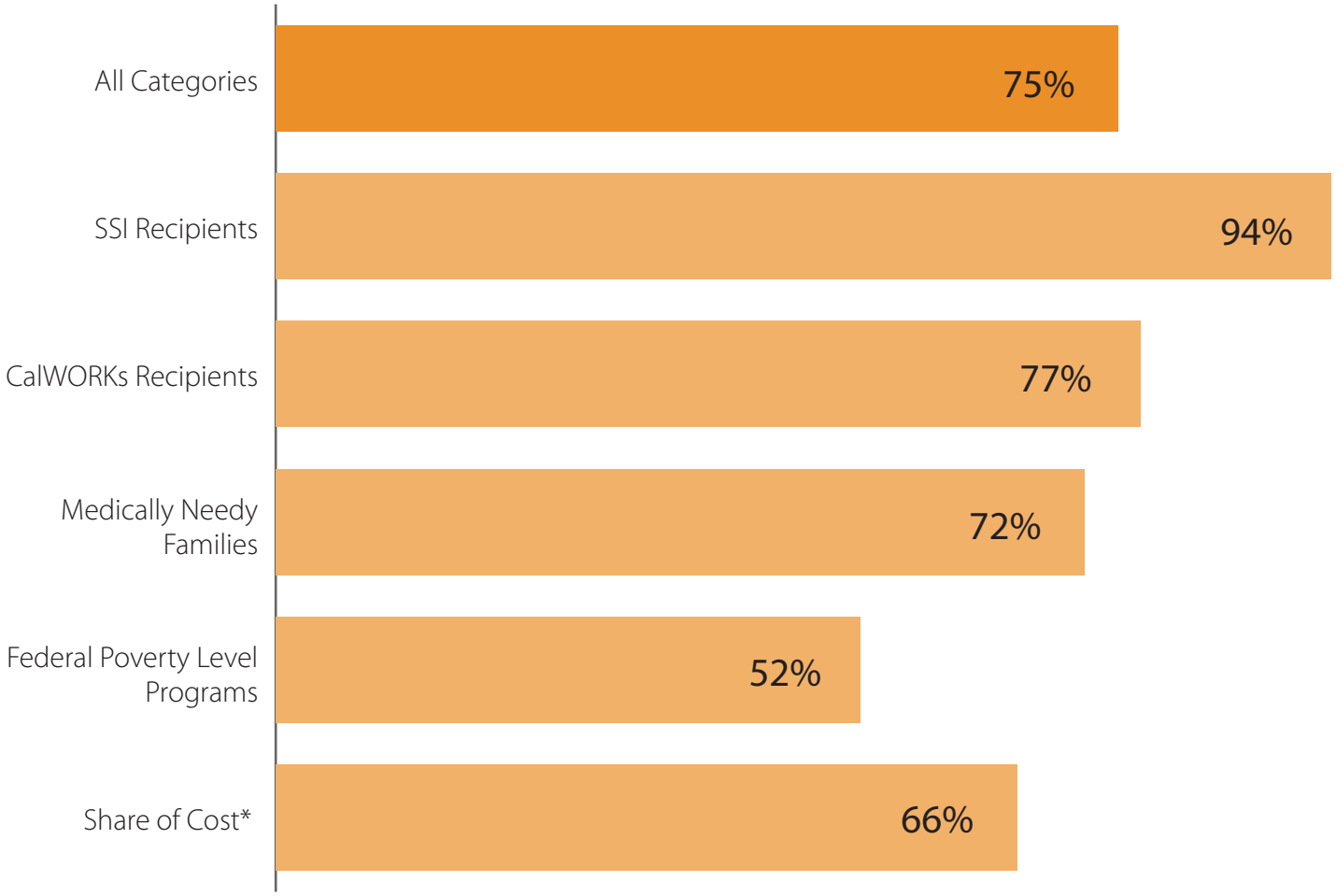
*Child Health and Disability Prevention program (CHDP).

†One-e-App is an electronic application for enrollment in a range of public sector programs, including Medi-Cal; Healthy Families; Supplemental Nutrition for Women, Infants, and Children (WIC); Earned Income Tax Credit (EITC); and food stamps.

‡Health-e-App is an electronic alternative to the paper Medi-Cal and Healthy Families application forms.

Source: The Lewin Group, California Senate Bill 24 X3, www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0001-0050/sbx3_24_bill_20090316_amended_sen_v98.pdf.

Enrollment After One Year



*Calculation includes both certified and uncertified eligibles. Certified eligibles includes beneficiaries with incomes below the Medi-Cal income limits, and also beneficiaries whose incomes exceed the income limits, requiring that they incur a share of cost before qualifying for Medi-Cal coverage. This determination is made each month. Uncertified eligibles have not yet met their share of cost for a given month.

Note: Percentages may differ from previous estimates due to the use of more complete data, including additional share-of-cost data.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS for the 12-month period ending June 30, 2008.

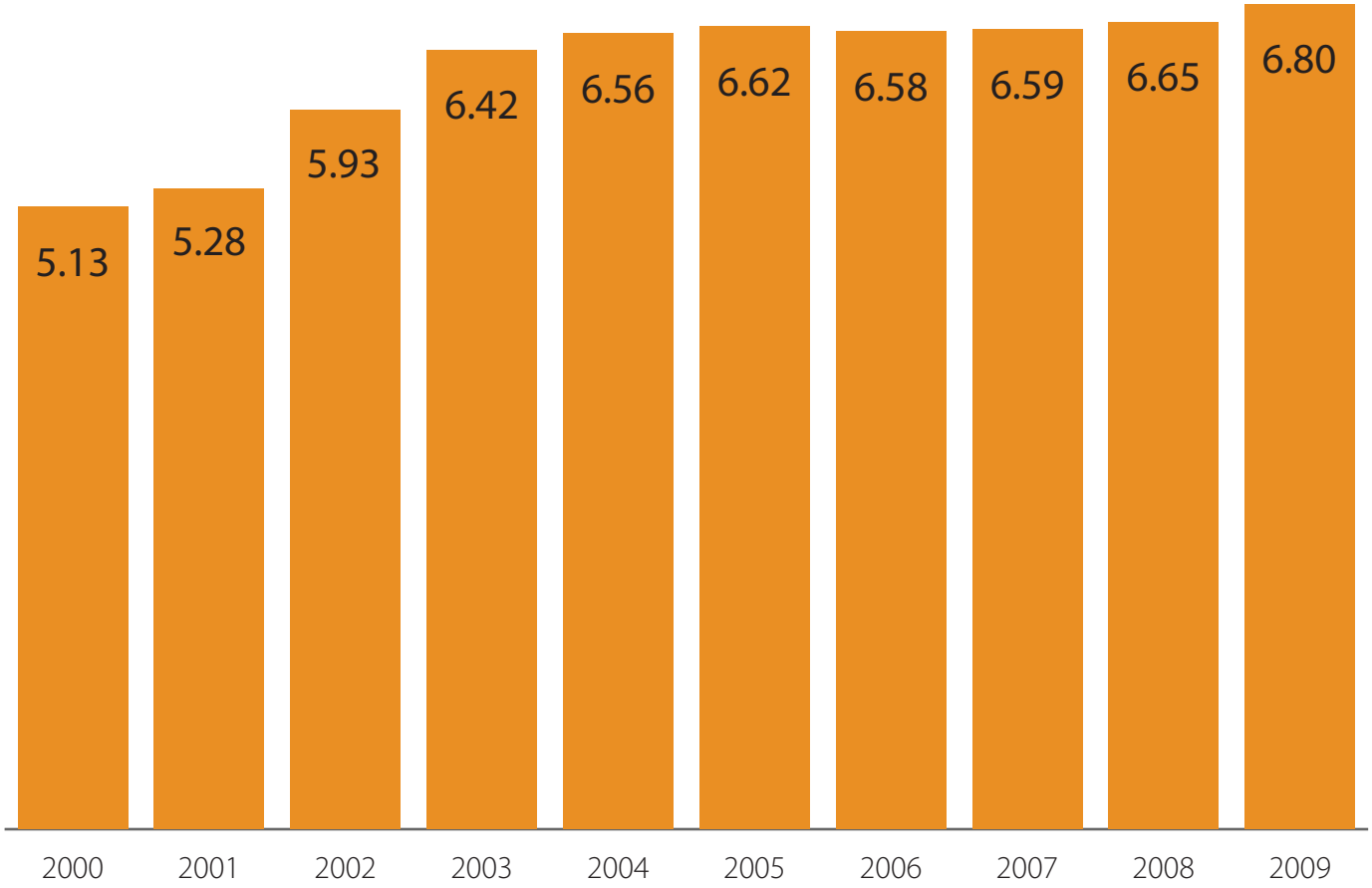
Nearly three-fourths of all beneficiaries remain enrolled after one year.

Nearly all people with disabilities who qualify for Medi-Cal through SSI stay covered for more than 12 months.

Two-thirds of individuals who are required to pay a share of their costs retain coverage for a full year.

Enrollment Trends

AVERAGE MONTHLY ENROLLMENT (IN MILLIONS)

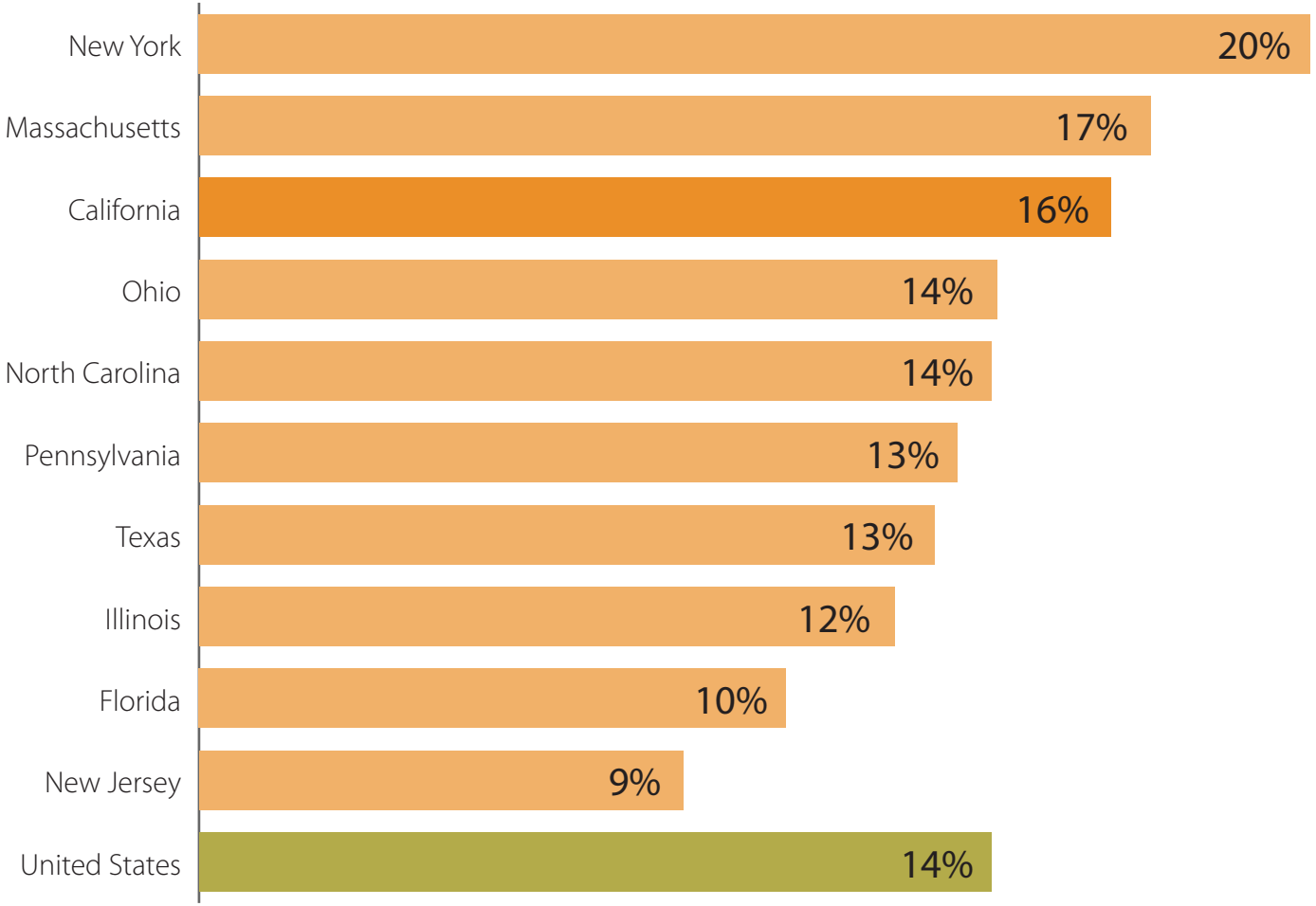


Following a period of rapid growth at the start of the decade, Medi-Cal enrollment growth has levelled off in recent years.

Sources: California Department of Health Care Services (DHCS), Fiscal Forecasting and Data Management Branch, May Medi-Cal estimates, 1992 through 2006. DHCS *Estimated Average Monthly Certified Eligibles, November 08 Medi-Cal Estimate, Fiscal Years 2007–2008, 2008–2009, & 2009–2010,* www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2008_nov_estimate/NOV08_CL01_Page_A.pdf.

Enrollment in Other States

NON-ELDERLY POPULATION COVERED BY MEDICAID



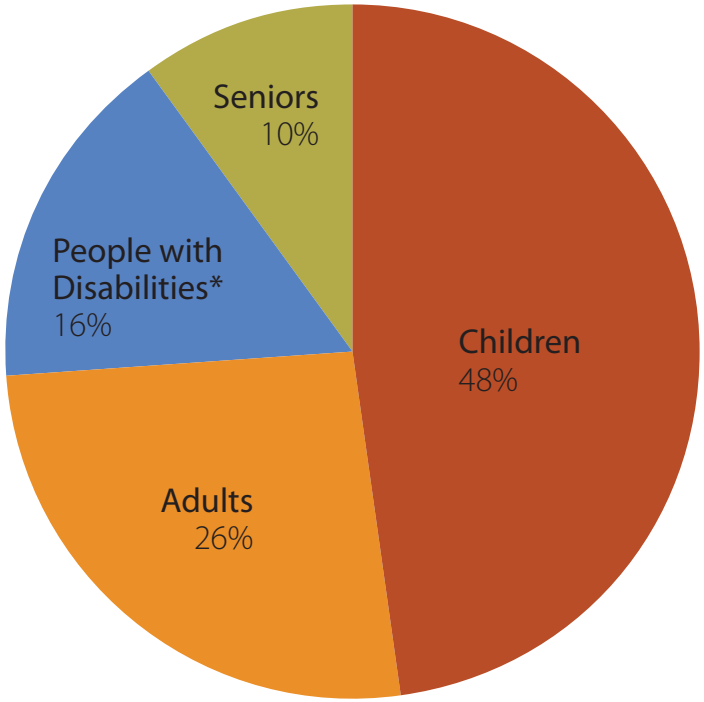
Note: The states with the ten largest Medicaid programs in terms of FFY2006 expenditures are represented along with the national enrollment level.

Source: Kaiser Family Foundation State Health Facts, *Health Insurance Coverage of Nonelderly 0 – 64, states (2006 – 2007), U.S. (2007),* www.statehealthfacts.org/comparebar.jsp?ind=126&cat=3.

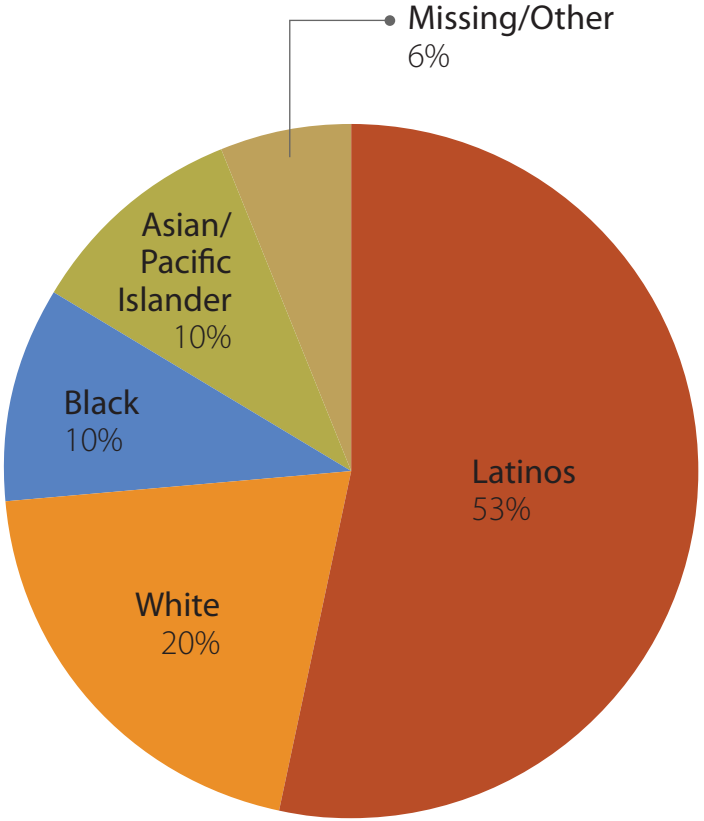
With 16 percent of non-elderly residents enrolled in Medi-Cal, California ranks third among the ten largest Medicaid programs and is just above the national enrollment level of 14 percent.

Beneficiary Profile

AGE/DISABILITY



ETHNICITY



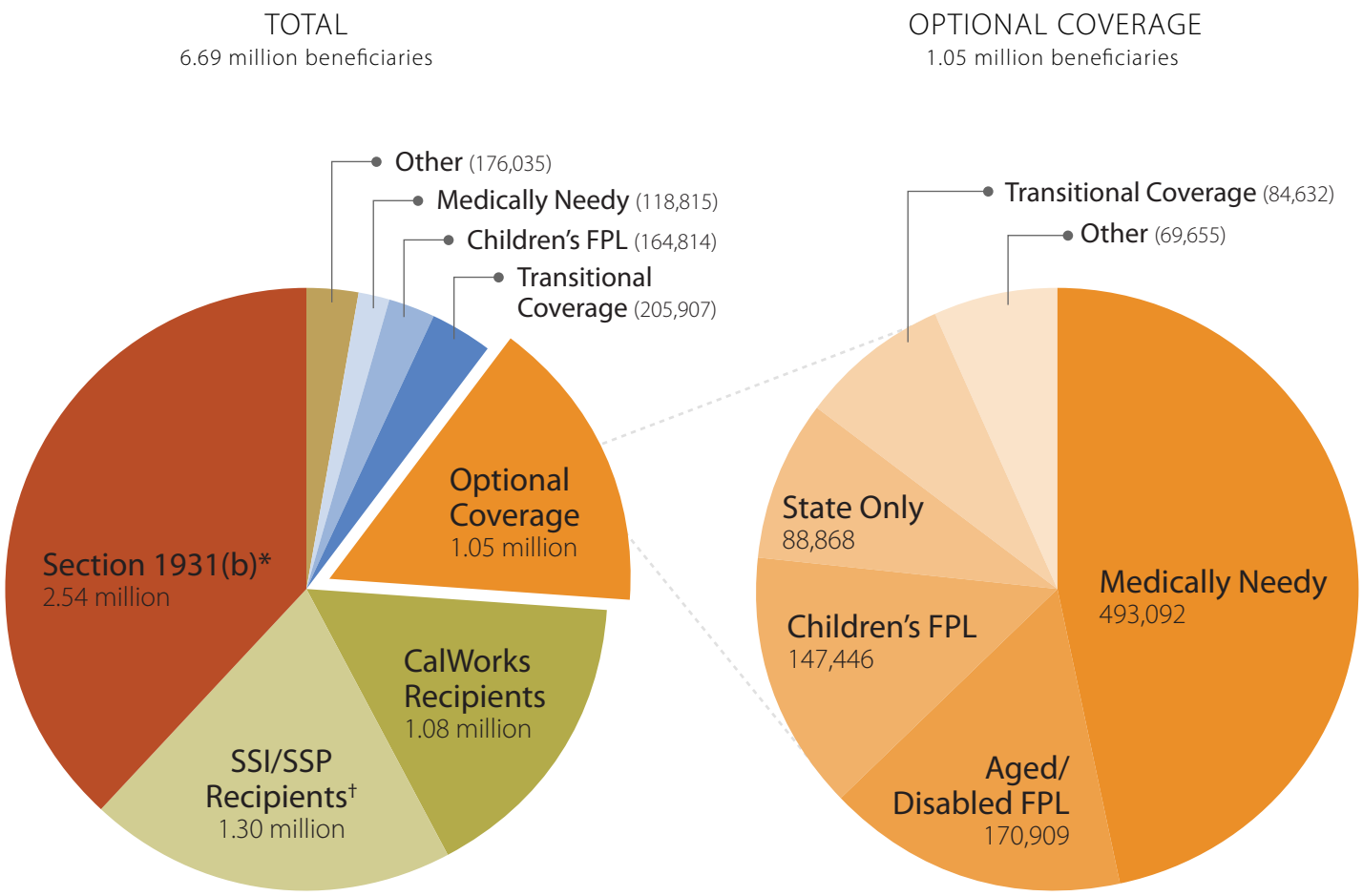
Children account for nearly half of Medi-Cal beneficiaries. Among ethnic populations, Latinos make up the largest group.

*Includes children and adults under age 65.

Note: Figures may not total 100 percent due to rounding.

Source: Lewin/Ingenix analysis of MIS/DSS for the 12 month period ending June 30, 2008.

Enrollment by Program



Groups receiving mandatory coverage account for 84 percent of Medi-Cal enrollment. The medically needy population — typically beneficiaries who qualify by spending down their income to specified levels — account for nearly half of those for whom Medi-Cal coverage is optional.

*1996 federal welfare reform legislation replaced Aid to Families with Dependent Children (AFDC) with Temporary Assistance for Needy Families (TANF), and granted states greater flexibility in designing their TANF programs. In order to ensure that states would not decrease families' access to Medicaid, a new category of Medicaid coverage, called 1931(b), was created. Under Section 1931(b) of the Social Security Act, states are required to grant Medicaid eligibility to anyone who would have been eligible under the AFDC requirements in place on July 16, 1996, primarily single women with young children. Additionally, 1931(b) criteria cannot be more restrictive than their TANF requirements. Subsequently, all TANF recipients remain automatically eligible for Medicaid through 1931(b).

†The Supplemental Security Income/State Supplementary Program (SSI/SSP) provides cash assistance to eligible aged, blind, and disabled people.

Note: There were 48,000 beneficiaries (less than one percent of the total) in aid codes that were unidentified as mandatory or optional.

Source: California Department of Health Care Services (DHCS) *2008 – 09 Budget Act Highlights,* www.dhcs.ca.gov/Documents/Budget Act Highlights Dept of Health Care Services 2008-09.pdf.

Medi-Cal Benefits*

REQUIRED SERVICES	OPTIONAL SERVICES
• In/outpatient hospital	• Prescription drugs
• Physician visits	• Medical equipment and supplies
• Lab tests and x-rays	• Targeted case management
• Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children under 21	• Adult day health
• Family planning and supplies	• Personal care services
• Federally Qualified Health Centers (FQHC)	• Physical therapy
• Certified midwife	• Intermediate Care Facilities for Mentally Retarded (ICF/MR)
• Certified nurse practitioner	• Inpatient psychiatric for children under 21
• Nursing home care for adults over 21	• Rehabilitation for mental health and substance abuse
• Home health services†	• Home health care therapies
• Nurse midwife services	• Hospice
• Pregnancy-related services, including 60-days postpartum care	• Occupational therapy
	• Vision services and eyeglasses‡
	• Dental care and dentures‡
	• Audiology and speech therapy‡
	• Chiropractic‡
	• Psychology services‡
	• Acupunture‡

All state Medicaid programs are federally required to provide specific benefits and may also receive federal matching funds for certain optional benefits. As of July 2009, Medi-Cal no longer pays for some benefits (e.g., dental, audiology and speech therapy, and optometric and optician services) for most adults.‡

*Partial list; effective July 1, 2009.

†For people who meet the criteria for nursing facility level of care.

‡These benefits will only be covered for Medi-Cal beneficiaries who are under 21 years of age or who reside in a nursing facility.

Source: Centers for Medicare and Medicaid Services (CMS), Medicaid at a Glance, 2005, *Change in California State Law for Medi-Cal Benefits,* www.dhcs.ca.gov/Pages/ChangeinCaliforniaStateLawforMedi-CalBenefits.aspx.

Medi-Cal Waivers

- 1915(b) waivers allow states to limit an individual's choice of provider. Medi-Cal's County Health Systems (COHS), Two Plan, and Geographic Managed Care (GMC) models of managed care, as well as mental health services consolidation, operate under the authority of 1915(b) waivers.
- 1915(c) waivers allow states to provide long term care services in community settings. Medi-Cal's 1915(c) waiver programs include Home and Community-based Services (HCBS) for Persons with Developmental Disabilities. In-Home Medical Care, AIDS, Assisted Living, Multipurpose Senior Services Program, and a new Pediatric Palliative Care pilot.
- 1115 waivers give states broad authority to test policy innovations, so long as federal spending is no greater than it would have been otherwise (without the waiver). Medi-Cal's major 1115 waivers include Hospital Financing for the Uninsured and Family Planning, Access, Care, and Treatment (Family PACT).

Medi-Cal operates over two dozen waiver programs.

Source: Centers for Medicare and Medicaid Services (CMS), *Medicaid Waivers and Demonstrations List*, www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp.

Cost Sharing

- Beneficiaries are sometimes charged copayments for selected services; however, providers are not allowed to refuse service for lack of payment.
- Common copayment amounts are:[1]
  - Physician office visit: $1
  - Non-emergency services received in an emergency room: $5
  - Drug prescription or refill: $1
- Copayment amounts do not apply to emergency services, family planning services.
- Several groups of beneficiaries are exempt from copayments, including children 18 and younger or living in foster care, and, in general, pregnant women and the institutionalized.

The implementation of federal regulations that would give states greater flexibility on cost sharing has been delayed until December 2009.

1. There are several exceptions, including but not limited to beneficiaries age 18 and younger, and for any service in which the state payment is $10 or less.

Source: California Department of Health Care Services (DHCS), California Medicaid State Plan, www.dhcs.ca.gov/formsandpubs/laws/Pages/SPdocs.aspx.

Multiple Delivery Systems

MEDI-CAL SERVICES

Primary and Acute Care | Long Term Care

DHCS

CALIFORNIA DEPARTMENT OF AGING

CDSS

DDS

- County Mental Health Departments
  - Mental Health Services
- Nursing Facilty Care
- Health Plans
  - Managed Care Services
- FFS Primary and Acute Care
- Adult Day Health
- County Social Services Departments
  - Personal Care Services
- Regional Centers and Community-Based Services

Note: This is not a complete list of services provided by Medi-Cal. Other departments whose budgets include substantial funding for Medi-Cal services include the Department of Alcohol and Drug Programs and Local Education Agency (LEA) providers.

Medi-Cal beneficiaries, particularly individuals with multiple chronic conditions and disabilities, must navigate through layers of uncoordinated service delivery mechanisms for which there is no single accountable entity.

Managed Care and FFS

	MANAGED CARE	FEE-FOR-SERVICE
Availability	25 counties	All 58 counties
Market Share	50% of all beneficiaries	50% of all beneficiaries
Population	Mandatory enrollment: • Children • Pregnant women • Non-disabled parents Voluntary enrollment: • Most elderly and disabled	Most elderly and disabled In counties without managed care: • Children • Pregnant women • Non-disabled parents
Expenditures*	18%	82%
Carve Outs	• Mental health • Dental • Long term care • California Children Services (CCS) for the seriously ill and disabled	N/A

Half of Medi-Cal beneficiaries are in managed care plans, but they account for less than 20 percent of total service spending. Most seniors and people with disabilities have fee-for-service coverage.

*FFS includes service categories: total FFS, dental, mental health, EPSDT screens, Medicare payments, state hospital/developmental centers, and misc. services. Audits/lawsuits and recoveries are excluded from the expenditures calculation.

Sources: Lewin/Ingenix analysis of Medi-Cal MIS/DSS for the 12-month period ending June 30, 2007. California Department of Health Care Services (DHCS), *Management Summary, Medi-Cal May 2009 Local Assistance Estimate for Fiscal Years 2008–09 and 2009–10,* www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/may_2009_estimate.aspx.

Managed Care Models, by County

County Organized Health System (COHS)

- 592,627 beneficiaries in 9 counties
- 5 county organized health plans
- Implemented in 1983

Geographic Managed Care (GMC)

- 340,083 beneficiaries in 2 counties
- 7 commercial health plans
- Implemented in 1993

Two Plan

- 2.36 million beneficiaries in 12 counties
- 9 local initiatives and 3 commercial health plans
- Implemented in 1993

Managed Care Expansion

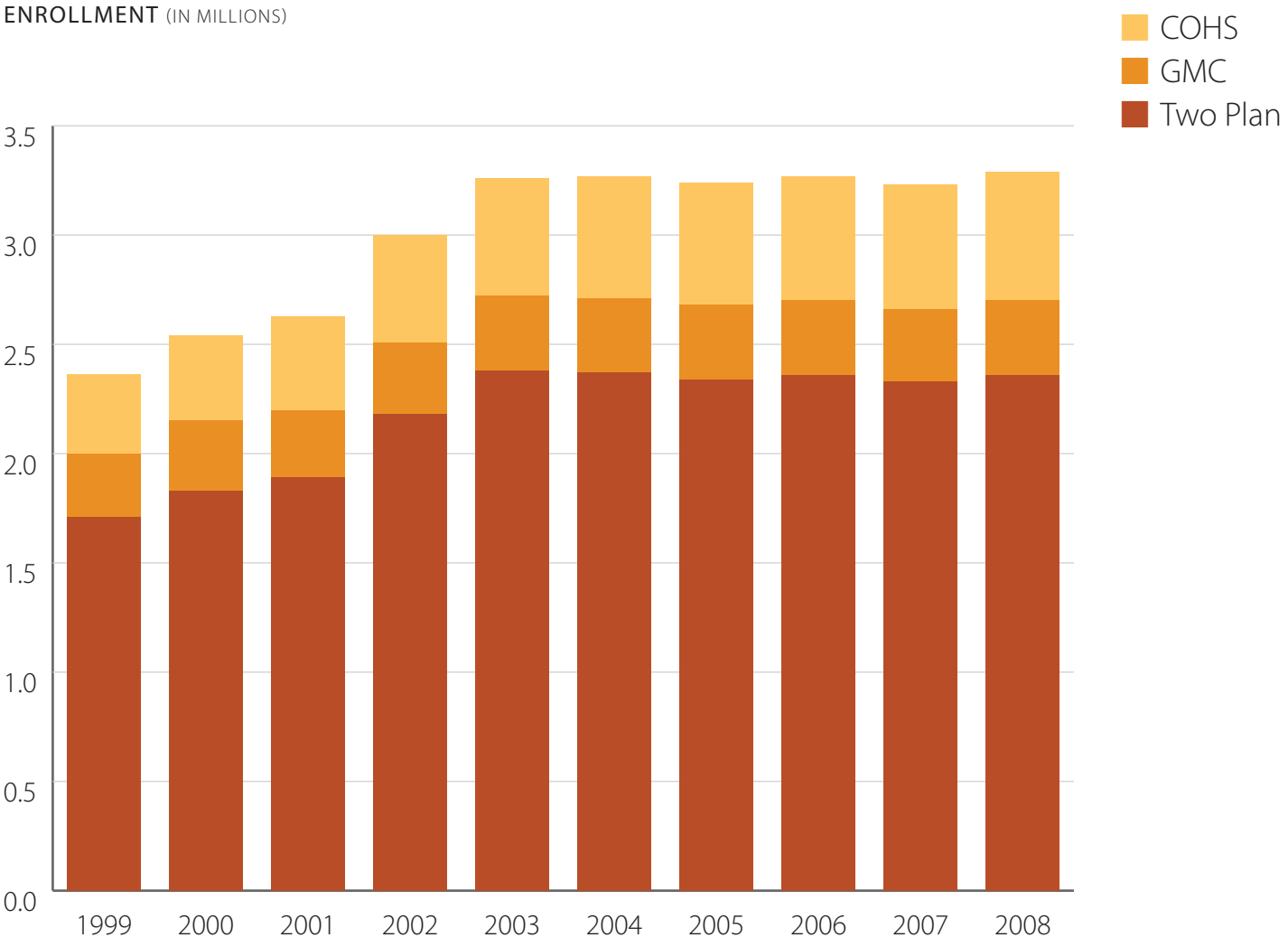
- Approved in 2005
- Implemented in San Luis Obispo in 2008; implementation in Merced and Sonoma scheduled for October 2009

California has a unique system of managed care, with three different models operating across 23 counties.

Sources: Lewin analysis of Medi-Cal MIS/DSS enrollment data for the 12-month period ending June 30, 2008. California Department of Health Care Services (DHCS), Provider Manual: Part 1 – Medi-Cal Program and Eligibility, files.medi-cal.ca.gov/pubsdoco/DocFrame.asp?wURL=publications%2Fmasters%2Dmtp%2Fpart1%2Fmcpcodedir%5Fz01%2Edoc. DHCS, Medi-Cal Managed Care Expansion, www.dhcs.ca.gov/provgovpart/Pages/MedicalManagedCareExpansion.aspx.

Managed Care Enrollment Trends

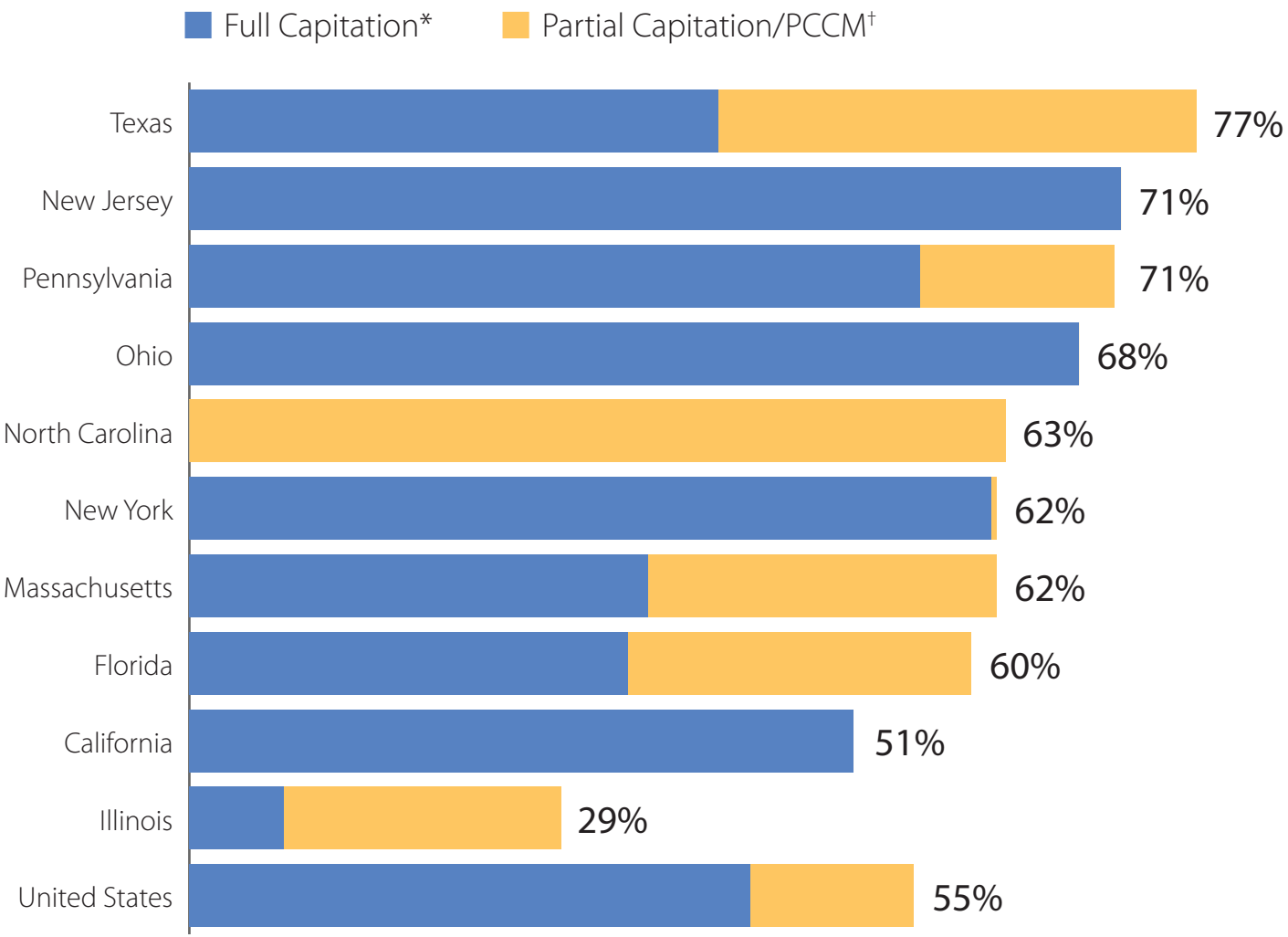
After several years of growth, managed care enrollment has remained fairly steady over the latter half of the decade.



Note: Enrollment counts may differ slightly from previously reported counts due to use of more complete data, including retrospective eligibility adjustments.

Source: Lewin/Ingenix analysis of MIS/DSS data for 12-month periods ending June 30, 1999 through June 30, 2008.

Managed Care Penetration



*Includes commercial and Medicaid only. Prepaid Inpatient Health Plans (PIHP), Prepaid Ambulatory Health Plans (PAHP), Programs for All-inclusive Care (PACE), and other are excluded.

†Primary Care Case Management

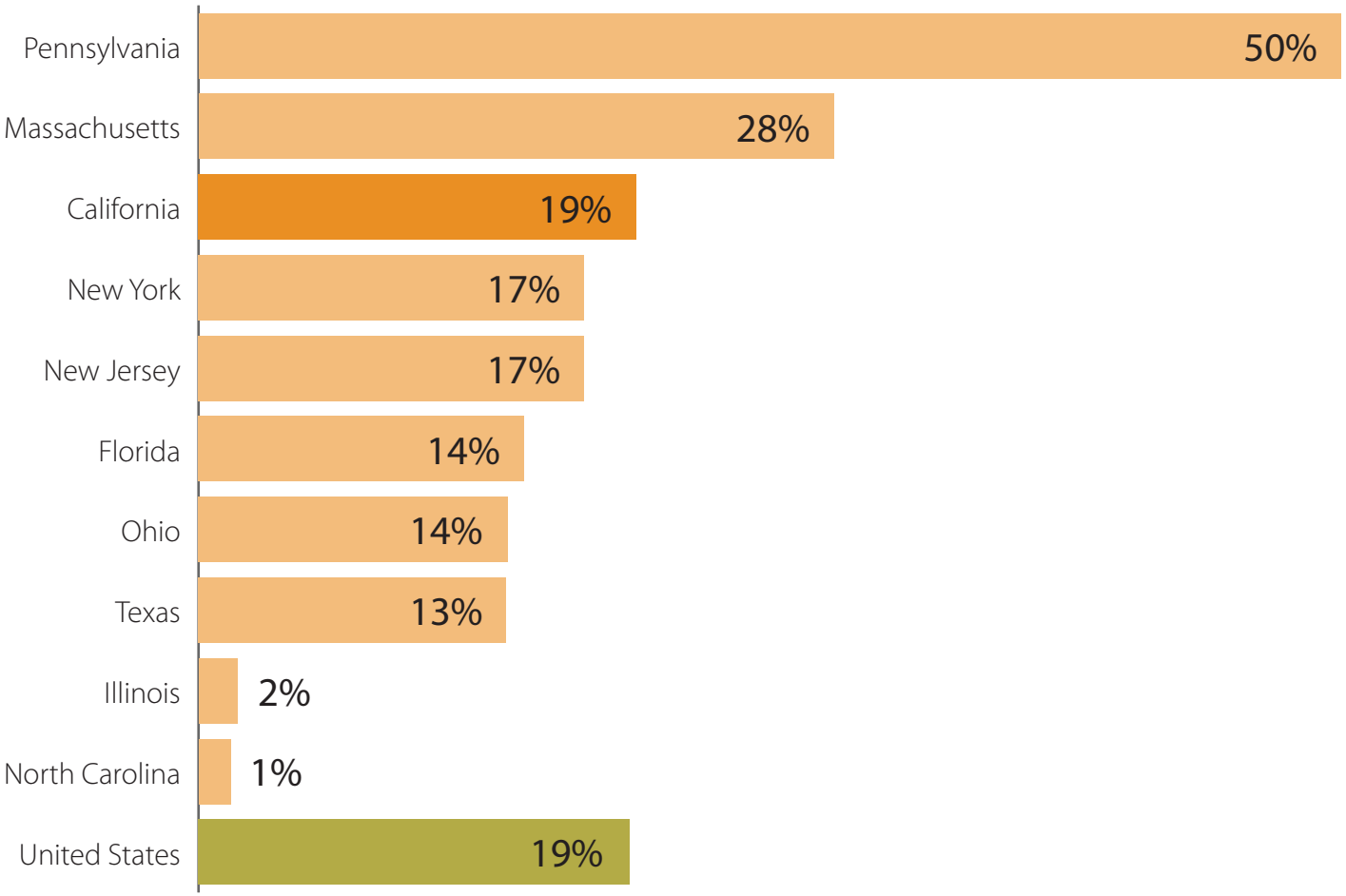
Note: The states with the ten largest Medicaid programs (in terms of expenditures from October 1, 2005 through September 30, 2006) are represented along with the national percentage.

Sources: Kaiser Family Foundation State Health Facts, Medicaid Enrollment in Managed Care by Plan Type, June 2007, www.statehealthfacts.org/comparetable.jsp?ind=218&cat=4. MSIS 2007 Medicaid Monthly State Summary. Unique Eligibles Count, January 2007. In the data California reported to CMS, the unique eligibles count for January 2007 is 8,059,158.

Compared to other state Medicaid programs, California has a larger share of its beneficiaries in fully capitated managed care, but a smaller share in managed care overall.

Managed Care Penetration, by Medicaid Spending

CAPITATION AS A PERCENTAGE OF TOTAL SPENDING



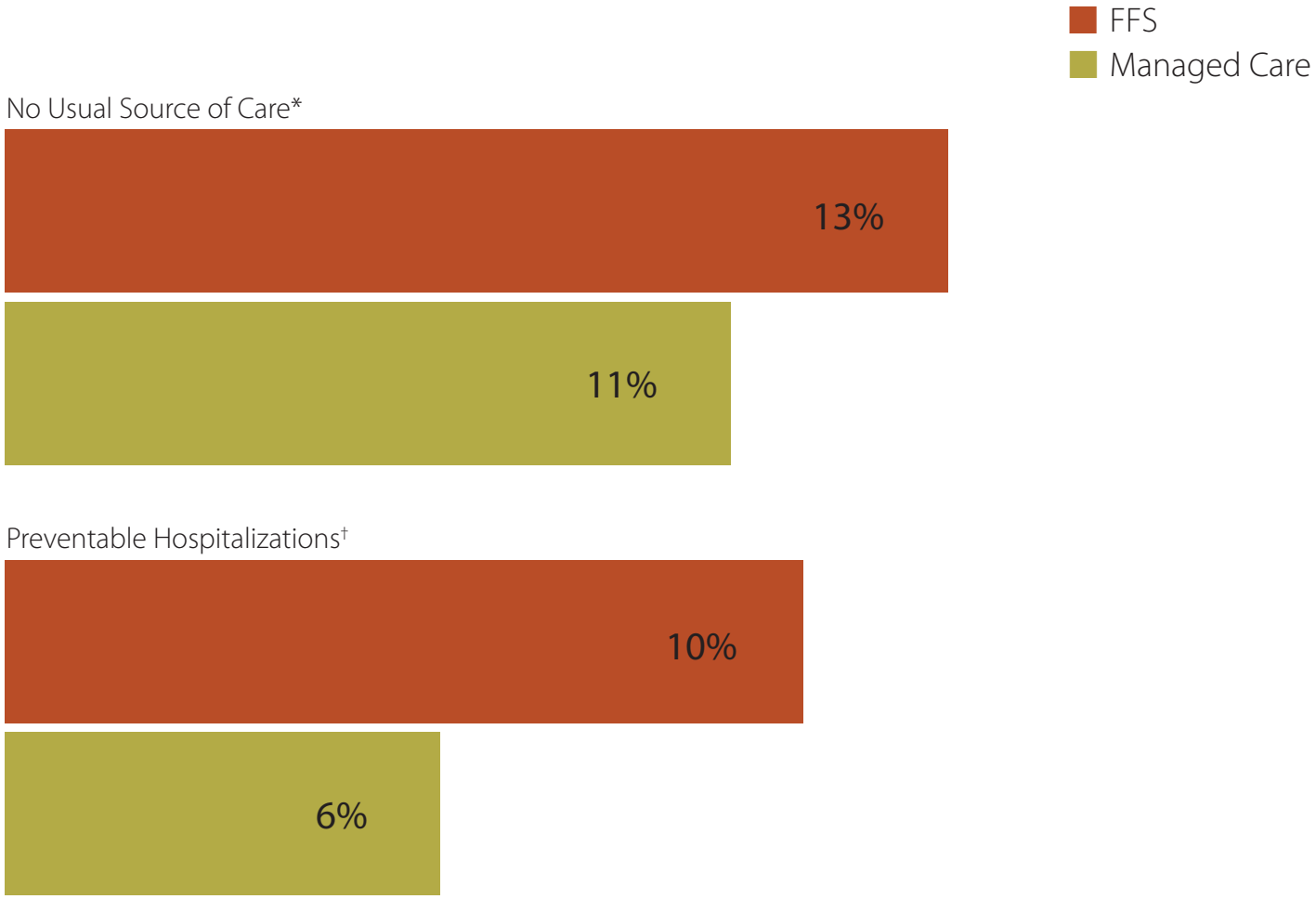
*Includes all expenditures in the MSIS Claim Type for "Capitated Payments" which includes capitated carve outs.

Note: The states with the ten largest Medicaid programs (in terms of expenditures from October 1, 2005 through September 30, 2006) are represented along with the national average. The national average excludes ME and NV, for which MSIS data is not yet available from October 1, 2005 through September 30, 2006.

Source: Lewin analysis of MSIS data for 12-month period ending September 30, 2006.

While half of the Medi-Cal population is enrolled in capitated health plans, capitation payments account for only 19 percent of Medi-Cal expenditures. Most high-need, high-cost beneficiaries are covered through fee-for-service.

Comparing Access Among Beneficiaries



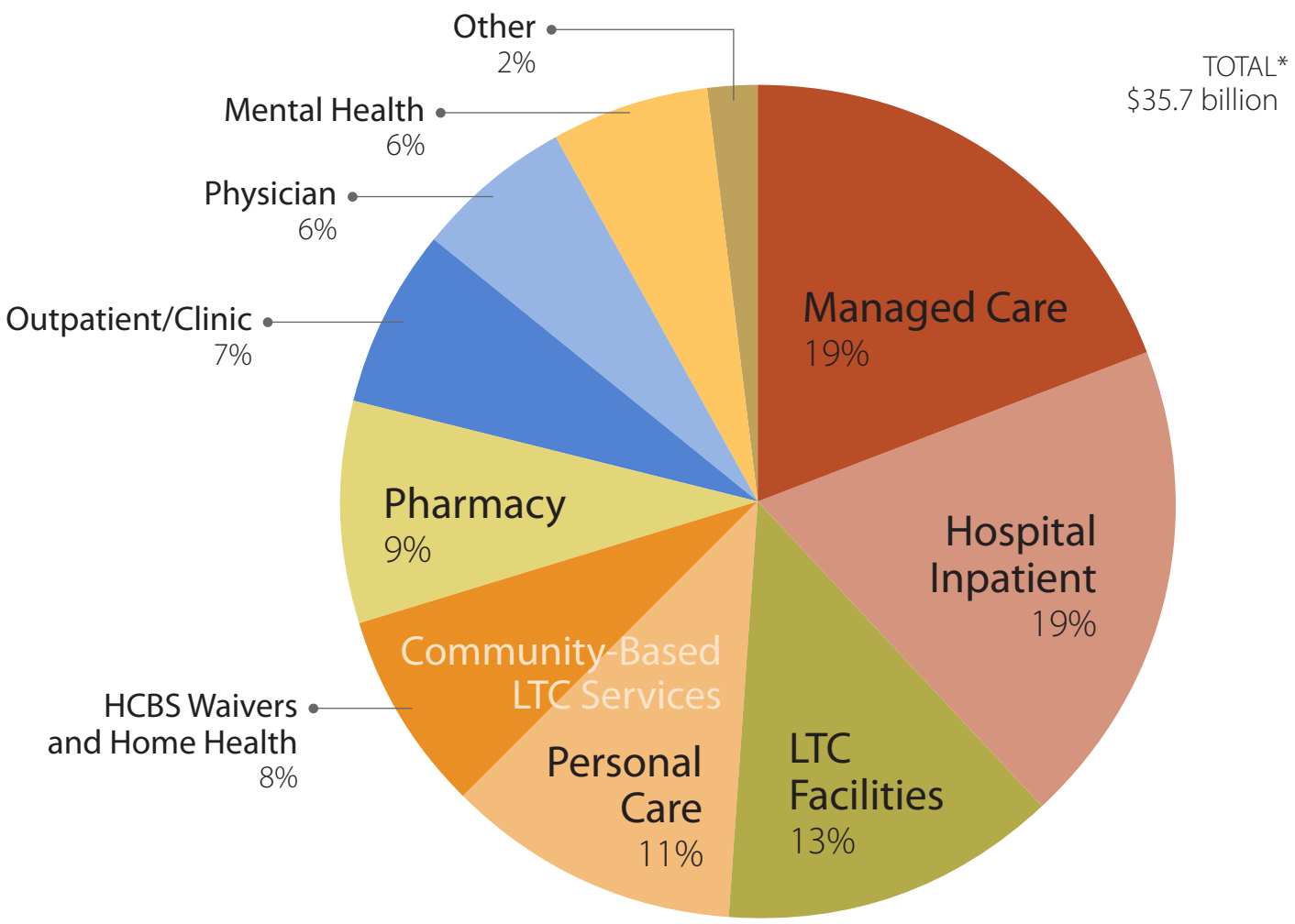
Fee-for-service (FFS) beneficiaries are somewhat more likely than those enrolled in managed care to be without a usual source of care, and much more likely to be hospitalized for ambulatory-sensitive conditions, such as asthma or diabetes, that generally can be managed on an outpatient basis.

*Among non-elderly adults enrolled exclusively in Medi-Cal for the last 12 months

†Average adjusted rates per 1,000 CalWORKs-linked beneficiaries, 1994 – 2002

Sources: Lewin analysis of 2005 California Health Interview Survey Data. Bindman, A.B., K. Goodwin, A. Chattopadhyay, G. Auerback, *Preventable Hospitalizations among Medi-Cal Beneficiaries and the Uninsured,* California HealthCare Foundation, December 2007.

Expenditure Distribution



*Does not include Medi-Cal payments for county administration, disproportionate share hospital (DSH) and supplemental hospital payments, Safety Net Care Pool payments, payments to Medicare for the buy-in program or the Part D "clawback," recoveries, and certain other payments. Also excludes payments for services to people awaiting final Medi-Cal eligibility determination (presumptive eligibles). Altogether, these payments accounted for nearly $10 billion in Medi-Cal spending in the 12-month period ending June 30, 2008. Expenditures for clinics include Federally Qualified Health Centers (FQHCs), hospital outpatient clinics, rural clinics, and other clinics.

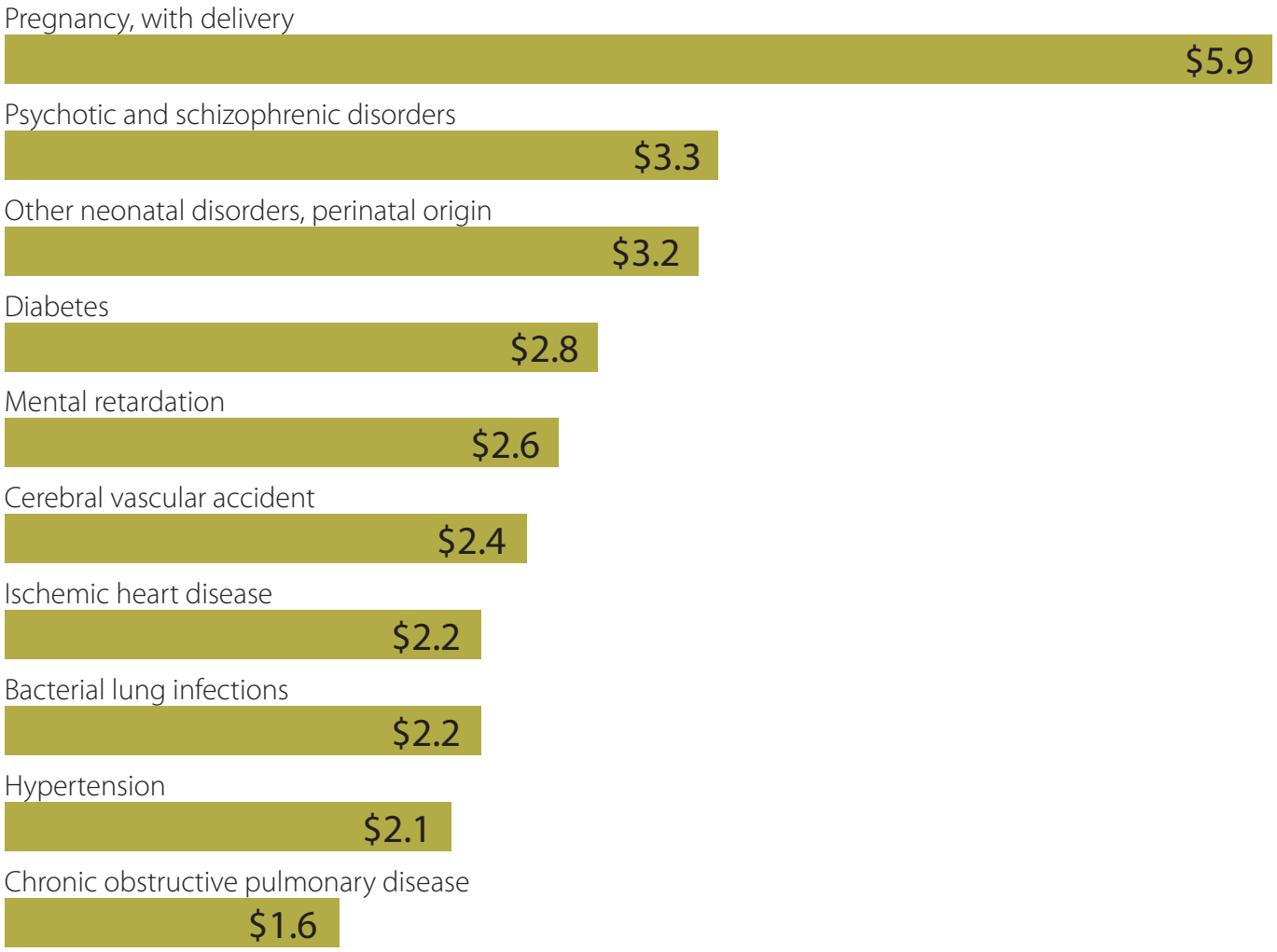
Category Notes: "LTC Facilities" includes nursing facilities and intermediate care facilities serving people with developmental disabilities and mental retardation. "Managed Care" reflects capitated payments to physical health plans. "Other" includes rehabilitation services, ancillary, and other services.

Source: Analysis of MIS/DSS data, July 2007 through June 2008. Expenditures include only paid claims for Medi-Cal beneficiaries.

Payments to managed care plans and spending on hospital inpatient services account for the largest categories of Medi-Cal spending. The Medi-Cal program spends more on community-based long term care services than on nursing and intermediate care facilities for the developmentally disabled (LTC Facilities).

Most Expensive Conditions

CONDITIONS WITH HIGHEST TOTAL MEDI-CAL FEE-FOR-SERVICE SPENDING (IN BILLIONS), 2003 TO 2008



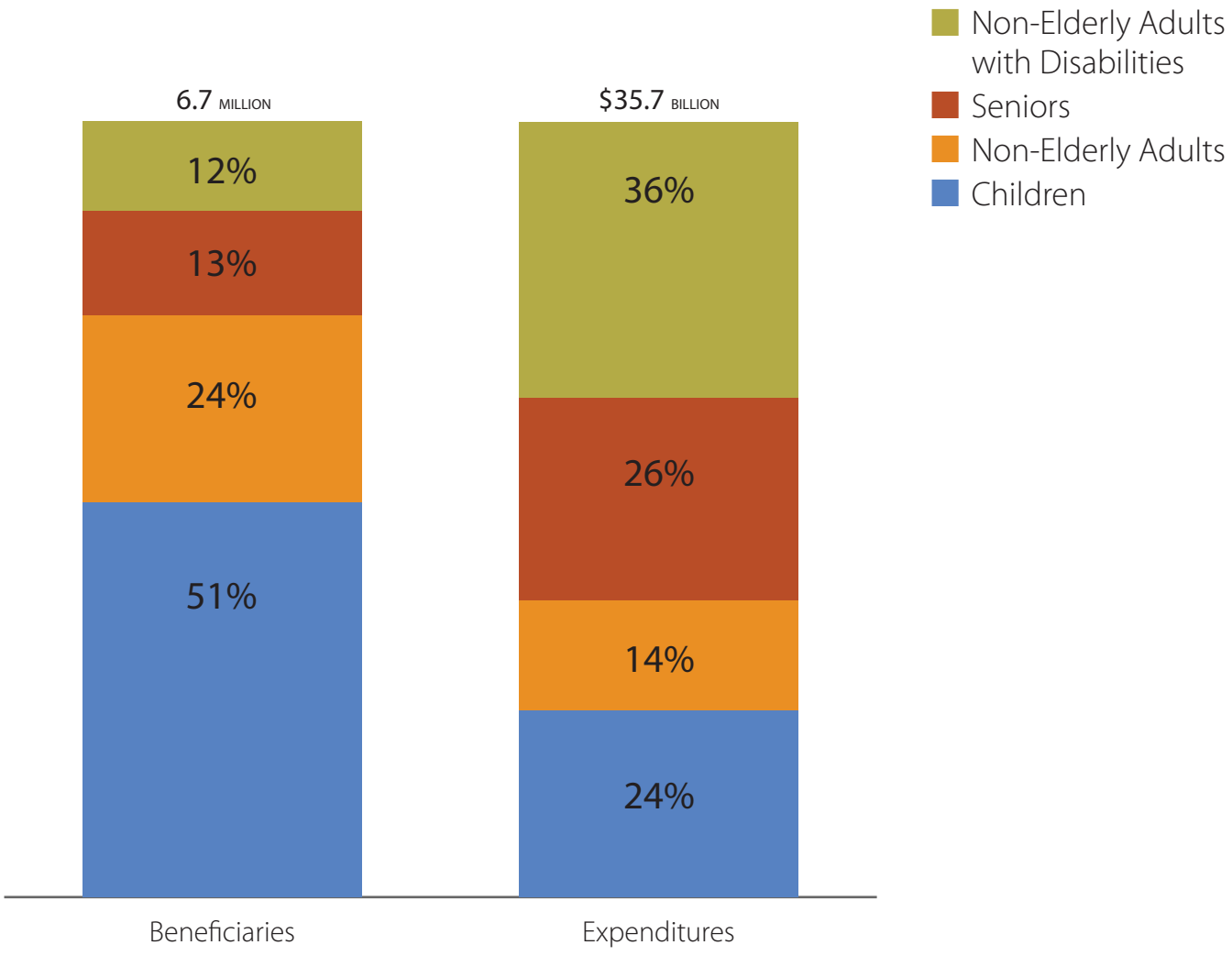
Notes: Reflects ten most costly episodes of care categories among more than 450 total categories over the five year period of July 1, 2003 through June 30, 2008. (Not all medical encounters are grouped to an episode. Episodes will not be initiated by a laboratory, radiology or drug claim unless they can be related to a clinically relevant diagnosis.) Total payments for all 2008 episodes of care totaled $13 billion.

Source: Lewin/Ingenix analysis of MIS/DSS data, Episode Treatment Group, July 1, 2003 through June 30, 2008.

Treatment related to chronic conditions* accounts for six of the top ten most expensive conditions in Medi-Cal fee-for-service (FFS) over the past five years. Pregnancy and psychiatric disorders are the most costly conditions.

*Chronic conditions include psychotic and schizophrenic disorders, diabetes, mental retardation, ischemic heart disease, hypertension, and chronic obstructive pulmonary disease. In addition, cerebral vascular accident and conditions categorized as other neonatal disorders of perinatal origin could cause chronic health problems and require long term treatment.

Beneficiaries and Cost

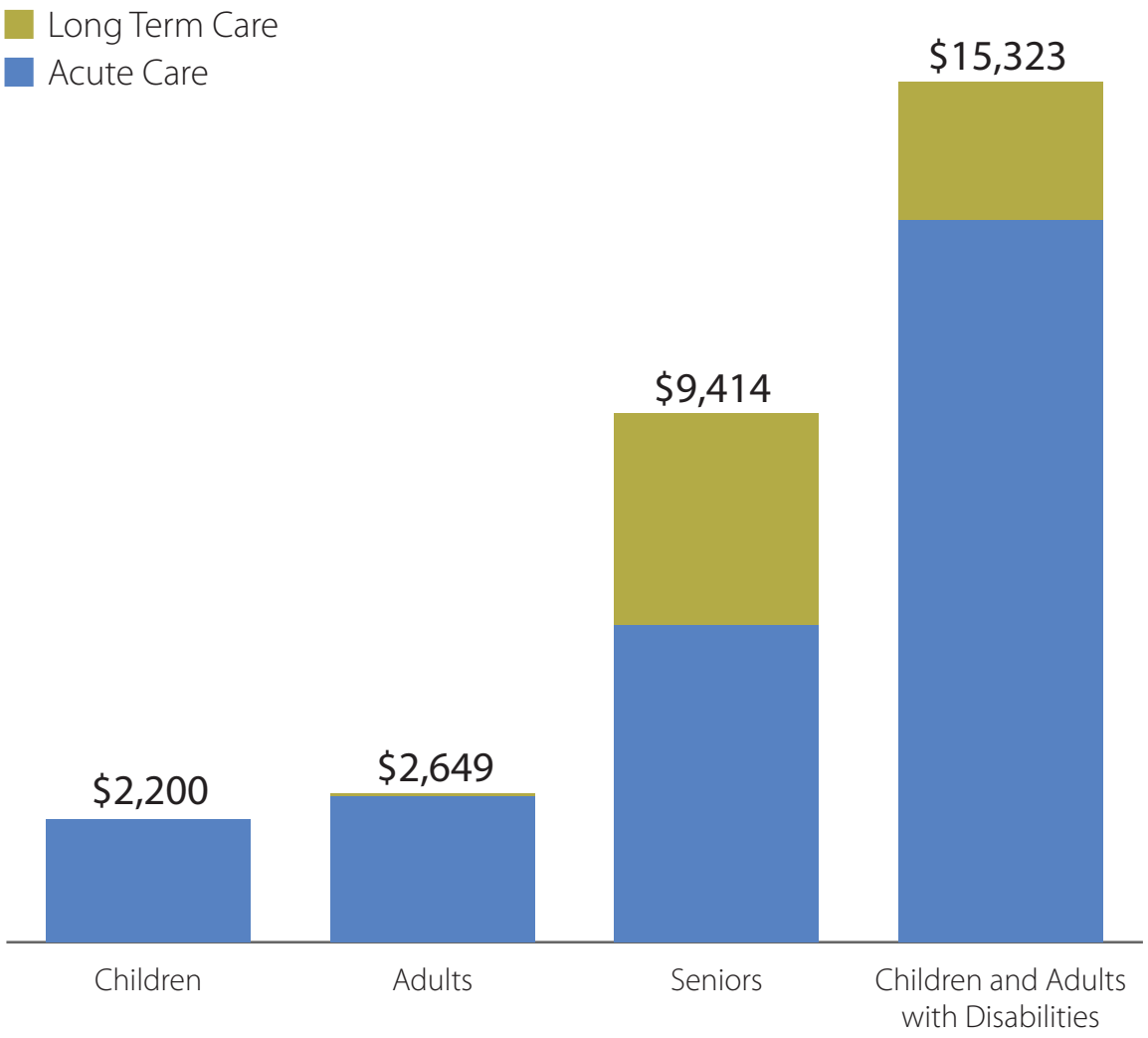


Seniors and non-elderly adults with disabilities account for 25 percent of beneficiaries and 62 percent of expenditures.

Note: Number of beneficiaries is the January 2007 eligibility count and expenditures are for the 12-month period ending September 30, 2007. Excludes 1.65 million Family PACT beneficiaries.

Source: Lewin analysis of FFY2007 MSIS data.

Annual Cost per Beneficiary

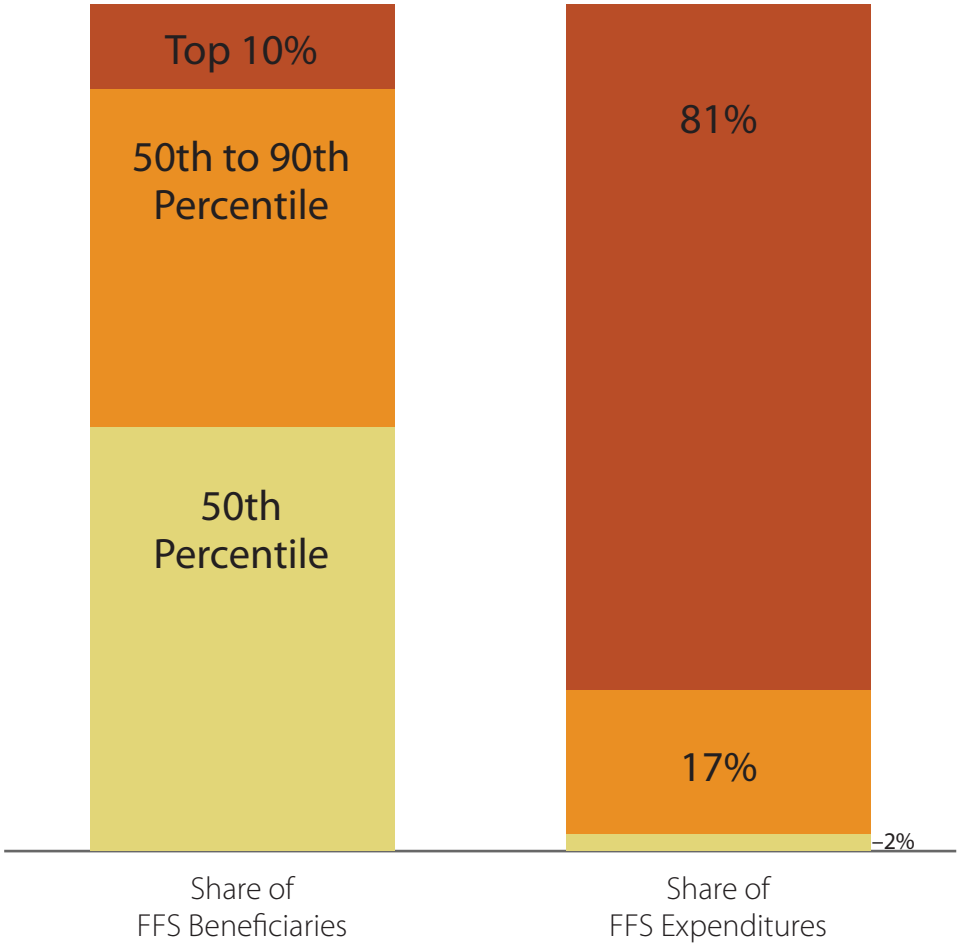


Note: FFS payments for FFS beneficiaries.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for July 1, 2007 through June 30, 2008.

Intensive use of both acute and long term care services generates greater expenditures for seniors and people with disabilities than for other beneficiaries.

High Cost Beneficiaries

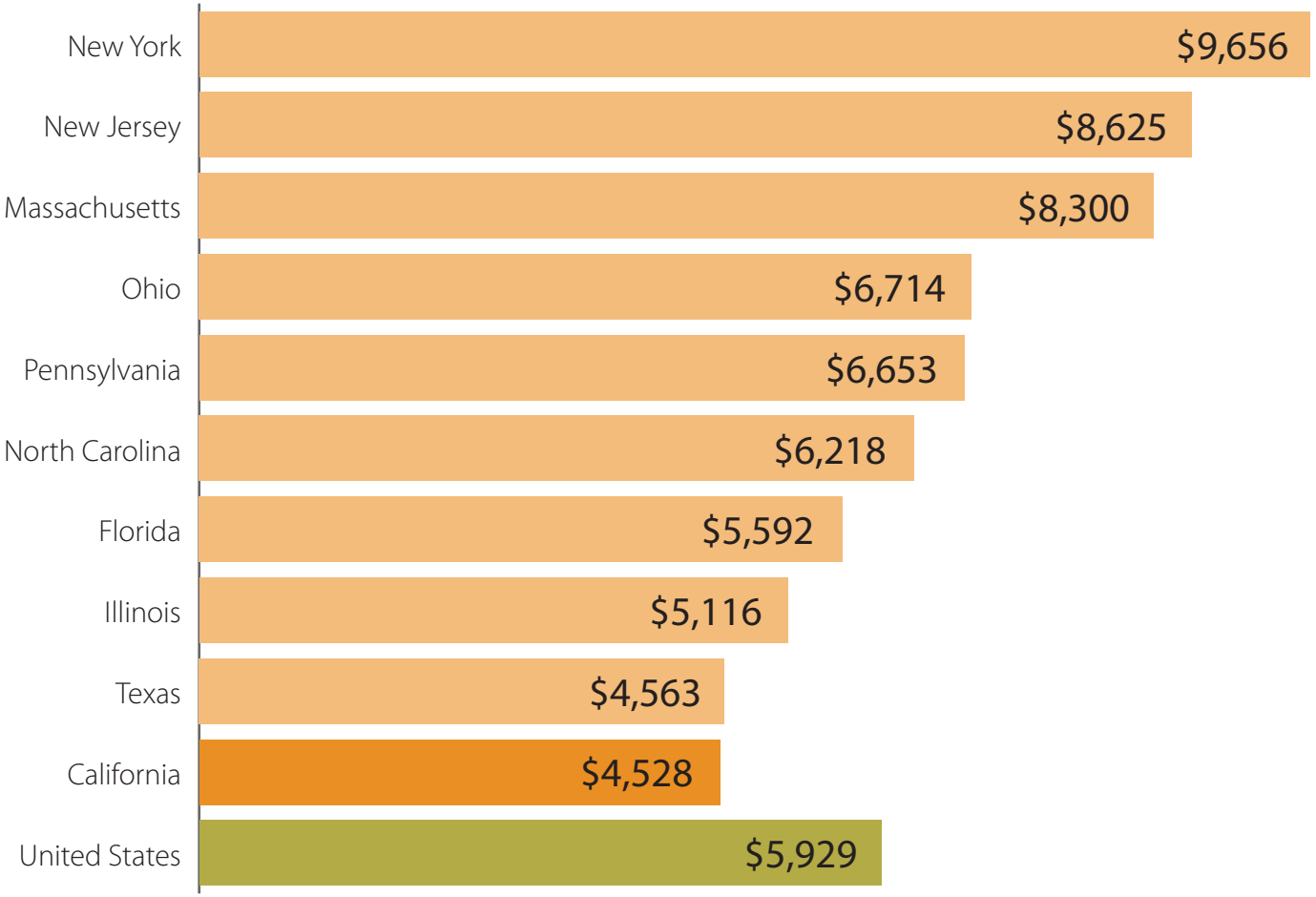


Source: Lewin/Ingenix analysis of MIS/DSS data for 12-month period ending June 30, 2008.

Medi-Cal spending is highly concentrated among a small share of beneficiaries, most of whom are seniors and people with disabilities.

This concentration of spending provides an opportunity to target interventions aimed at improving care while reducing costs.

Annual State Spending per Beneficiary



California spends 25 percent less per Medicaid beneficiary than the national per-capita amount, and the least among the ten largest states.

Notes: The states with the ten largest Medicaid programs (in terms of expenditures from October 1, 2005 through September 30, 2006) are represented along with the national average. The national average excludes ME and NV, for which MSIS data is not yet available from October 1, 2005 through September 30, 2006. Per-beneficiary calculations are based on MSIS January 2006 data for unique eligibles count and data for the 12-month period ending September 30, 2006 for total Medicaid payments made, excluding payments that are not allocated to any particular beneficiary group ("Unknown").

Source: Lewin analysis of MSIS data for 12-month period ending September 30, 2006.

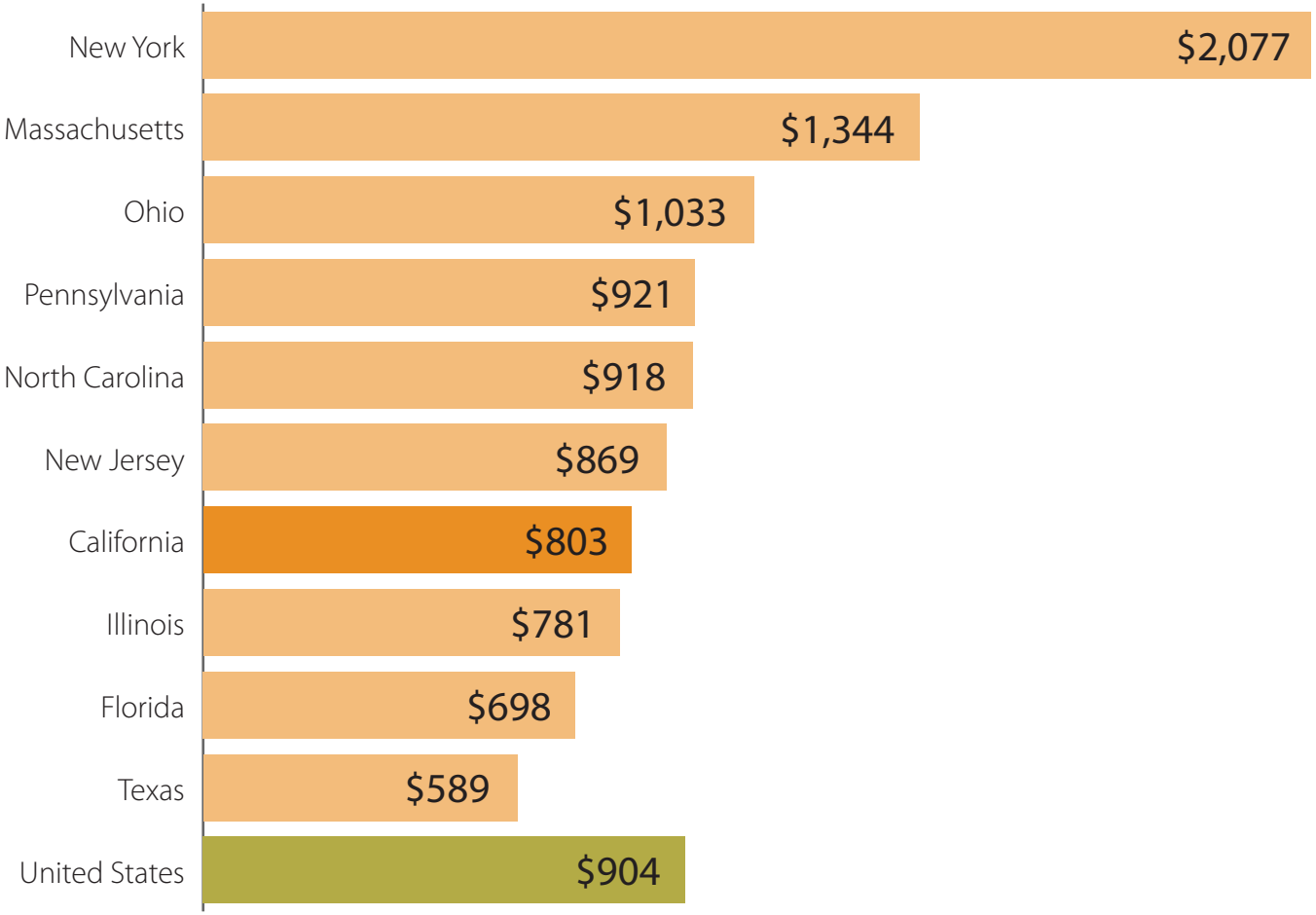
Spending for Beneficiaries, by Group

ANNUALIZED (PMPM X 12) PER-CAPITA MEDICAID COSTS

Source: Lewin analysis of MSIS data for 12-month period ending September 30, 2006

California ranks 34th among states in per beneficiary costs among the blind and disabled and 45th among the non-disabled. Across all beneficiaries with disabilities, Medi-Cal per-capita costs are 11 percent below the national Medicaid amount. Across beneficiaries without disabilities, Medi-Cal per-capita costs are 25 percent below the national number.

Spending per Resident



California is below the national amount in Medicaid spending per resident, which reflects both the generosity of its eligibility policies and the level of spending per beneficiary.

Notes: The states with the ten largest Medicaid programs (in terms of expenditures from October 1, 2005 through September 30, 2006) are represented along with the national per-resident amount. The national number excludes Maine and Nevada, for which MSIS data is not yet available from October 1, 2005 through September 30, 2006.

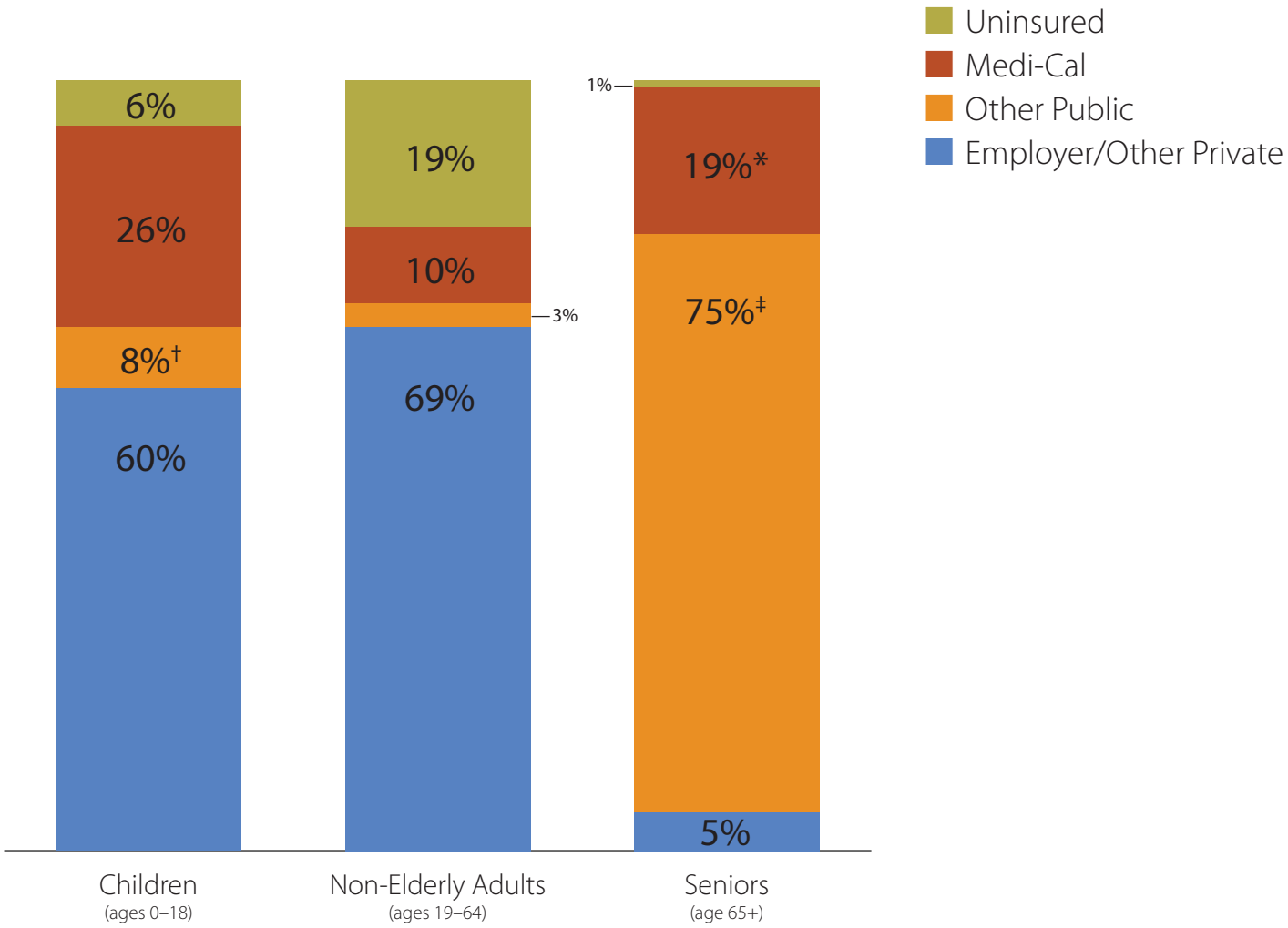
Sources: Lewin analysis of MSIS data for 12-month period ending September 30, 2006. U.S. Census Bureau, Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2000 to July 1, 2008, www.census.gov/popest/states/NST-ann-est.html.

Medi-Cal's Crucial Role

- Provides affordable coverage to children and adults in low-income families.
- Pays for a broad array of services that are not available through the commercial market to people with disabilities.
- Fills gaps in Medicare coverage for low-income beneficiaries.
- Helps keep commercial premiums affordable by insuring certain high-cost populations and keeping them out of the risk pool.
- Pulls in federal financial support for safety-net providers and state coverage initiatives targeting the uninsured.

Medi-Cal plays several distinct roles in California's health care system.

Sources of Coverage



*Among seniors, nearly all those covered by Medi-Cal are dual eligibles who also have Medicare coverage.

†Among children, "Other Public" is predominantly Healthy Families.

‡Among seniors, "Other Public" includes Medicare-only and Medicare plus other coverage.

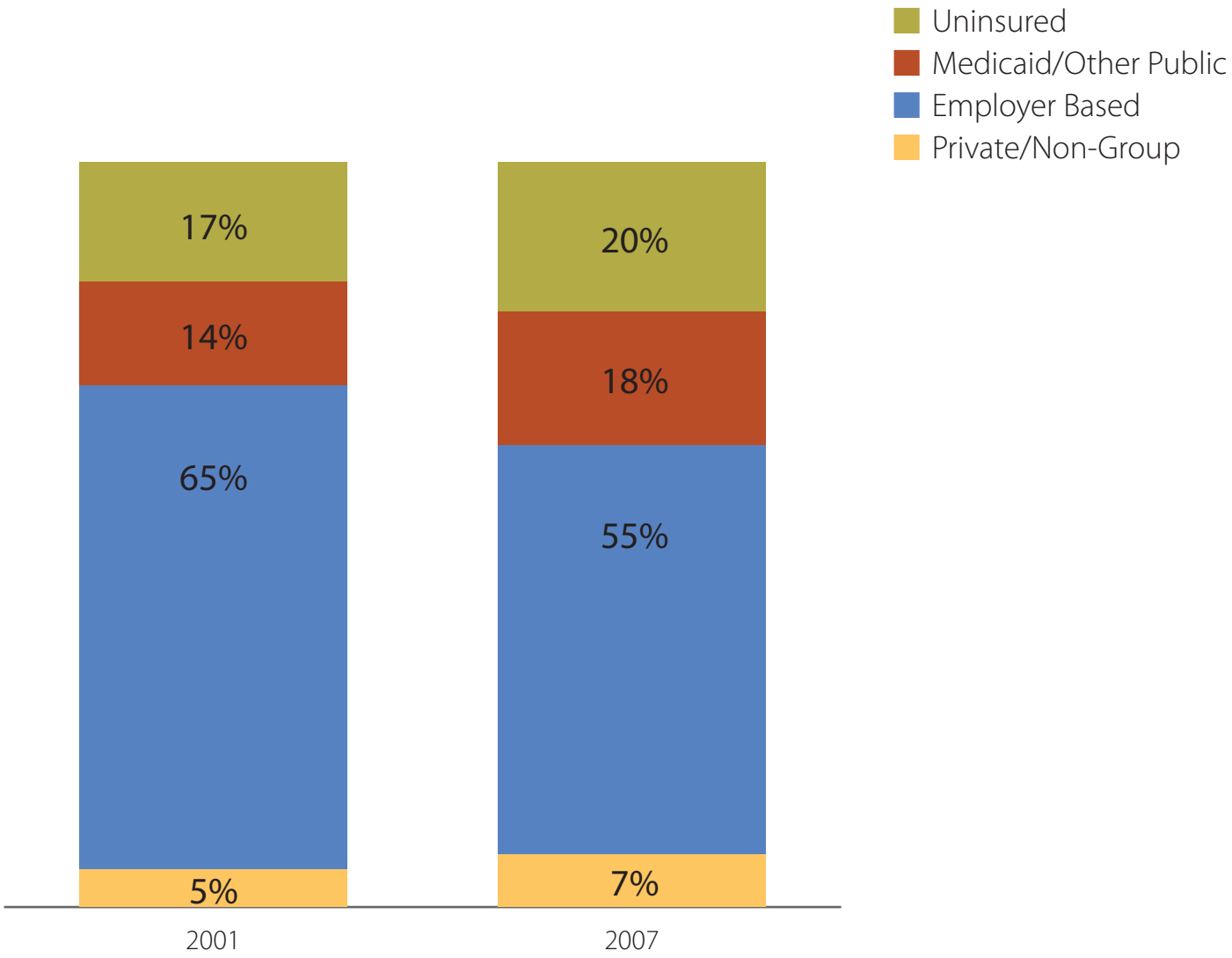
Notes: Insurance status at the time of the survey. "Other" includes public and private and those enrolled in both Medicare and Medicaid. Less than 1 percent of children are in this dual coverage category. Topic Restrictions: Type of current health coverage source — under 65 years old has these restrictions: Asked of respondents less than 65 years of age. Insurance status at the time of the survey. Figures may not total 100 percent due to rounding.

Source: 2007 California Health Interview Survey (CHIS) data, www.chis.ucla.edu.

Medi-Cal provides coverage to:

- 26 percent of children;
- 10 percent of non-elderly adults; and
- 19 percent of elderly adults.

U.S. Health Insurance Trends



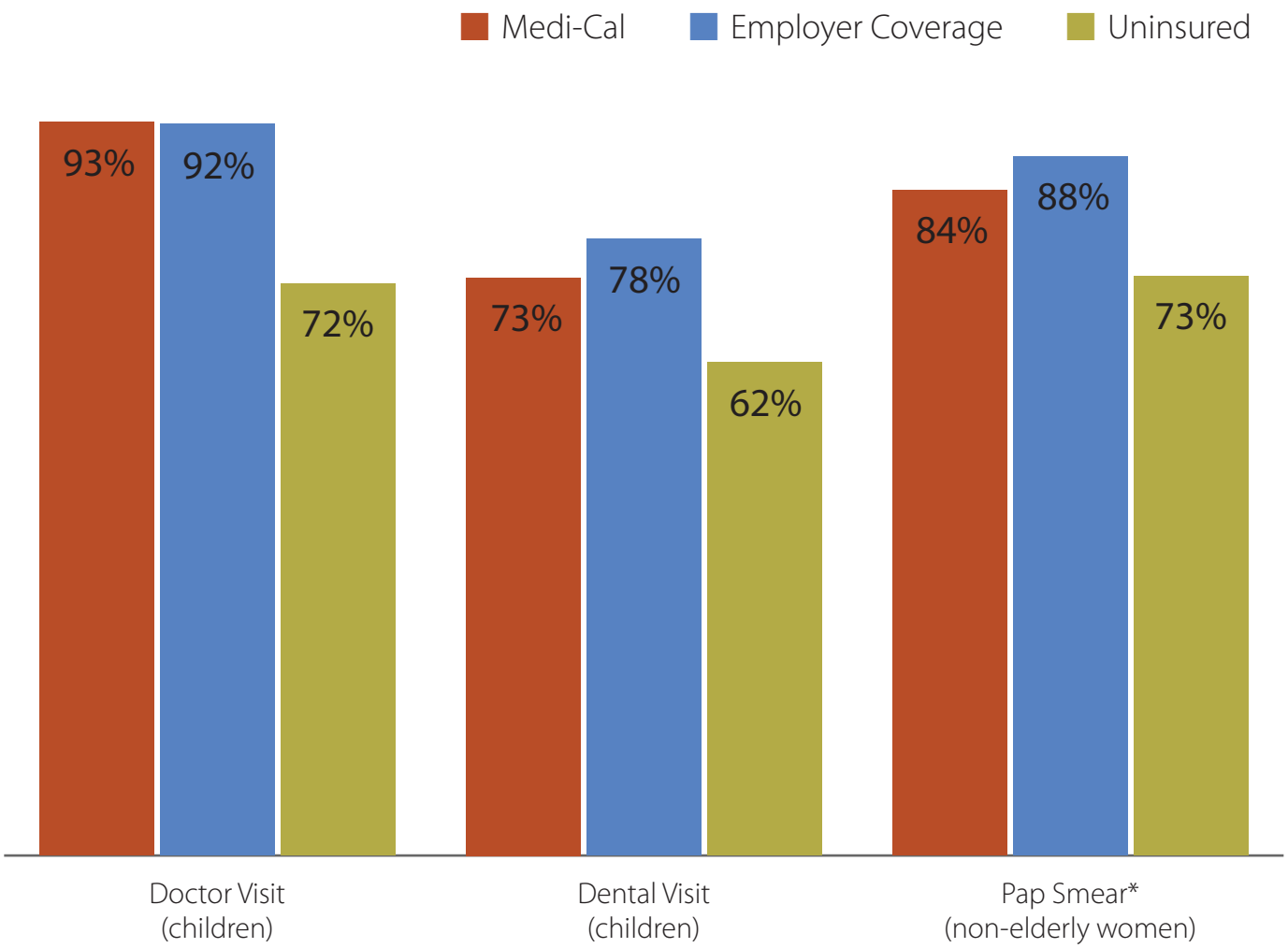
About one-half of the decline in employer-based coverage between 2001 and 2007 was offset by increases in Medicaid and other public coverage.

Note: Figures may not total 100 percent due to rounding.

Source: Kaiser Family Foundation State Health Facts, California: Health Coverage & Uninsured 2006 – 2007, www.statehealthfacts.org/profileind.jsp?cat=3&sub=39&rgn=6.

Access to Primary Care

RATES OF USE FOR SELECTED PRIMARY CARE SERVICES

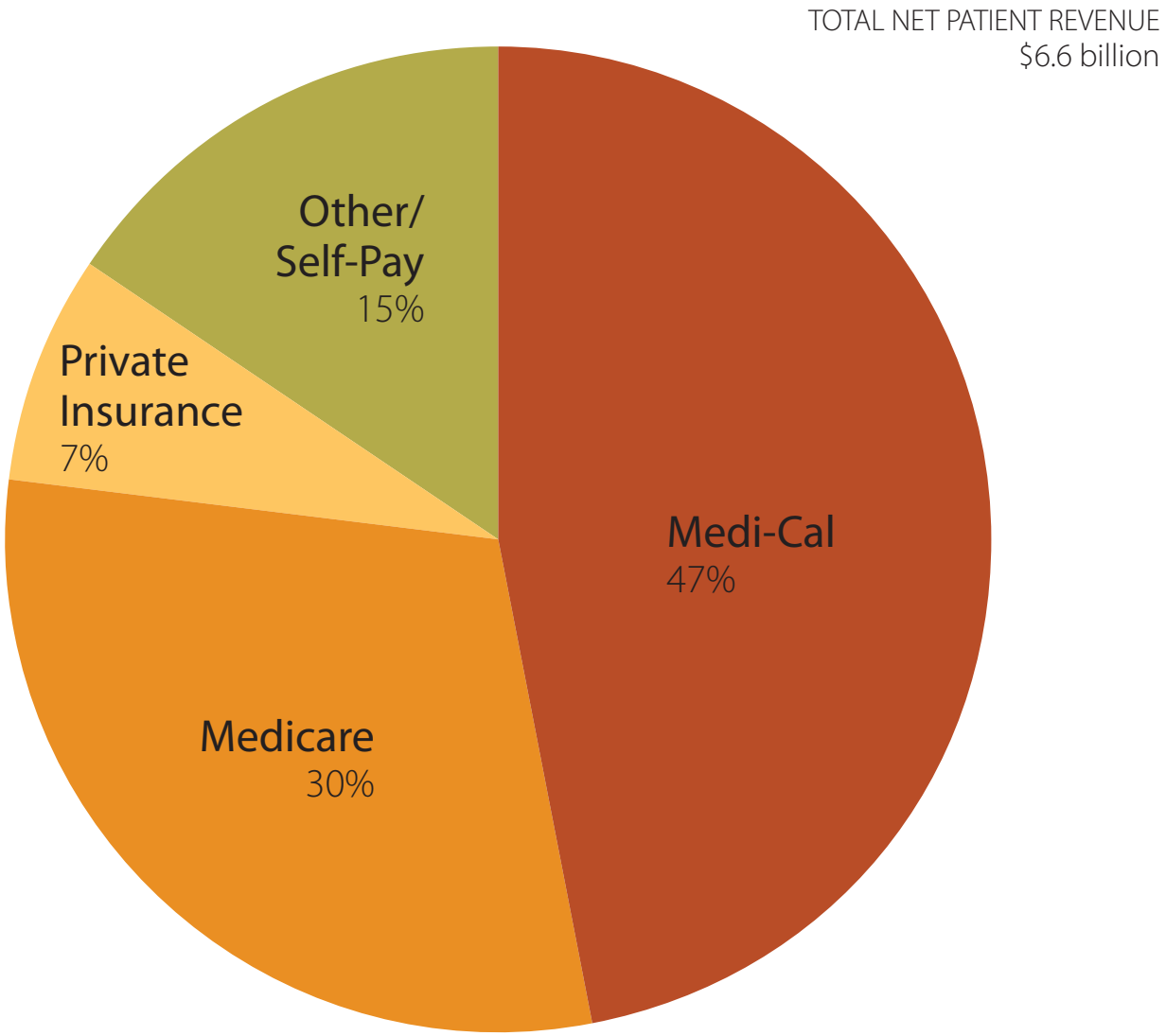


*Received pap screen within last three years.

Sources: Lewin analysis of CHIS 2007 data. California Health Interview Surveys. *CHIS 2007 Child Survey* and *CHIS 2007 Adult Survey.* UCLA Center for Health Policy Research. Los Angeles, CA: December 2008.

Medi-Cal coverage improves access to care. Children and women enrolled in Medi-Cal report use rates for primary care services that are comparable to those for people enrolled in employer coverage and much greater than for those who are uninsured.

Nursing Facility Revenues

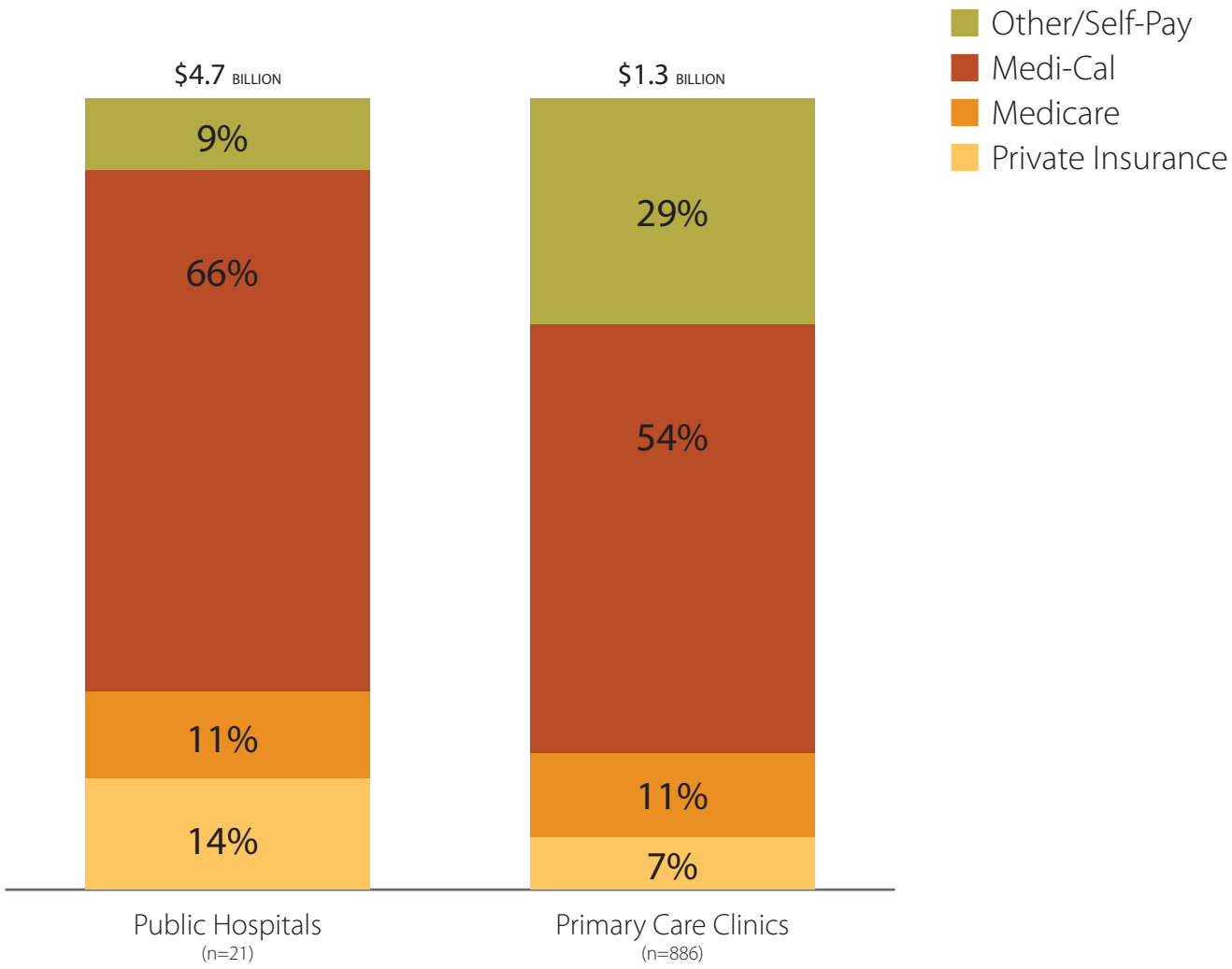


Notes: Net patient revenue includes gross inpatient and outpatient revenue after accounting for deductions from revenue and capitation premium revenue but prior to expenses. "Private" (insurance) as reported for nursing facilities data includes managed care. Self-pay represents 79 percent of patient days and 80 percent of revenues in the "Other/Self-Pay" category. In 2007 there were 1,008 skilled nursing facilities and 5 intermediate care facilities that submitted long term care facility financial reports to OSHPD. Figures may not total 100 percent due to rounding.

Source: California Office of Statewide Health Planning and Development (OSHPD), 2007.

Medi-Cal pays for nearly one-half of care delivered in nursing facilities.

Safety-Net Revenues



Notes: Includes gross inpatient and outpatient revenue after accounting for deductions from revenue and capitation premium revenue but prior to expenses. "Other/Self-Pay" as reported for primary care clinics includes Healthy Families, CHDP, FPACT, county medically indigent programs, and all others. Forty-nine licensed Primary Care Clinics that failed to provide their utilization data for 2007 and 38 Primary Care Clinics that were not in operation in 2007 are excluded. Figures may not total 100 percent due to rounding.

Source: California Office of Statewide Health Planning and Development (OSHPD), 2007.

Medi-Cal is a key source of funding for major providers of care to the uninsured. It accounts for about one-half of patient revenues to community clinics and nearly two-thirds of patient revenues for public hospitals.

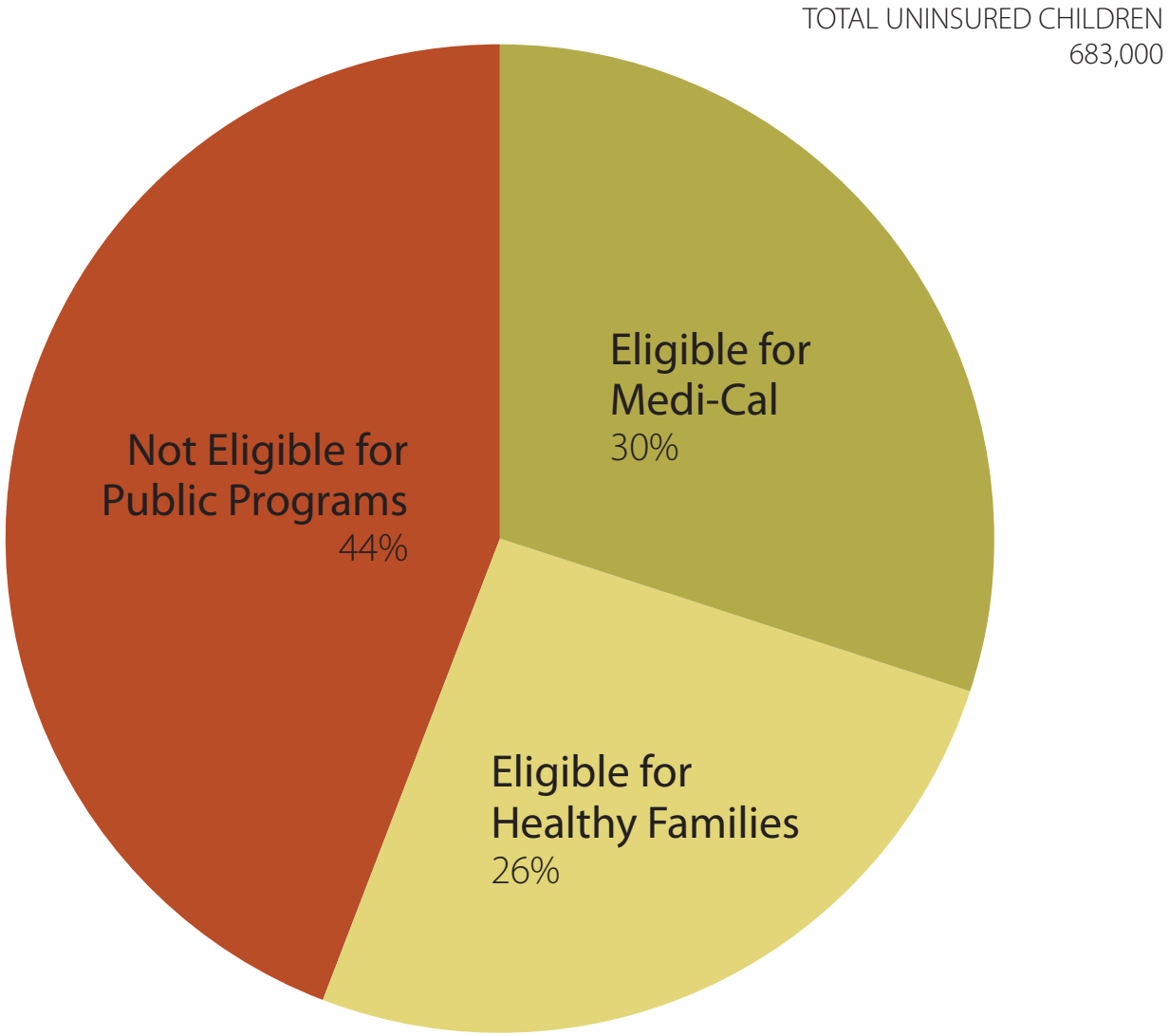
Supplemental Hospital Payments

- Safety-net hospitals are public hospitals that make up just 6 percent of hospitals statewide, but provide more than half of all hospital care to the state's 6.6 million uninsured.
- Medi-Cal pays additional (or supplemental) reimbursement to safety-net hospitals that care for a disproportionate share of Medi-Cal and uninsured patients.
- In September 2005, California negotiated a five-year Hospital Financing Waiver with the federal government that capped the amount of federal funding available and created a Safety-Net Care Pool to help fund services to the uninsured; some federal funding was tied to the state achieving specific program goals. The waiver expires on August 1, 2010.
- In January 2007, the federal government issued a proposed rule that would further limit the amount of funding available to certain safety-net hospitals; implementation of the rule as proposed has been delayed and may be indefinitely postponed.

Medi-Cal remains an important source of financing for safety-net hospitals, allowing the draw of significant federal funding to match state and local contributions and support coverage for not only Medi-Cal beneficiaries but also a large proportion of the state's uninsured.

Sources: CAPH, *California's Essential Public Hospitals,* February 2008, www.caph.org/CAPH_EssentialsLegDay_08.pdf. Medicaid Regulation of Governmental Providers, Congressional Research Service, 2008. Centers for Medicare and Medicaid Services (CMS), California Medi-Cal Hospital Uninsured Care Fact Sheet, www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/downloads/California Medi-Cal Hospital Uninsured Care Fact Sheet.pdf.

Children Eligible but Not Enrolled



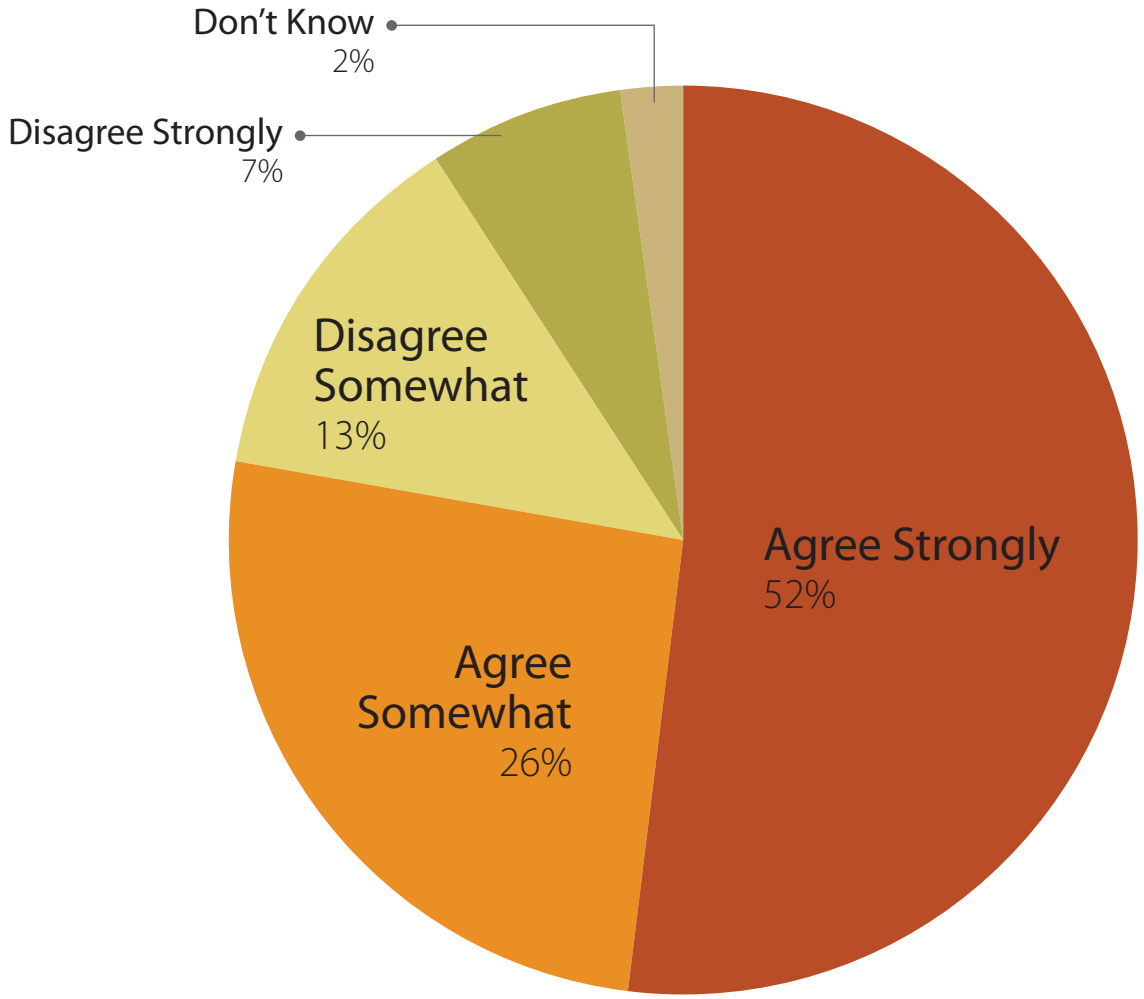
Note: Eligibility for public programs under current eligibility rules among currently uninsured children, ages 0 to 18, California, 2007.

Source: Lewin analysis of CHIS 2007 data.

According to recent estimates, nearly one-third of the 683,000 uninsured children in California are eligible for Medi-Cal.

Enrollment Process Experience

"SIGNING UP FOR MEDI-CAL REQUIRES TOO MUCH PAPERWORK."



Source: Medi-Cal Policy Institute, *Medi-Cal Beneficiary Survey, 1999.*

Barriers to enrollment include:

- Complexity of application process;
- Difficulty obtaining required documentation such as income verification;
- Lack of knowledge about the program;
- Stigma associated with Medi-Cal because of its historic links to welfare; and
- Fear that enrollment in Medi-Cal will adversely effect future opportunities for citizenship among immigrant families.

Access to Care Experience, by Health Status

Medi-Cal Managed Care Enrollees Sometimes/Never…	EXCELLENT/ VERY GOOD HEALTH	GOOD HEALTH	FAIR/POOR HEALTH
Found it easy to get appointments with specialists	21%	33%	35%
Received the information or help they needed from customer service	17%	26%	35%
Found it easy to get the care, tests or treatment they or the doctor believed they needed	15%	21%	33%
Got an appointment as soon as they wanted*	25%	27%	30%

Even in health plans, where beneficiaries are more likely to have a usual source of care, many beneficiaries have difficulty getting care. The sickest beneficiaries report the most difficulty getting care and assistance.

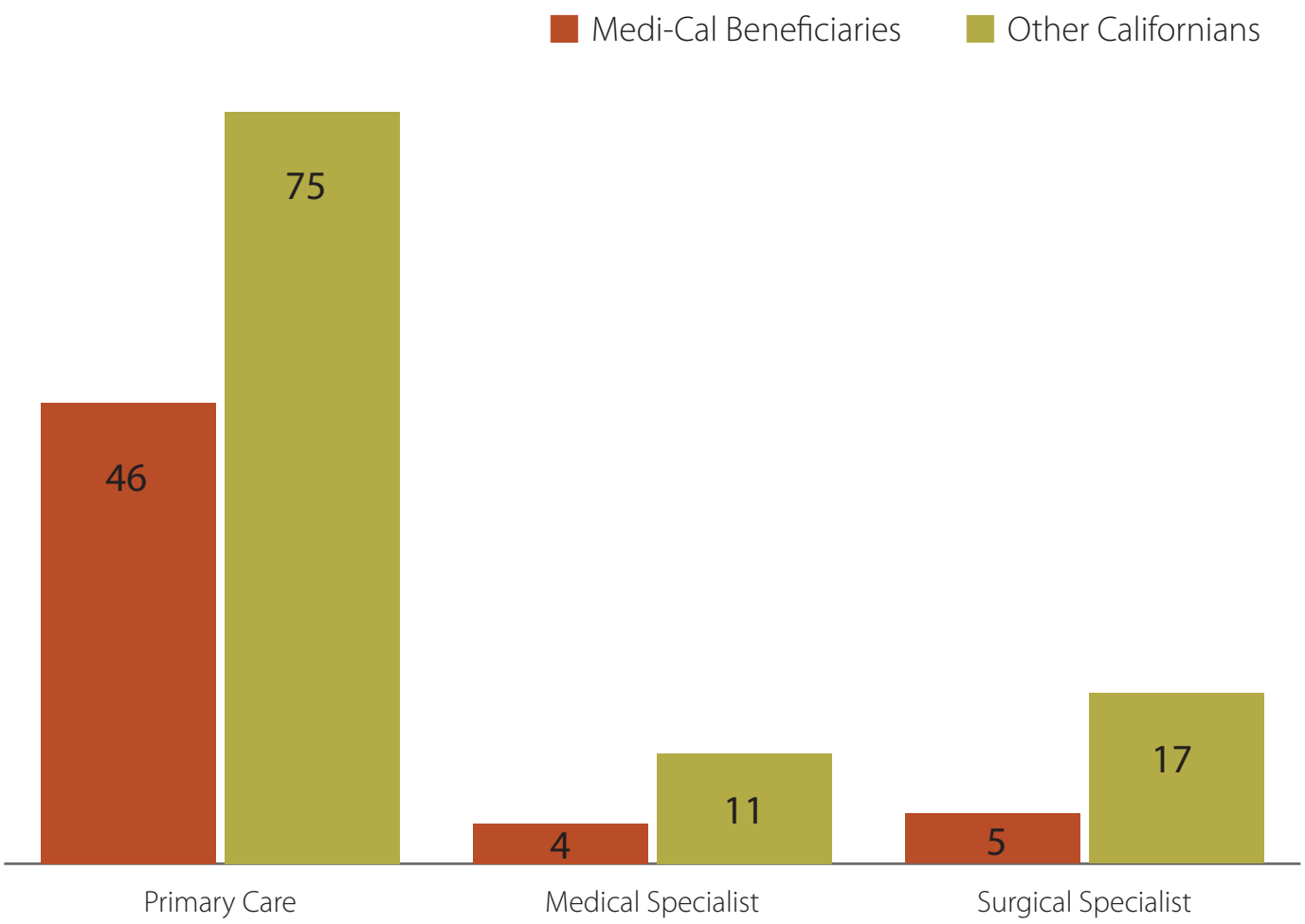
*Measure does not include cases when enrollees needed care immediately.

Note: Unweighted percentages based on average of scores of five largest plans, accounting for 73 percent of Medi-Cal managed care enrollment.

Source: California Department of Health Care Services (DHCS) analysis of data from the 2007 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results for Medi-Cal Managed Care Health Plans.

Physician Participation

PER 100,000 PEOPLE, BY SPECIALTY

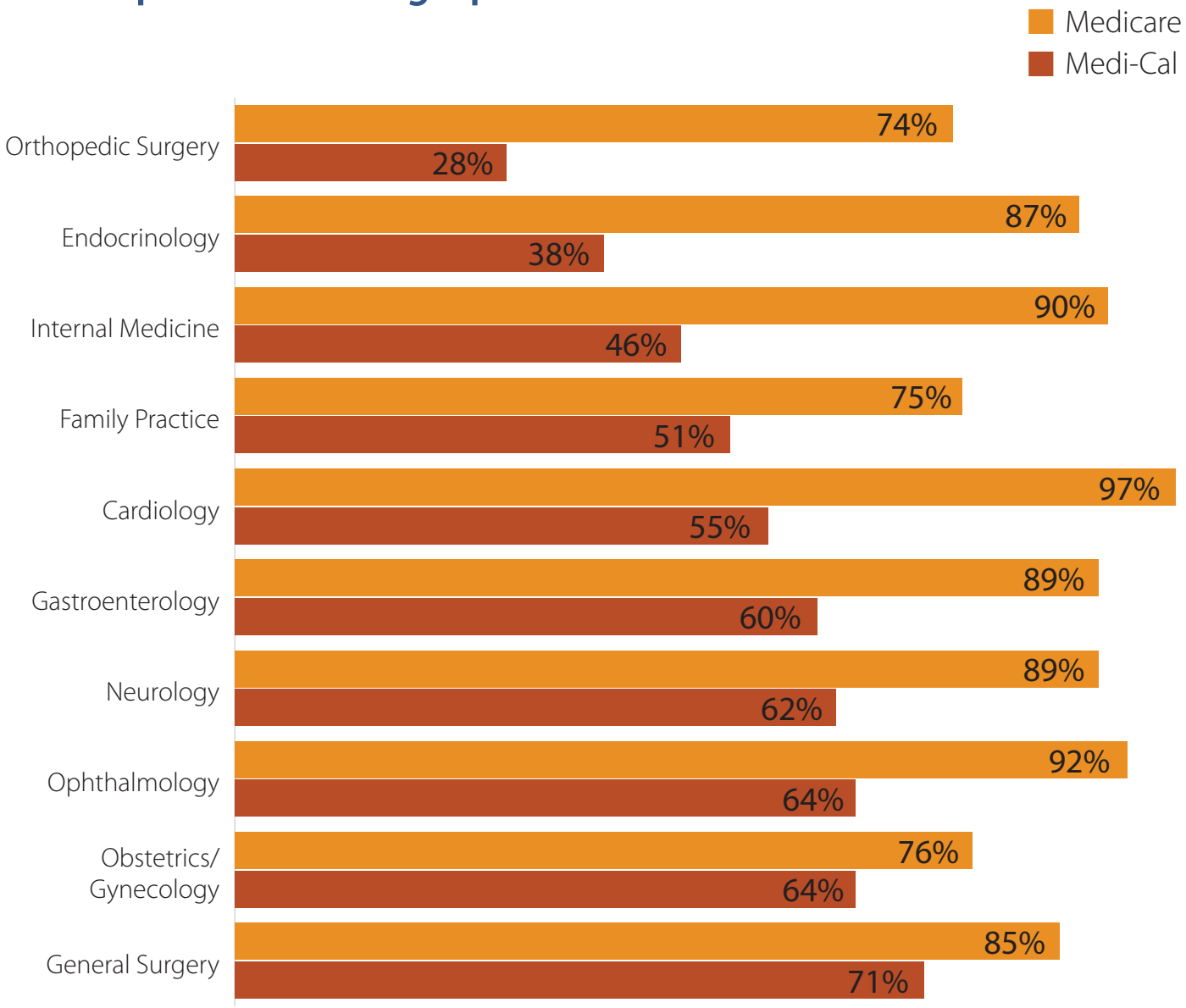


Note: Numbers based on Full-Time Equivalents (FTEs).

Source: Bindman, A., *Physician Participation in Medi-Cal,* 2001, California HealthCare Foundation, Oakland, CA: May 2002.

- In 2001, there were only 46 primary care providers for every 100,000 beneficiaries in California, well below commonly cited estimates of the amount needed of 60 to 80 physicians per 100,000 people.
- Rates of participation in Medi-Cal were even lower among medical and surgical specialists.

Participation Among Specialists

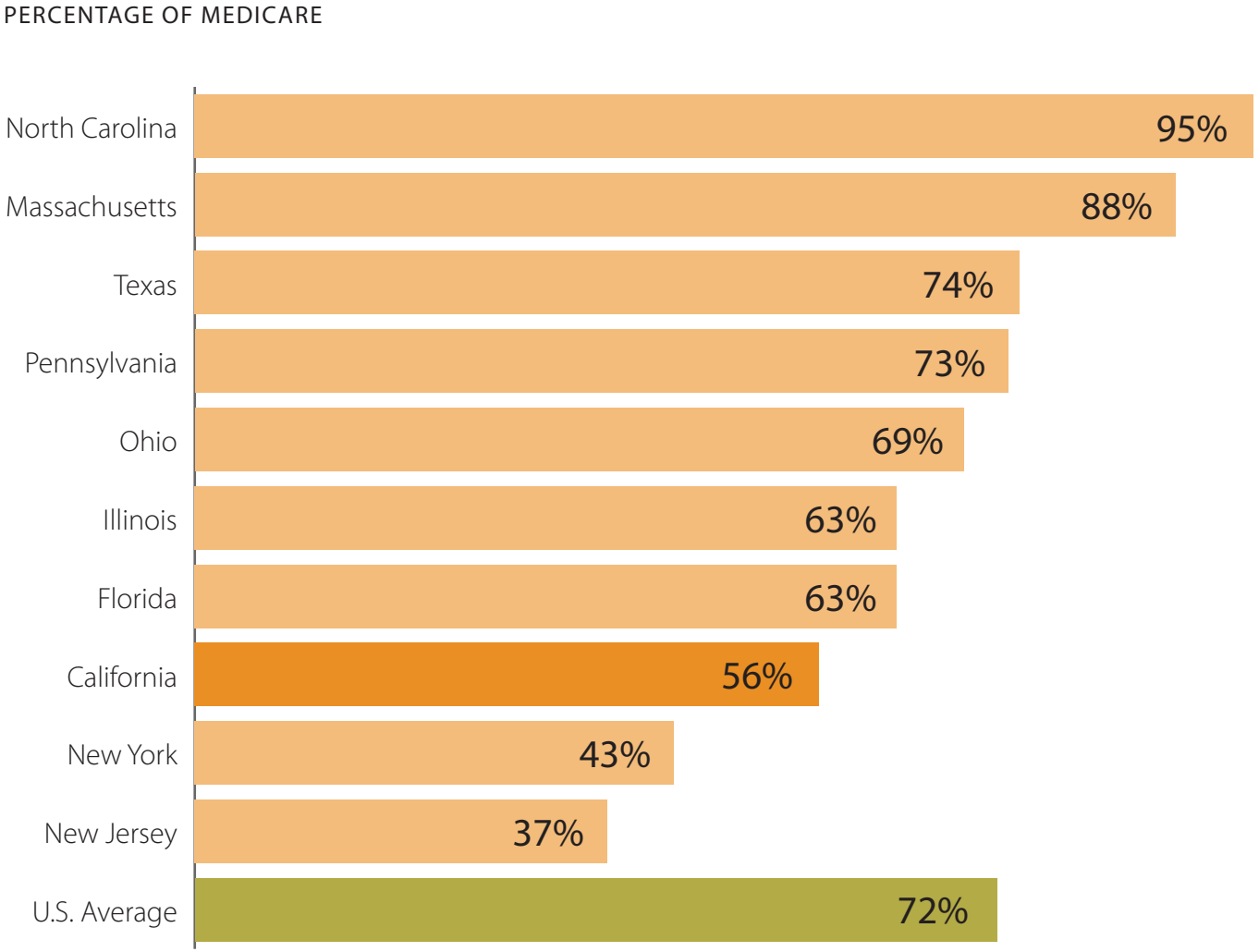


Note: The difference between Medicare and Medi-Cal is statistically significant ($P < 0.05$) for all the specialties categories except obstetrics/gynecology and general surgery.

Source: UCSF Survey of California Physicians, 2001.

Low rates of participation in Medi-Cal among medical and surgical specialists is a contributing factor to the problem of poor specialty care access for Medi-Cal beneficiaries.

Physician Payment Rates

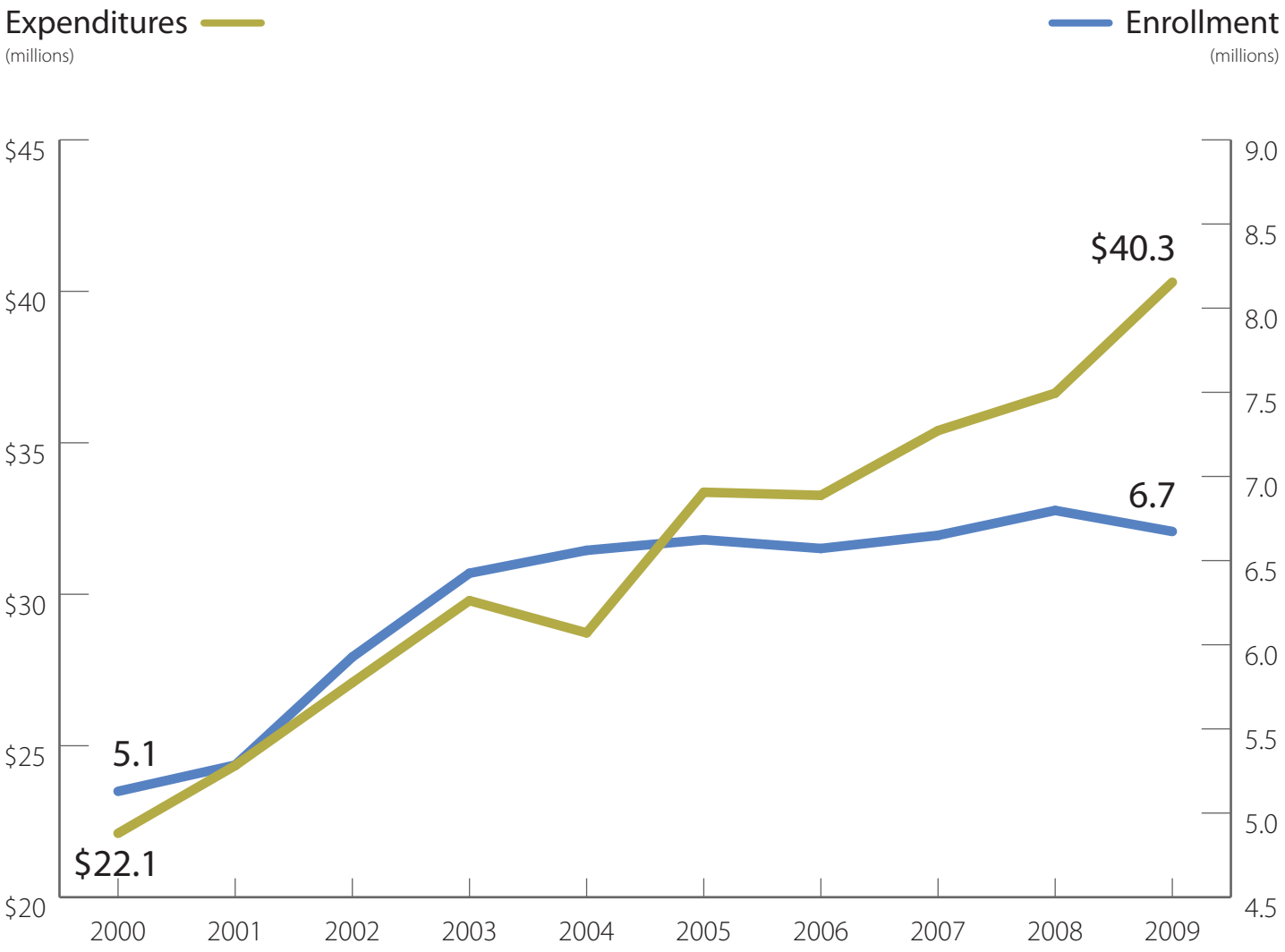


Note: The states with the ten largest Medicaid programs (in terms of expenditures from October 1, 2005 through September 30, 2006) are represented along with the national average.

Source: Urban Institute 2008 Medicaid Physician Survey.

Medi-Cal pays physicians 56 percent of Medicare rates for the same service, an amount below the national average.

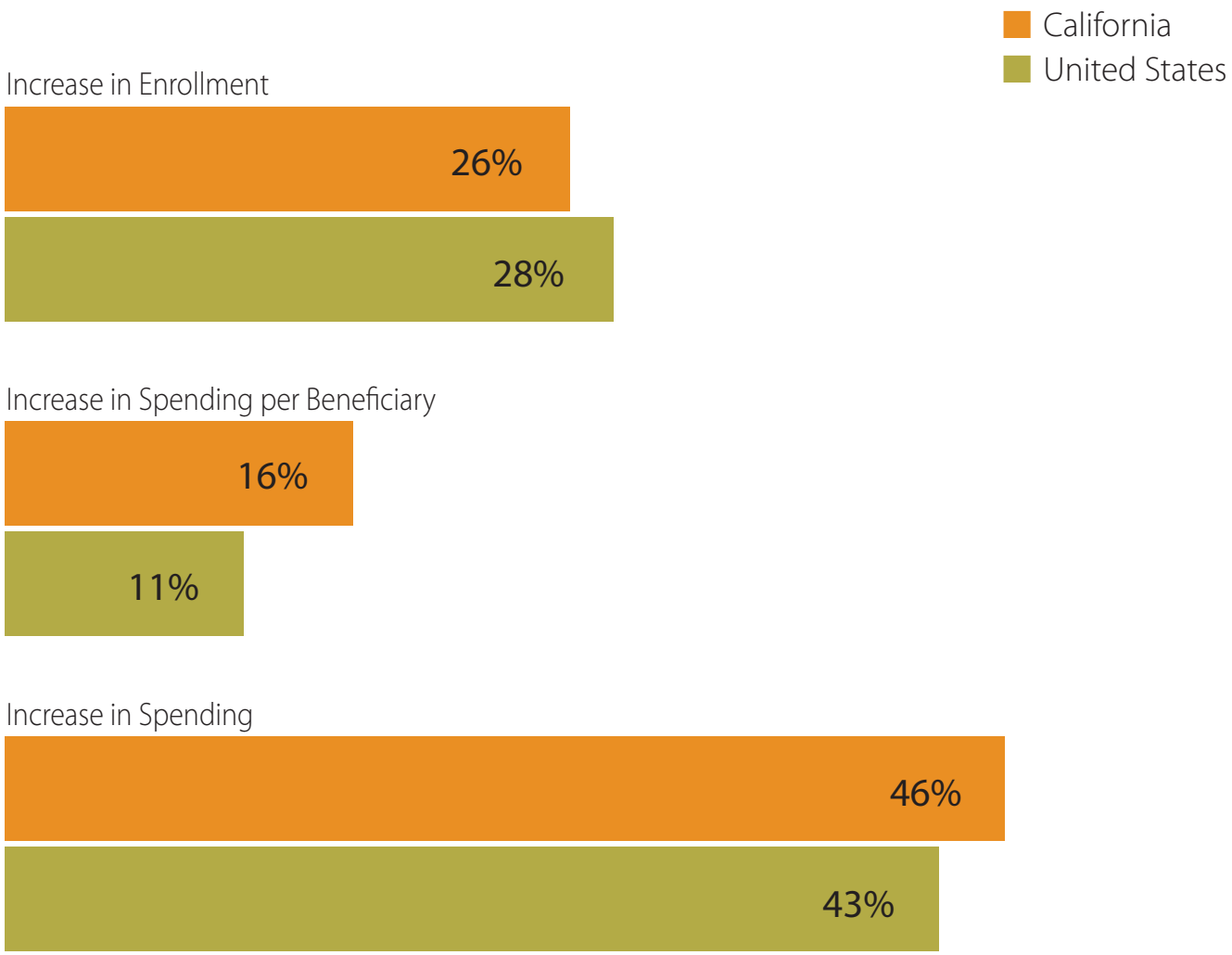
Spending and Enrollment Trends



Source: California Department of Health Care Services (DHCS) Fiscal Forecasting and Data Management Branch, Medi-Cal Local Assistance Estimates, 1992 through 2008, www.dhcs.ca.gov/dataandstats/reports/mcestimates. Expenditures do not reflect DHCS estimates of Medi-Cal spending by other departments.

Over the past decade, Medi-Cal spending has nearly doubled, reflecting an average annual increase of 7 percent. Increases in enrollment and per-person costs accounted for the spending growth in roughly equal measure.

Enrollment and Spending Comparison

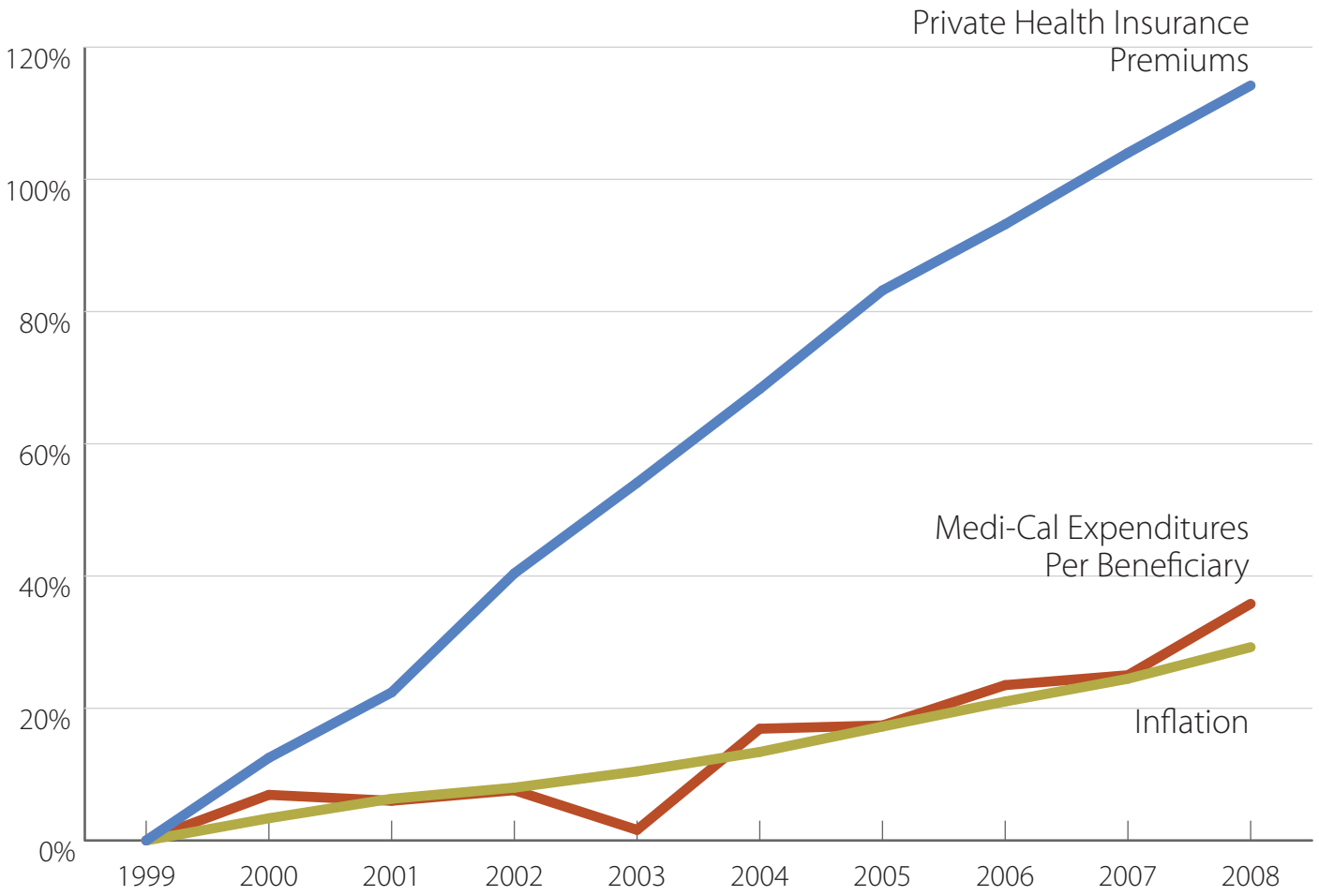


Source: Lewin analysis of MSIS data. Increase in beneficiaries is based on unique eligible counts data for January 2001 and January 2006. Increase in spending is based on expenditures for the 12-month periods ending September 30, 2001 and September 30, 2006.

Between 2001 and 2006, Medi-Cal grew by nearly the same percent as Medicaid nationwide.

Health Care Cost Trends

CUMULATIVE CHANGE

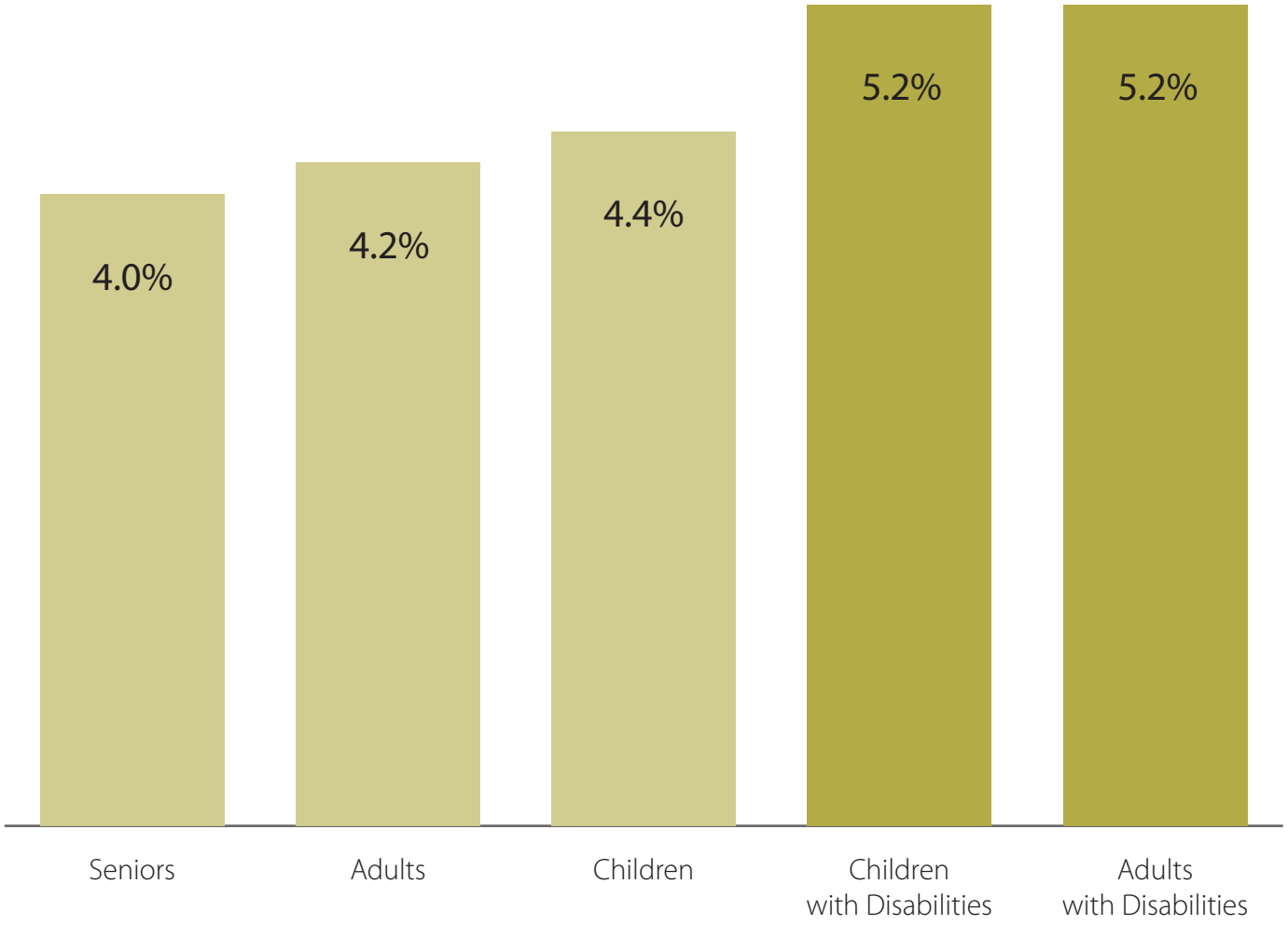


Sources: Figures for private health insurance premiums, which reflect single coverage, are from the Kaiser Family Foundation, *HRET Survey of Employer-Sponsored Health Benefits, 1999 – 2008.* Inflation numbers are derived from the Bureau of Labor Statistics Inflation Calculator, data.bls.gov/cgi-bin/cpicalc.pl. Medi-Cal data calculated using expenditure and enrollment data from the California Department of Health Care Services (DHCS) Fiscal Forecasting and Data Management Branch, Medi-Cal Local Assistance Estimates, 1992 through 2008, www.dhcs.ca.gov/dataandstats/reports/mcestimates.

Over the past decade, Medi-Cal spending per beneficiary has grown at a much slower rate than private health insurance premiums.

Per-Person Cost Trends

AVERAGE ANNUAL GROWTH RATES

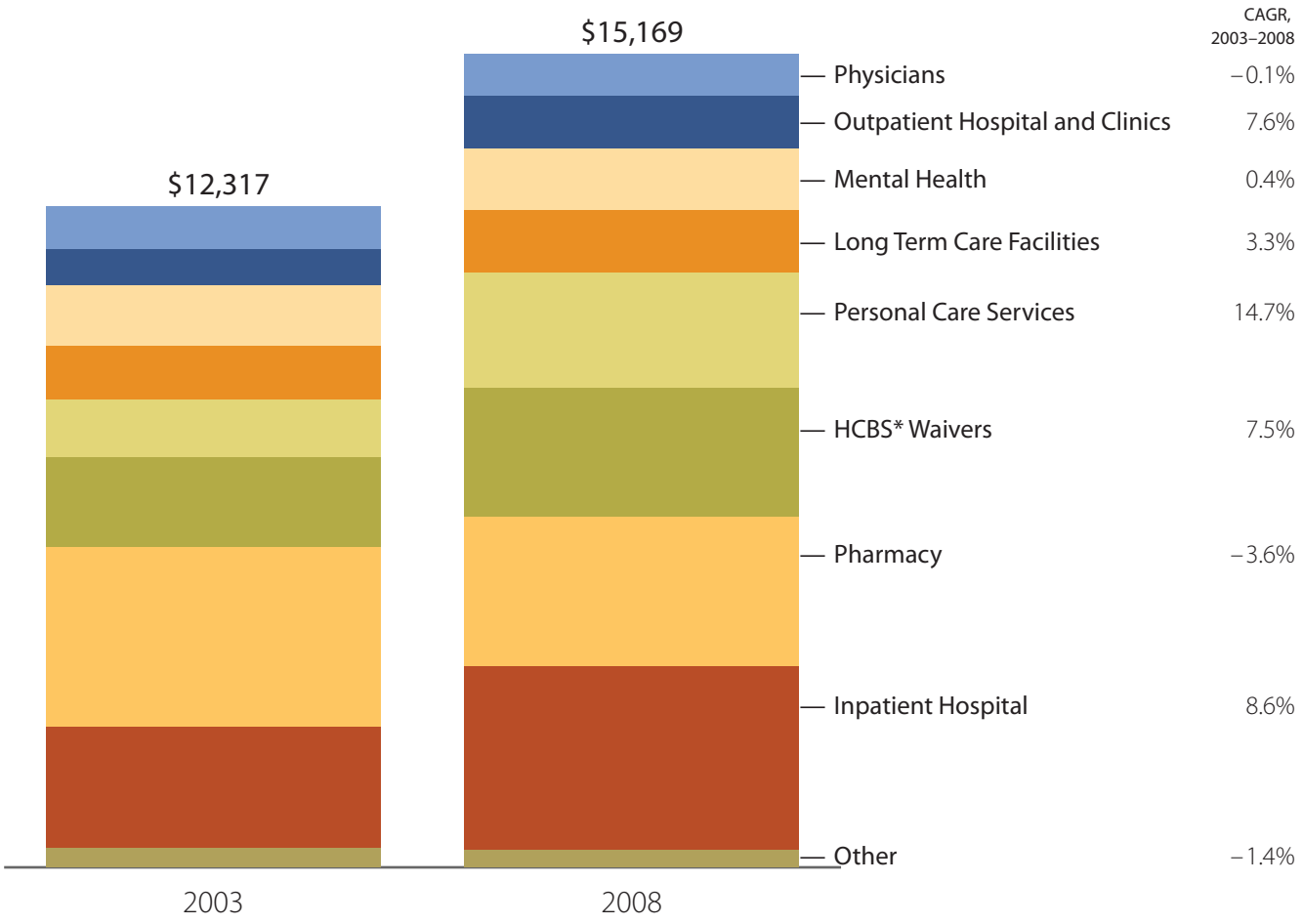


Source: Lewin analysis of MSIS data for 12-month periods ending September 30, 1999 and September 30, 2007.

Between 1999 and 2007, per beneficiary spending grew at similar rates for children, adults, and the elderly; growth rates for those with disabilities were slightly higher.

Spending Trends, by Service, Adults with Disabilities

MONTHLY FFS SPENDING PER ADULT



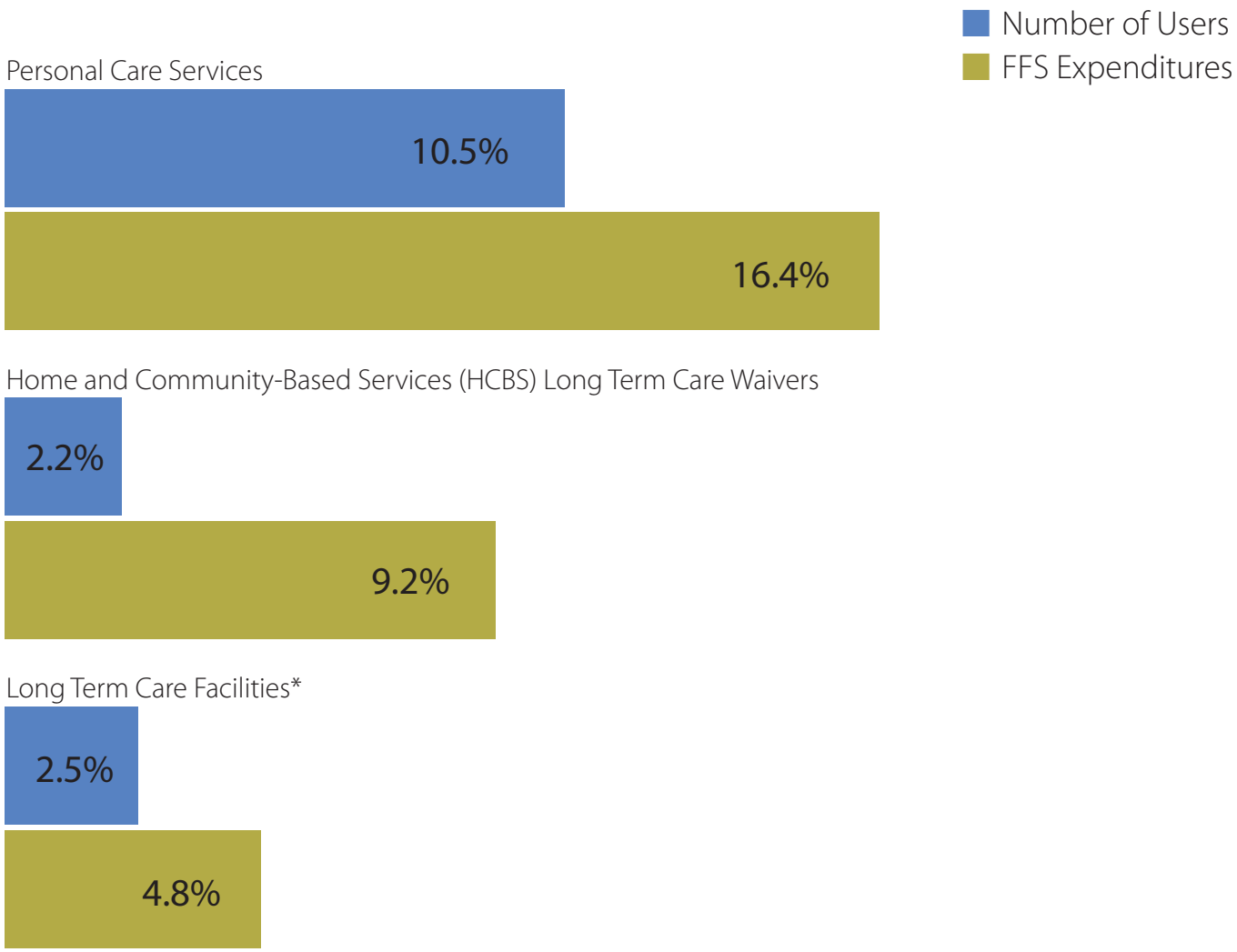
*Home and Community-Based Services

Notes: "Long Term Care Facilities" includes skilled nursing facilities, intermediate care facilities for the developmentally disabled, and state hospitals for the developmentally disabled. "Other" includes rehabilitation, local education authorities, ancillary services (e.g., lab, durable medical equipment, x-ray, and transportation), and some unknown vendors. Among people with disabilities enrolled only in Medi-Cal, per-beneficiary spending on prescription drugs rose at an average annual rate of 8 percent.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS for 12-month periods ending June 30, 2003 and June 30, 2008. Fee-for-service payments for adults with disabilities only.

Among adults with disabilities, spending has grown most rapidly for personal care services (i.e., in-home supportive services). Spending on prescription drugs has dropped because Medicare is now the primary source of drug coverage for beneficiaries with dual eligibility.

Growth of Medi-Cal Long Term Care Users and Spending



*Includes skilled nursing facilities, intermediate care facilities for the developmentally disabled, and state hospitals for the developmentally disabled.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS for July 1, 2002 through June 30, 2003 and July 1, 2007 through June 30, 2008. Fee-for-service payments for adults with disabilities only.

Among adults with disabilities, Medi-Cal spending on long term care services over the past five years has grown fastest for personal care services, driven largely by an increase in the number of beneficiaries using these services.

Looking Ahead

Despite the crucial role Medi-Cal plays in California's health care system, the program faces significant challenges. Chief among these is the continuing rise of health care costs and increasing demand for Medi-Cal coverage during a time when general revenues are declining or stagnating. To slow the growth of Medi-Cal spending, state lawmakers made substantial cuts to Medi-Cal coverage and provider reimbursement in recent years. Were it not for provisions of the federal stimulus bill that provide a temporary enhancement of federal matching funds under Medicaid, lawmakers would likely have made much deeper cuts to Medi-Cal.

Medi-Cal's priorities include:

- Responding to policy changes at the federal level, such as the new emphasis on outreach and enrollment simplification and retention and, potentially, national health reform.
- Negotiating a new five-year hospital financing waiver to support care and coverage for Medi-Cal beneficiaries and the uninsured and maximixe federal funding to California.
- Finding ways to more effectively manage care and measure outcomes for high-cost, fee-for-service beneficiaries.

Principal Data Sources

Medi-Cal MIS/DSS: The NextGen MIS/DSS is a data warehouse containing 10 years of Medi-Cal data from 30 different source systems, which is refreshed each month. Data contained in the MIS/DSS includes paid and denied claims from the Medi-Cal fee-for-service program, encounter data from the managed care and County Organized Health System plans, Short-Doyle (mental health) claims, dental claims, and proxy capitation payments to managed care plans. The system also includes information on providers serving the FFS, managed care, Short-Doyle, and dental programs, as well as various reference data (e.g., ICD-9, HCPCS, and CPT-4 codes). Analysis of MIS/DSS data excludes 1.65 million beneficiaries who received limited family planning benefits through Family PACT in federal fiscal year 2007.

Episode Treatment Groups® (ETG®): ETG comprise an illness classification and episode building methodology that identifies clinically homogenous episodes of care, regardless of treatment location or duration. (The ETG methodology is similar to that of Diagnosis Related Groups [DRGs] but identifies and classifies an entire episode of care irrespective of whether the patient has received medical treatment as an outpatient, inpatient, or both.) Using routinely collected claims or encounter data as input, the ETG software captures the relevant services provided during a patient's treatment and organizes the claims/encounter data into meaningful episodes of care.

Medicaid Statistical Information System (MSIS): All states participating in the Medicaid program submit data on eligibles, beneficiaries, utilization, and payment for services quarterly through the Medicaid Statistical Information System (MSIS). Each state eligible file contains one record for each person covered by Medicaid for at least one day during the reporting quarter. Paid claims files contain information from adjudicated medical service related claims and capitation payments. Public use files containing aggregate information are available to researchers for health care research and evaluation activities, program utilization and expenditures forecasting, and analyses of policy alternatives. Analysis of MSIS data excludes Family PACT beneficiaries.

Kaiser Family Foundation/State Health Facts: Statehealthfacts.org is a project of the Henry J. Kaiser Family Foundation and is designed to provide up-to-date, and easy-to-use health data for all 50 states.

Information for the 2009 *Medi-Cal Facts and Figures* databook was compiled from a number of sources. Detailed reference information is included with each figure. The data sources described here were used to develop multiple facts and figures for this databook.

Acknowledgments

Much of the information and data for this presentation was prepared by The Lewin Group and Ingenix Public Sector Solutions. The Lewin Group delivers objective analyses and strategic counsel in the health and human services industries to prominent public agencies, nonprofit organizations, industry associations, and private companies across the United States. Ingenix Public Sector Solutions is the data warehousing and analytic technology arm of Ingenix, and serves as the prime contractor for the Medi-Cal NexGen Management Information System/Decision Support System (MIS/DSS).

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