

CALIFORNIA HEALTH CARE ALMANAC



Medi-Cal Facts and Figures: A Program Transforms

MAY 2013

Introduction

Medi-Cal, California's Medicaid program, is the main source of health insurance for more than 7 million people, or one in five Californians. It pays providers for essential primary, specialty, acute, and long term care services delivered to children, their parents, pregnant women, seniors, and nonelderly adults with disabilities. In fiscal year 2012–13, Medi-Cal is projected to draw more than \$37 billion in federal funds into the state's health care system and will account for nearly 23% of General Fund spending.

The program is in the midst of a major transformation, as it shifts most enrollees to managed care and prepares for a major expansion due to the Patient Protection and Affordable Care Act (ACA). Enrollment in the program will surge in 2013 as more than 850,000 children transition to Medi-Cal from the Healthy Families Program. Medi-Cal will see an estimated total increase of one million or more enrollees due to the ACA, including 680,000 people in 2014, the first year of Medi-Cal expansion under health reform.

As Medi-Cal evolves, it faces numerous challenges, including ensuring that enrollees have appropriate access to care and controlling health care costs. *Medi-Cal Facts and Figures: A Program Transforms* serves as an up-to-date overview of Medi-Cal, covering program eligibility and enrollment, benefits, service delivery, background on policy issues, budget, and forces that affect the program's costs.

Medi-Cal Facts and Figures

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Note: General Fund spending includes Medi-Cal expenditures reported by all departments, including but not limited to the California Department of Health Care Services (DHCS).

Sources: DHCS, *Medi-Cal Certified Eligible County Pivot Table — Most Recent 24 Months*, www.dhcs.ca.gov. United States Census Bureau, State and County QuickFacts — California, quickfacts.census.gov. DHCS, Fiscal Forecasting and Data Management Branch, *Local Assistance Estimate for Fiscal Years 2011–12 and 2012–13 Management Summary*, May 2012, www.dhcs.ca.gov and *November 2012 Medi-Cal Estimate — Interface with Other Departments, FY2012–13*, March 2013. DHCS, Healthy Families Program (HFP) Transition To Medi-Cal, www.dhcs.ca.gov. UCLA Center for Health Policy and UC Berkeley Labor Center, *Medi-Cal Expansion Under the Affordable Care Act: Significant Increase in Coverage with Minimal Cost to the State*, January 2013, laborcenter.berkeley.edu.

About Medicaid

- Created by Title XIX of the Social Security Act in 1965
- Provides coverage for acute and long term care services to 57 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 operate mandatory program components
- The nation's largest purchaser of health care services, collectively spending more than \$389 billion in federal and state dollars in fiscal year 2010

Medi-Cal Facts and Figures

Overview

Medicaid, a 48-year-old federal/state program that now serves more people than Medicare, is on the verge of major changes and growth as a result of the ACA.

Sources: Centers for Medicare & Medicaid Services (CMS), *CMS Fast Facts*, www.cms.gov. CMS, *Brief Summaries of Medicare and Medicaid: Title XVIII and Title XIX of The Social Security Act, as of December 31, 2012*, www.cms.gov. Kaiser Family Foundation, *United States: Medicaid Spending, FY 2010*, www.statehealthfacts.org.

About Medi-Cal

- The nation's largest Medicaid program, with nearly 2.5 million more enrollees than the next largest state (New York)
- A source of health care coverage for:
 - More than 1 in 5 Californians under age 65
 - 1 in 3 of the state's children
 - The majority of people living with AIDS
- Pays for:
 - 46% of all births in the state
 - 2/3 of all nursing home residents
 - 60% of all net patient revenues in California's public hospitals
- Will bring in \$37 billion in federal funds in FY2012–13

Medi-Cal Facts and Figures

Overview

Medi-Cal is the nation's largest Medicaid program in terms of the number of people served.

Sources: Kaiser Family Foundation, State Health Facts, *Total Medicaid Spending*, June 2011, www.kff.org and *California: Nursing Facilities, 2010*, www.statehealthfacts.org. United States Census Bureau, State and County QuickFacts — California, quickfacts.census.gov. California Health Interview Survey, 2009, www.chis.ucla.edu. California Department of Public Health (CDPH), Office of AIDS, *HIV/AIDS Case Registry Section, Data as of June 30, 2008*, www.cdph.ca.gov. CDPH, *2007 Birth Records*, www.cdph.ca.gov. California Office of Statewide Health Planning and Development, Healthcare Information Division, *Annual Financial Data, 2011*, www.oshpd.ca.gov. California Department of Health Care Services, *Fiscal Forecasting and Data Management Branch, November 2012 Medi-Cal Estimate, FY2012–13*, www.dhcs.ca.gov.

Comparison to Medicare

	MEDI-CAL	MEDICARE
Population	<ul style="list-style-type: none"> • Low-income families and children • People with disabilities • Pregnant women • Seniors (65+) 	<ul style="list-style-type: none"> • Seniors (65+) • People with permanent disabilities
Enrollment	7.6 million Californians	5.0 million Californians
Services Covered	Primary, specialty, acute, and long term care	Primary, specialty, and acute care
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

Medi-Cal Facts and Figures

Overview

Medi-Cal and Medicare provide coverage to different populations, cover different services, and are administered separately. However, there are more than 1.2 million California seniors and people with disabilities who are eligible for both Medi-Cal and Medicare; this population is referred to as dual eligibles.

Sources: California Department of Health Care Services, *Duals Demonstration Project Proposal*, May 31, 2012, www.dhcs.ca.gov. Lewin analysis of Medicaid Statistical Information System (MSIS) data for 12-month period ending September 30, 2011. Centers for Medicare & Medicaid Services (CMS), *Medicare Program — Overview*, www.cms.gov.

Legislative History, Selected Milestones

Medi-Cal Facts and Figures

Overview

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

FEDERAL

- **1965** Passed Medicaid law
- **1972** Required states to extend Medicaid to Supplemental Security Income (SSI) recipients or to seniors and disabled
- **1980** Created Disproportionate Share Hospital (DSH) program
- **1988** Expanded coverage to low-income pregnant women and families with infants
- **1996** Delinked Medicaid and welfare
- **1997** Established State Children's Health Insurance Program and limited DSH payments
- **2006** Required individuals to provide proof of citizenship
- **2009** Expanded coverage to legal immigrants for up to five years
- **2010** State option to provide Medicaid coverage for all individuals under 133% federal poverty level (FPL) at enhanced federal matching rate

CALIFORNIA

- **1966** Created Medi-Cal
- **1973** Established first Medi-Cal managed care plans
- **1982** Created hospital selective contracting program
- **1993** Required most children and parents with Medi-Cal to enroll in managed care plans
- **1994** Began consolidation of mental health services at county level
- **1997** Expanded access to family planning services*
- **1998** Created Healthy Families program for children
- **2000** Extended Medi-Cal to families with incomes at or below 100% FPL
- **2004** Expanded coverage for home and community-based services
- **2010** Expanded coverage for uninsured adults, and required seniors and people with disabilities to enroll in managed care (excluding those with Medicare)
- **2012** Authorized transition of children from Healthy Families to Medi-Cal and expansion of managed care to rural counties

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

Sources: Centers for Medicare & Medicaid Services (CMS), *Medicaid's Milestones*, www.cms.hhs.gov. Committee on Budget and Fiscal Review, *Quick Summary: The Governor's Special Session Reduction Proposals and Proposed 2009 – 10 Budget*, January 6, 2009, www.sen.ca.gov. California Department of Health Care Services (DHCS), *California's Medicaid State Plan (Title XIX)*, 2012, www.dhcs.ca.gov. DHCS, *Description of Medi-Cal Waivers Chart*, August 1, 2008, www.dhcs.ca.gov. DHCS, *Medi-Cal Program Highlights Calendar Year 1997*, Medical Care Statistics Section, December 1998, www.dhcs.ca.gov. DHCS, *California Bridge to Reform: A Section 1115 Waiver Fact Sheet*, November 2010, www.dhcs.ca.gov. DHCS, *2011 Legislative Summary*, 2012, www.dhcs.ca.gov. California HealthCare Foundation, *The Affordable Care Act Implementation Timeline for California*, May 2010, www.chcf.org.

Agencies Governing Medi-Cal

Federal Centers for Medicare & 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 Department

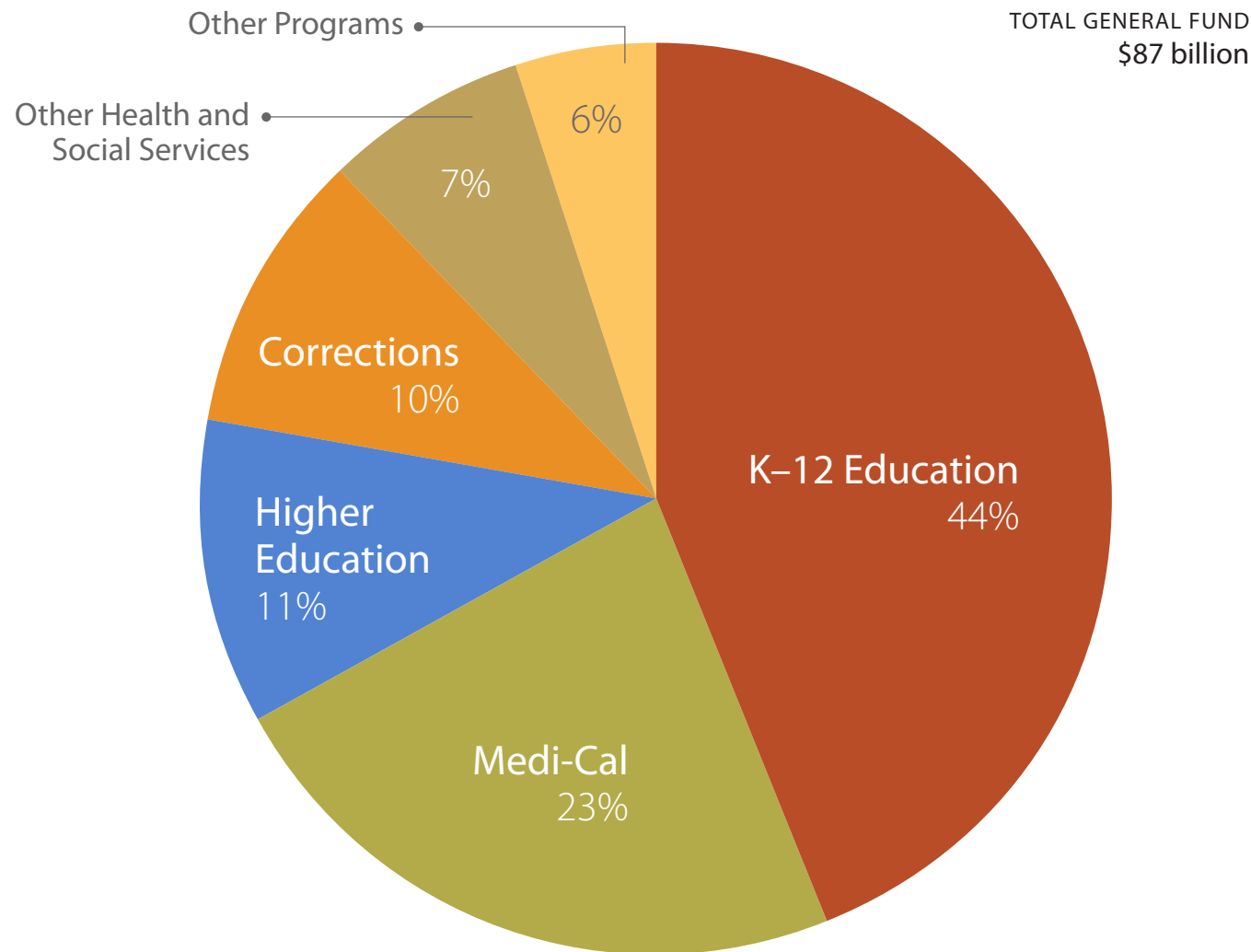
- Conducts eligibility determination
- Oversees enrollment and recertification

Medi-Cal Facts and Figures

Overview

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

State Budget Distribution, FY2012–2013



Notes: Medi-Cal spending estimate includes California Department of Health Care Services (DHCS) local assistance expenditures as well as Medi-Cal spending from other departments. Temporary federal relief provided under the American Recovery and Reinvestment Act (ARRA).

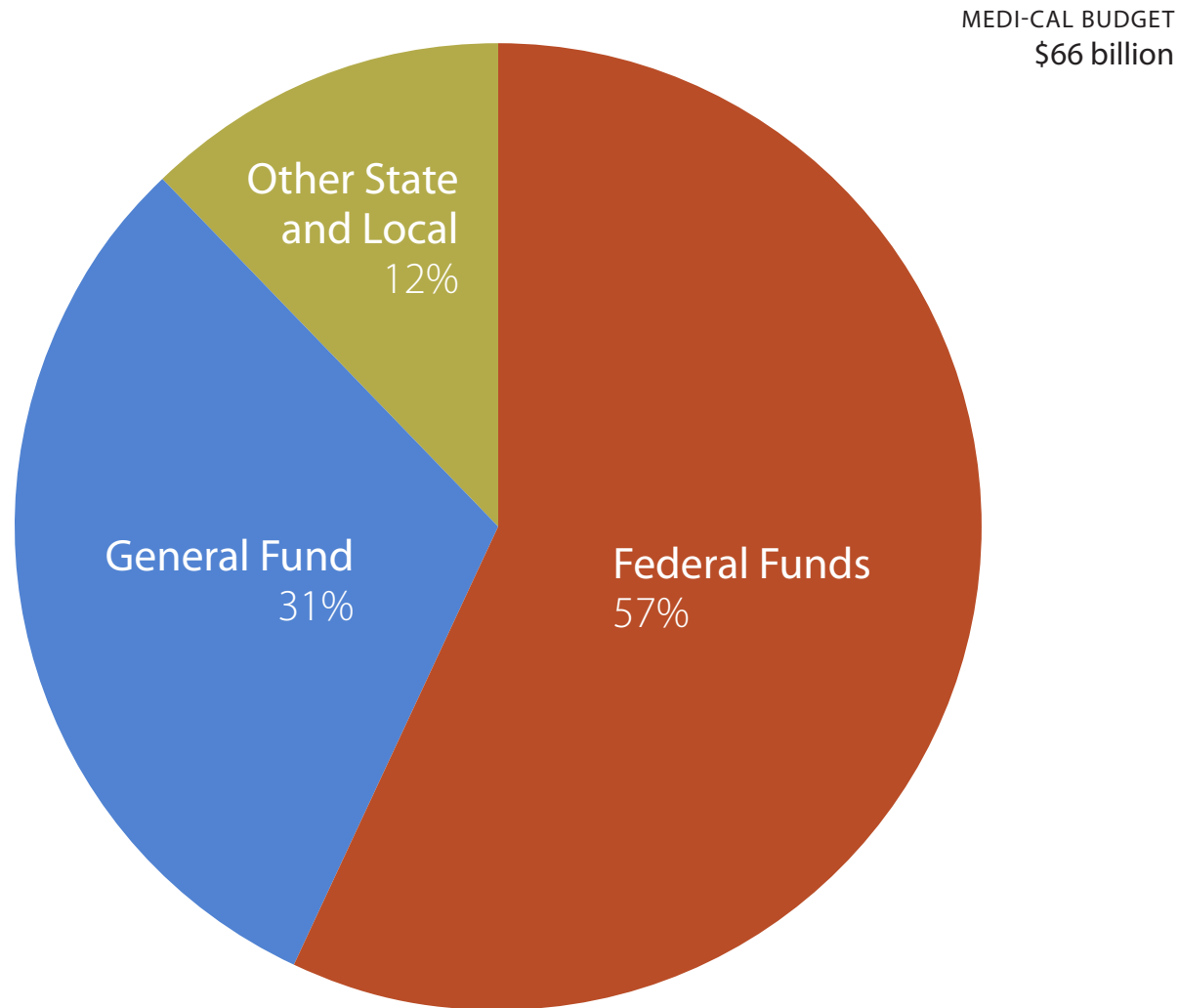
Sources: California Legislative Analyst's Office, *Historical Data, State of California Expenditures, 1984–85 to 2012–13*, www.lao.ca.gov. DHCS, *Local Assistance Estimate Management Summary*, November 2012, www.dhcs.ca.gov. DHCS, Fiscal Forecasting and Data Management Branch, November 2012. *Medi-Cal Estimate — Interface with Other Departments, FY2012–13*. Kaiser Family Foundation, *Medicaid Today: Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013*, October 2012, www.kff.org.

Medi-Cal Facts and Figures

Overview

Medi-Cal accounts for the second largest share of the state's General Fund, behind K-12 education. Over the past four years, the Medi-Cal share of General Fund expenditures jumped from 19% to 23% due to increased enrollment during the economic downturn, the end of temporary federal fiscal relief to states for Medicaid, and spending cuts in other areas of the state budget, among other factors.

Funding Sources, FY2012–2013



Federal funds supply over 50% of Medi-Cal's budget.

Note: Includes California Department of Health Care Service (DHCS) estimate of Medi-Cal spending by other departments.

Sources: DHCS, Local Assistance Estimate Management Summary, November 2012, www.dhcs.ca.gov. DHCS, Fiscal Forecasting and Data Management Branch, November 2012.

Medi-Cal Estimate — Interface with Other Departments, FY2012–13.

Eligibility Factors

- Eligibility for other public assistance programs (see page 11)
- Family income (see page 12)
- Family assets:
 - For families and children under 21; aged, blind, or disabled individuals; and individuals in long term care; the upper limit is \$2,000 for one person and increases with family size.
 - For most beneficiaries in low-income families, the upper limit is \$3,000 for a family of two.
 - 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 (up to age 19) who are under certain levels of federal poverty.
- US citizenship
- California residency
- Resident of a skilled nursing facility or other long term care facility
- Deprivation*

*Deprivation is defined as 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% of FPL (\$19,090 for a family of three in 2012).

Sources: California Department of Health Care Services, *Medi-Cal General Property Limitations*, 2012, www.dhcs.ca.gov. Department of Health and Human Services, *Poverty Guidelines*, 2012, www.aspe.hhs.gov.

Medi-Cal Facts and Figures

Eligibility and Enrollment

Medi-Cal eligibility is based on income, assets, and immigration status, among other factors. Starting in 2014, the ACA simplifies eligibility rules and expands Medicaid coverage (see page 52).

Eligible Groups

MANDATORY	OPTIONAL
States MUST Cover: <ul style="list-style-type: none"> • Low-income families participating in CalWORKs, and those who meet financial standards for AFDC that were in effect in July 1996* • Seniors and people with disabilities participating in the Supplemental Security Income (SSI) program† • Pregnant women and children with family incomes below specified levels • Children receiving foster care and adoption assistance • Certain low-income Medicare beneficiaries 	States MAY Cover: <ul style="list-style-type: none"> • Other pregnant women, children, seniors, and adults with disabilities, based on income levels and family size • 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 who do not meet medically needy deprivation requirements, and certain nursing facility residents, among others (medically indigent) • Children and pregnant women, while eligibility is being determined (accelerated enrollment and presumptive eligibility) • Certain low-income adults under 133% of the federal poverty level not otherwise eligible for Medicaid

*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 & Medicaid Services (CMS), Eligibility, www.medicaid.gov; *New Option for Coverage of Individuals under Medicaid*, www.cms.gov; and *California Bridge to Reform Section 1115 Demonstration Fact Sheet*, www.medicaid.gov.

Medi-Cal Facts and Figures

Eligibility and Enrollment

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

Nonelderly adults without disabilities or dependent children are generally not eligible for Medi-Cal, regardless of income.

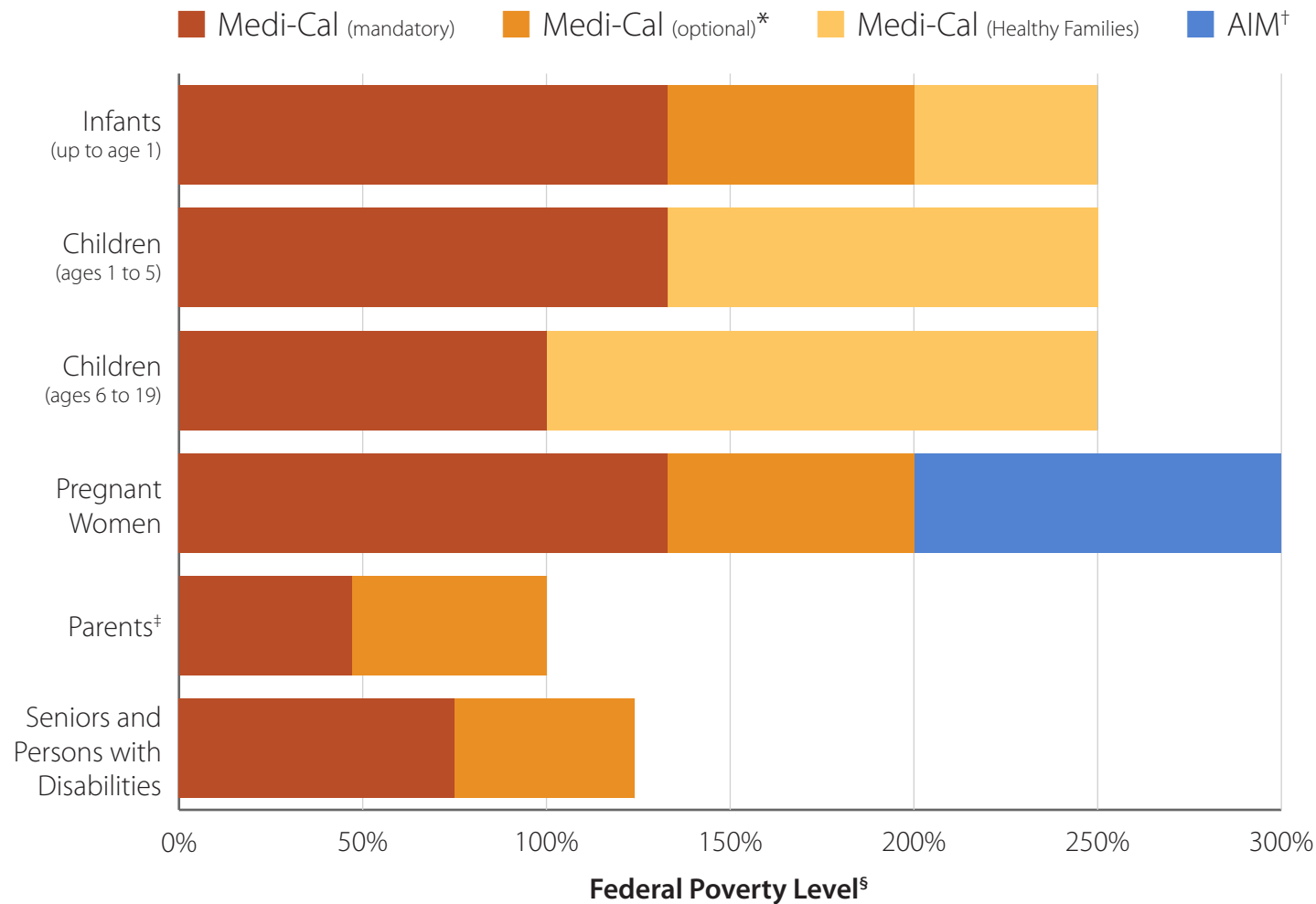
However, the ACA allows states to cover these adults under Medicaid beginning in 2014.

Income Limits

Medi-Cal Facts and Figures

Eligibility and Enrollment

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 Aid to Families with Dependent Children (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% are eligible for Access for Infants and Mothers (AIM). Babies born to mothers enrolled in AIM are eligible for enrollment in Healthy Families (CHIP).

‡Under current Medi-Cal rules, working parents may automatically deduct 6% of earnings, bringing their effective limit to 106% FPL.

§Set at \$19,530 for a family of three for the period beginning April 1, 2013 and ending March 31, 2014.

Sources: Centers for Medicare & Medicaid Services (CMS), Eligibility, www.medicaid.gov. Health Consumer Alliance, *Medi-Cal/Healthy Families Income Levels*, www.healthconsumer.org. Foundation for Health Coverage Education, *Federal Poverty Levels*, www.coverageforall.org. Social Security Administration's, *Income Limit Rates*, www.ssa.gov. AIM, *Income Guidelines*, www.aim.ca.gov.

Immigrant Coverage

Immigrants may be eligible for Medi-Cal if they meet categorical, financial, and residency requirements. For those who meet these requirements:

- Full-scope Medi-Cal, with federal matching funds, is available to lawful permanent residents, including legal immigrant children and pregnant women during their first five years in the country,* 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.‡

*The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) overrides the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which denied legal immigrants access to public assistance during their first five years.

†Permanent Residence Under Color of Law (PRUCOL) is not an immigration status but a public benefits eligibility category; PRUCOL individuals are not US citizens, but they are considered to have the same rights as legal residents for welfare eligibility purposes. 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*, 2005, www.wclp.org. H.R. 2 Child Health Insurance Program Reauthorization Act of 2009, passed on February 4, 2009, www.gpo.gov. Centers for Medicare & Medicaid Services (CMS), *State Health Official Letter 09-002, Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)*, April 17, 2009, www.cms.hhs.gov. National Health Law Program, Chapter 14, "Medi-Cal Services for Immigrants, Including Non-Citizens and Undocumented Immigrants," *Medi-Cal Overview*, 2008, www.healthconsumer.org.

Medi-Cal Facts and Figures

Eligibility and Enrollment

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

Individual Application Process

- **Automatic.** For those receiving SSI or SSP, CalWORKs, Refugee Assistance, Foster Care or Adoption Assistance, or In-Home Supportive Services, Medi-Cal coverage is automatic.
- **In person.** 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.
- **Temporary.** Doctors can request immediate temporary coverage for pregnant women and children while they apply for the program.
- **Mail in.** Pregnant women, children, and adults may also apply for Medi-Cal using a mail-in application.
- **Online.** Medi-Cal applications can be initiated electronically using the benefitscal.org website which links applicants to one of three county eligibility systems. Most applicants will be required to follow up in person or by phone with county eligibility offices.
- **Assistance.** Medi-Cal applications can also be submitted with the assistance of trained certified application assisters; many work at community-based organizations.

Medi-Cal Facts and Figures

Eligibility and Enrollment

The Medi-Cal application process varies based on the individual's circumstances and preferences. The majority of applicants apply in person at county offices.

Notes: SSI is the Supplemental Security Income program. SSP is the State Supplementary Payment program. CalWORKs is the California Work Opportunity and Responsibility to Kids program.

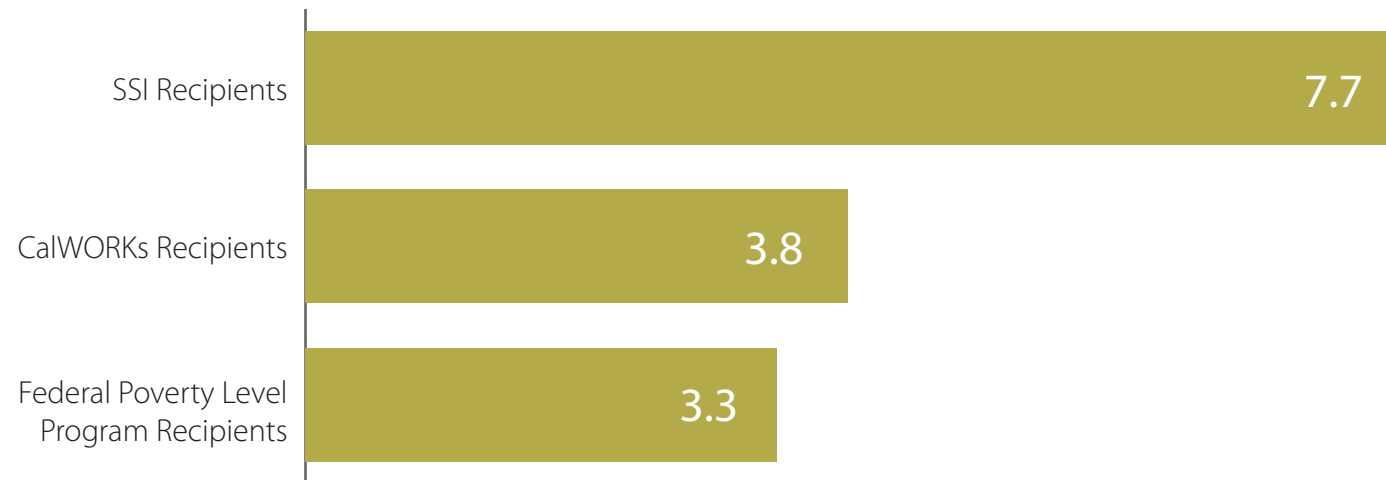
Sources: California Department of Health Care Services (DHCS), *Do You Qualify for Medi-Cal Benefits?* www.dhcs.ca.gov. DHCS, *Medi-Cal — How to Apply*, www.dhcs.ca.gov.

Continuity of Coverage

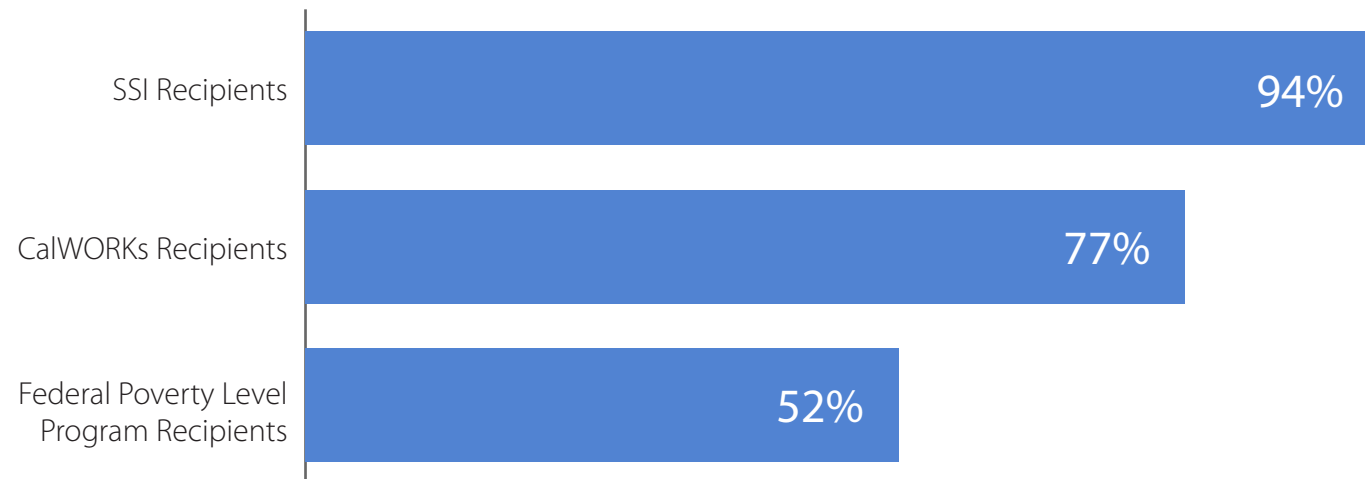
Medi-Cal Facts and Figures

Eligibility and Enrollment

AVERAGE LENGTH OF CONTINUOUS ENROLLMENT (IN YEARS)



PERCENTAGE CONTINUOUSLY ENROLLED FOR ONE YEAR OR MORE



The average length of Medi-Cal enrollment is about 4.5 years; seniors and people with disabilities receiving SSI are enrolled for more than seven years, on average.

However, many enrollees, particularly low-income families not enrolled in CalWORKs, maintain coverage for less than a year.

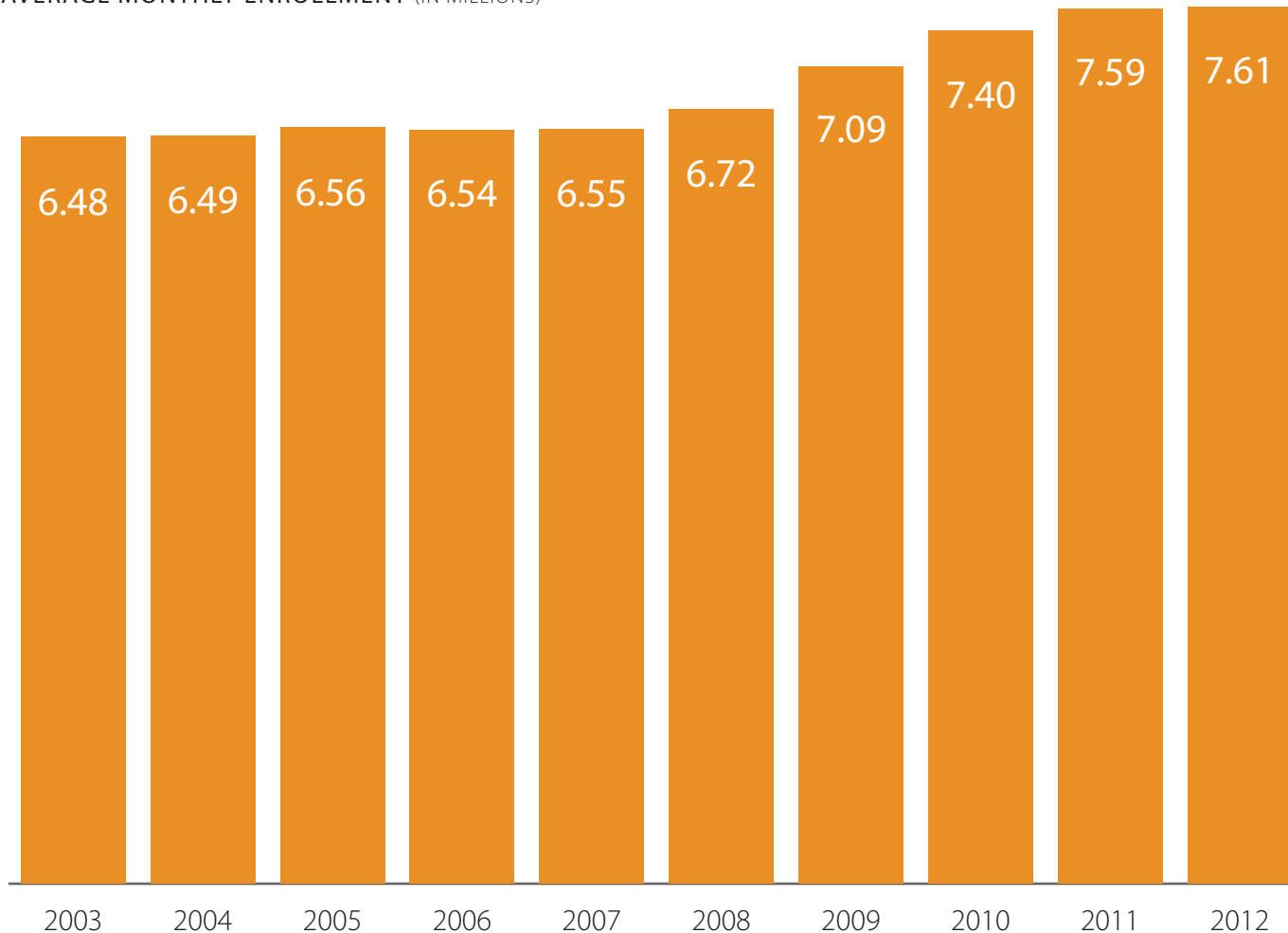
Notes: For enrollment length, SSI (Supplemental Security Income) recipients reflect seniors and disabled enrollees receiving public assistance; CalWORKs (California Work Opportunity and Responsibility to Kids) recipients reflect other enrollees receiving public assistance, and Federal Poverty Level Program Recipients reflect enrollees categorized as Medically Needy. Sources: California Department of Health Care Services, Research and Analytic Studies Section, *Average Months of Continuous Enrollment, as of January 1, 2011*, www.dhcs.ca.gov. Lewin/Ingenix analysis of Medi-Cal MIS/DSS for the 12-month period ending June 30, 2008.

Enrollment Trends, 2003 to 2012

Medi-Cal Facts and Figures

Eligibility and Enrollment

AVERAGE MONTHLY ENROLLMENT (IN MILLIONS)



Medi-Cal enrollment remained relatively flat in 2012, after several years of growth due to the recession.

Note: Enrollment estimates are for the month of July of each fiscal year.

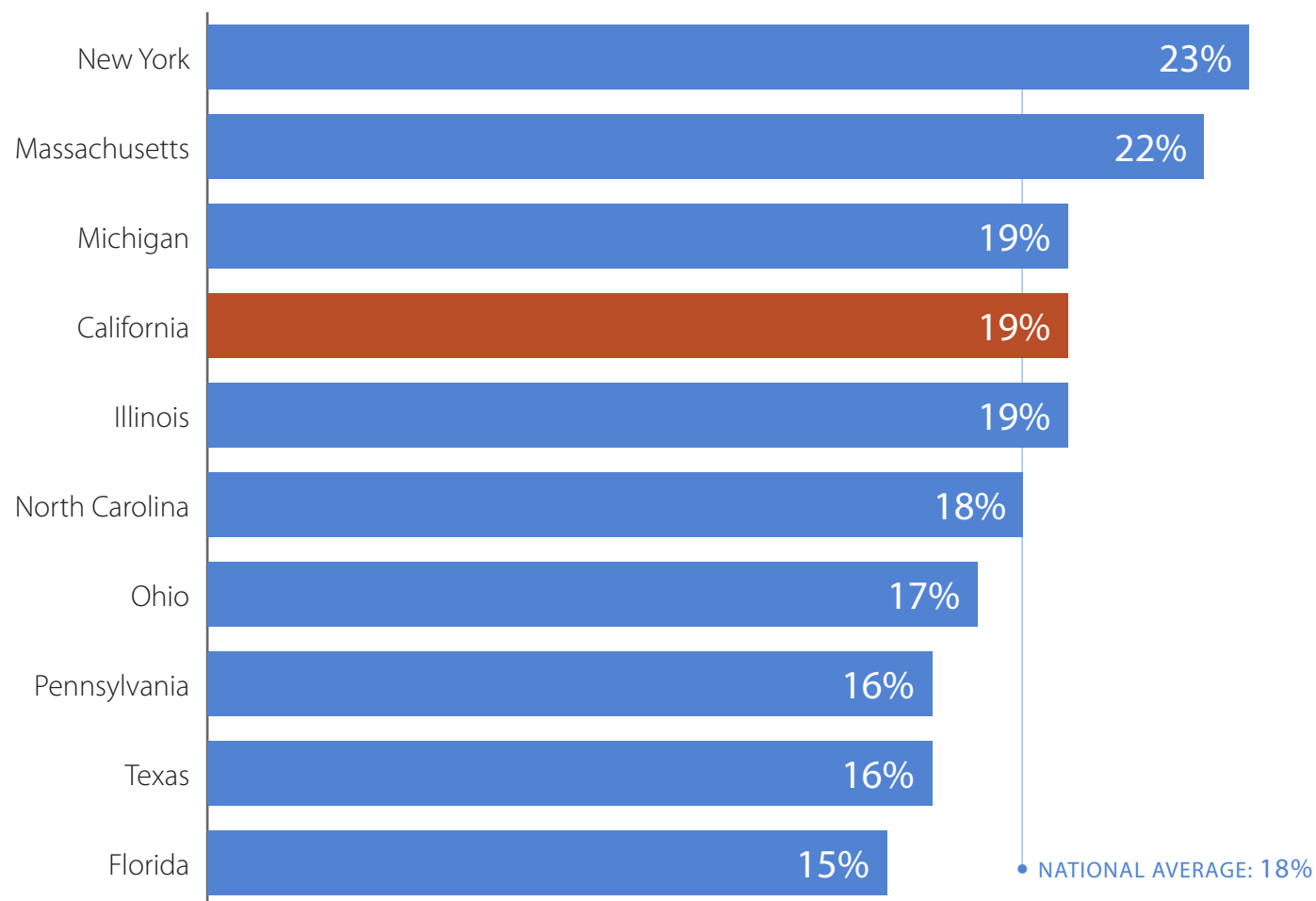
Sources: California Department of Health Care Services (DHCS), *Medicaid Certified Eligible County Pivot Table — Most Recent 24 Months*, www.dhcs.ca.gov. DHCS, *Trend in Medi-Cal Enrollment by Aid Category, for Fiscal Year 2003–2011*, www.dhcs.ca.gov.

Enrollment Compared to Other States, 2010–2011

Medi-Cal Facts and Figures

Eligibility and Enrollment

NONELDERLY POPULATION COVERED BY MEDICAID



The share of California's population enrolled in Medicaid (19%) is similar to the national average (18%).

Notes: States with the 10 largest Medicaid programs based on FY2009 expenditures are represented along with the national average. Medicaid Statistical Information System (MSIS) spending data exclude Disproportionate Share Hospital payments, other supplemental payments to providers, Medicare premium payments, administrative expenses, and accounting adjustments.

Sources: Kaiser Family Foundation, State Health Facts, *Health Insurance Coverage of Nonelderly 0–64 (2010–2011)*, www.statehealthfacts.org.

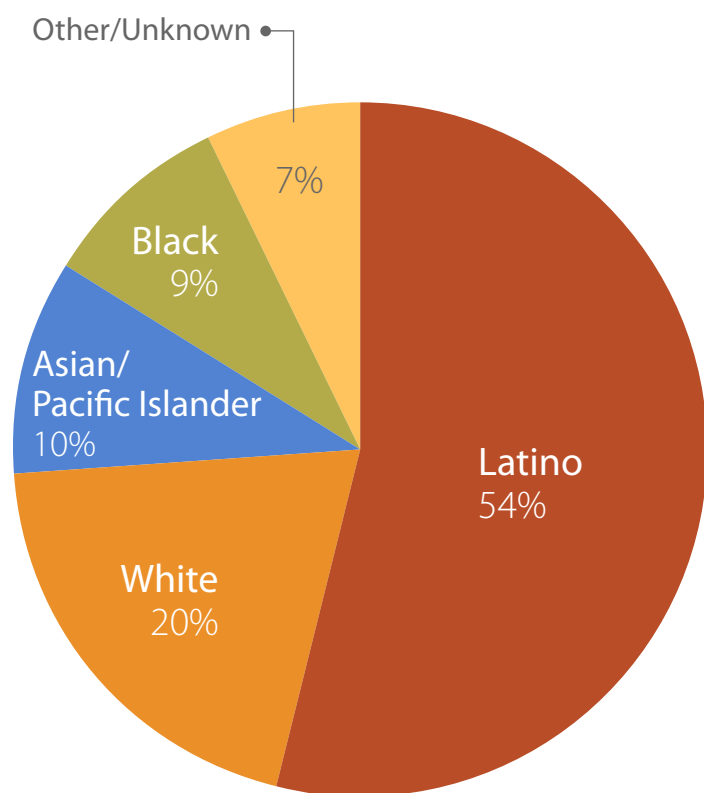
Beneficiary Profile, by Ethnicity and Primary Language, 2011

Medi-Cal Facts and Figures

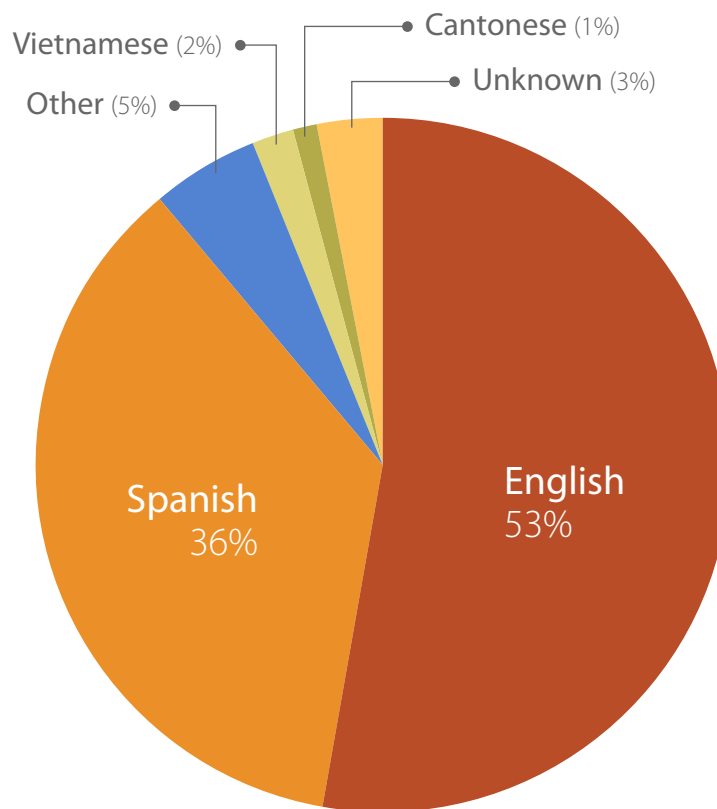
Eligibility and Enrollment

Latinos make up more than half of Medi-Cal enrollees. More than 40% of beneficiaries speak a primary or preferred language other than English.

Ethnicity



Primary Language



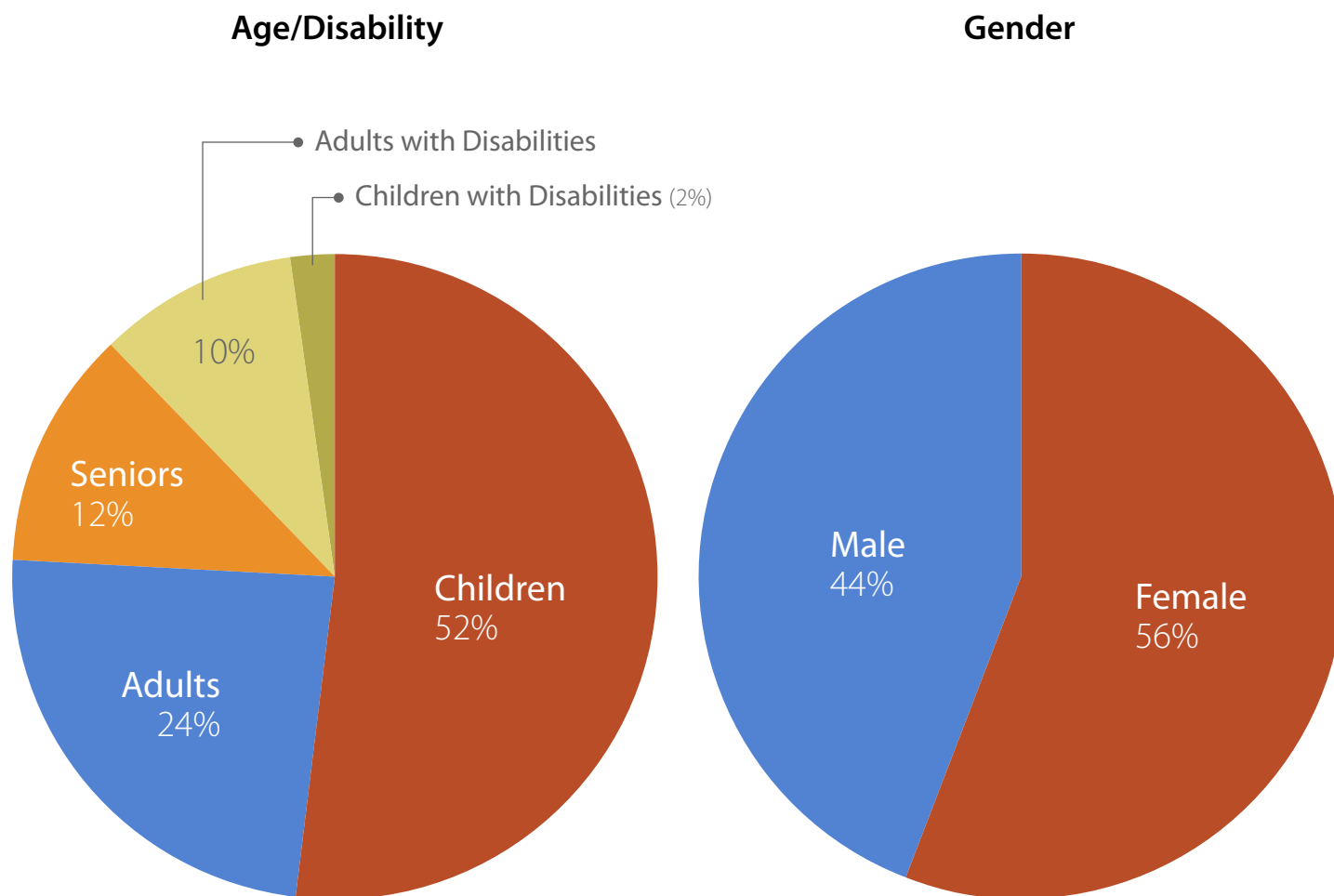
Sources: California Department of Health Care Services (DHCS), Research and Analytic Studies Section, *Population Distribution by Ethnicity, July 2011*, www.dhcs.ca.gov. DHCS, Research and Analytic Studies Section, *Population Distribution by Language, July 2011*, www.dhcs.ca.gov.

Beneficiary Profile, by Age/Disability and Gender, 2011

Medi-Cal Facts and Figures

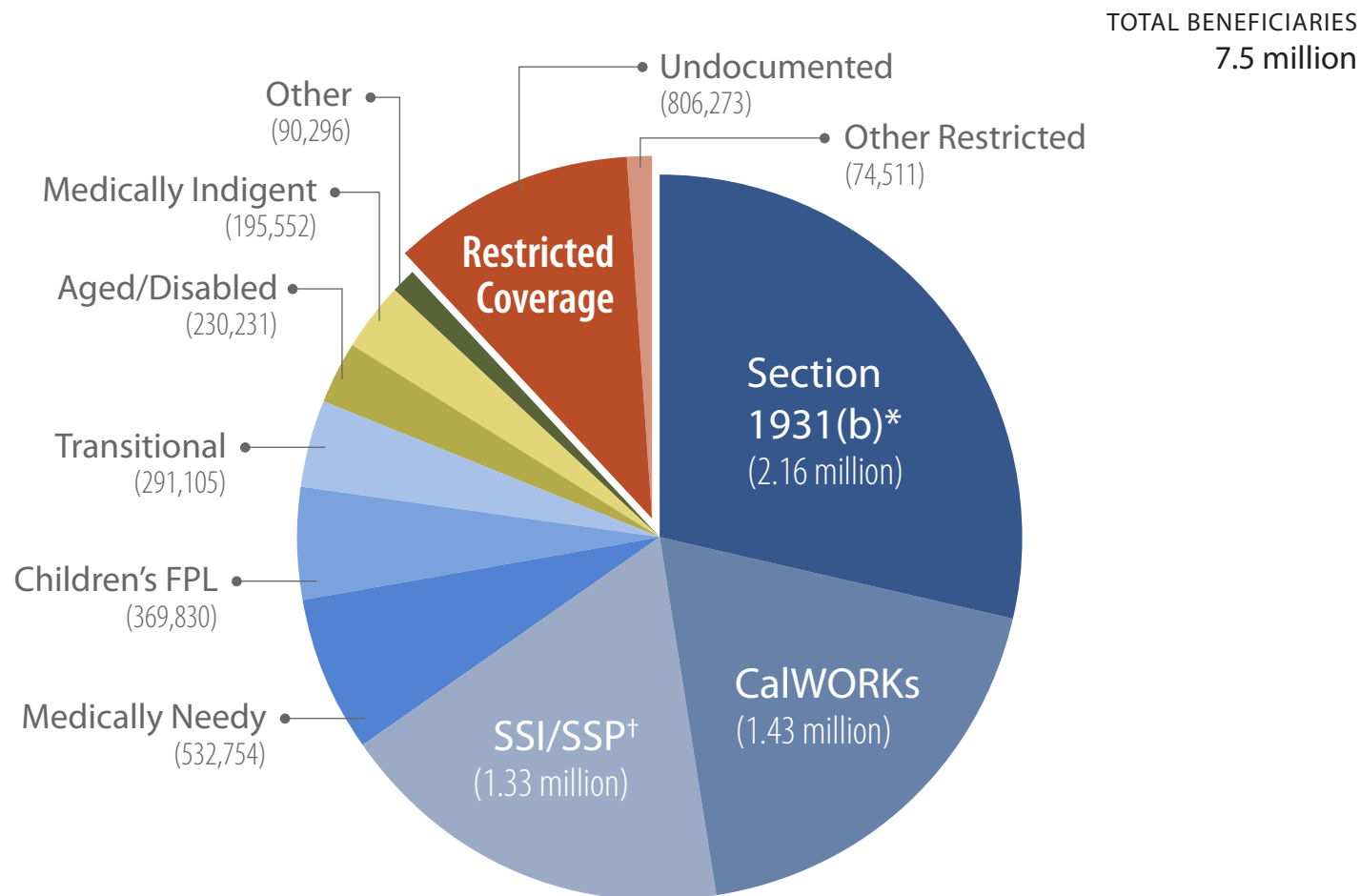
Eligibility and Enrollment

Children account for more than half of Medi-Cal beneficiaries. The majority of Medi-Cal beneficiaries are female.



Sources: California Department of Health Care Services, Research and Analytic Studies Section, *Population Distribution by Gender, July 2011*, www.dhcs.ca.gov. Lewin analysis of Medicaid Statistical Information System (MSIS) data for 12-month period ending September 30, 2011.

Enrollment, by Program, FY2010–2011



*1931(b): 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. 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 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 persons.

Notes: For more information about Medi-Cal eligibility groups, see California HealthCare Foundation, *The Guide to Medi-Cal Programs*, 2006, www.chcf.org. Segments may not add to total due to rounding. FPL is federal poverty level.

Sources: California Department of Health Care Services (DHCS), Research Analytical Studies Section, *Medi-Cal Member Months Aid Code Pivot Tables, July 2010–June 2011*, www.dhcs.ca.gov. Excludes 1.8 million Family Family Planning, Access, Care, and Treatment (PACT) beneficiaries. DHCS, *Local Assistance Estimate Caseload Tab*, May 2012, www.dhcs.ca.gov. DHCS, *Aid Codes Master Chart*, files.medi-cal.ca.gov.

Medi-Cal Facts and Figures

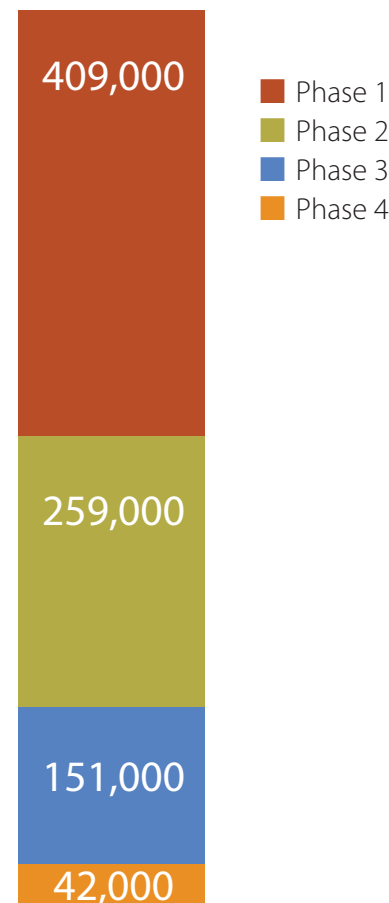
Eligibility and Enrollment

Individuals with full-scope coverage account for 88% of Medi-Cal enrollees, while those whose coverage is restricted to emergency and certain other services account for 12%. Families eligible through the Section 1931(b) category account for the largest share of full-scope enrollees. Undocumented immigrants account for the largest share of restricted-scope enrollees.

Healthy Families to Medi-Cal Transition

Starting January 1, 2013, California stopped enrolling children (other than babies enrolled in AIM) in Healthy Families. These children are now being enrolled in Medi-Cal. At the same time, the state began a phased transition of current Healthy Families enrollees to Medi-Cal.

- **Phase 1 (completed).** Approximately 409,000 children enrolled in a Healthy Families plan that is also a Medi-Cal managed care plan in the same county.
- **Phase 2 (no sooner than April 2013).** Approximately 259,000 children enrolled in a Healthy Families plan that is a subcontractor to a Medi-Cal managed care plan in the same county.
- **Phase 3 (no sooner than August 2013).** Approximately 151,000 children enrolled in a Healthy Families plan that is neither a Medi-Cal managed care plan nor a subcontractor to one in the child's county.
- **Phase 4 (no sooner than September 2013).** Approximately 42,000 children residing in a county where Medi-Cal managed care is not currently offered, provided that Medi-Cal completes a successful expansion of managed care to rural counties.



Medi-Cal Facts and Figures

Eligibility and Enrollment

More than 800,000 children will be transitioned from Healthy Families to Medi-Cal. Many of these children will be able to retain the same health plan and doctors, while others will have to choose a different plan and find new providers.

Note: AIM is the Access for Infants and Mothers program.

Source: California Health and Human Services Agency, *Healthy Families Program Transition to Medi-Cal Strategic Plan*, October 2012, www.dhcs.ca.gov.

Medi-Cal Benefits*

Medi-Cal Facts and Figures

Benefits and Cost Sharing

REQUIRED SERVICES	OPTIONAL SERVICES
<ul style="list-style-type: none"> • 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 • Federally Qualified Health Centers (FQHC) and other clinics • Certified midwife • Certified nurse practitioner • Nursing home care for adults over 21 • Home health services[†] • Certified midwife and nurse midwife services • Pregnancy-related services, including 60-days postpartum care • Tobacco cessation for pregnant women 	<ul style="list-style-type: none"> • Prescription drugs • Medical equipment and supplies • Targeted case management • 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 therapies • Hospice • Occupational therapy • Vision services and eyeglasses[‡] • Dental care and dentures[‡] • Audiology and speech therapy[‡] • Chiropractic[‡] • Psychology services[‡] • Acupuncture[‡] • Podiatric[‡]

All state Medicaid programs are federally required to provide specific benefits and may also receive federal matching funds for certain optional benefits.

*Partial list; effective July 1, 2009.

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

‡As of July 2009, these benefits are only covered for Medi-Cal beneficiaries who are under 21 years of age (through EPSDT) or who reside in a nursing facility.

Sources: Centers for Medicare & Medicaid Services, *Medicaid Benefits*, www.medicaid.gov. California Department of Health Care Services, *California Medicaid State Plan*, www.dhcs.ca.gov.

Cost Sharing

Medi-Cal Facts and Figures

Benefits and Cost Sharing

CURRENT MEDI-CAL POLICY*	PROPOSED RULE [†]
Beneficiaries are sometimes charged copayments for selected services; however, providers are not allowed to refuse service for lack of payment.	States would be permitted to allow providers to refuse service for lack of payment. [‡]
Common copayment amounts are: <ul style="list-style-type: none"> Physician office visit: \$1 Nonemergency services received in an emergency room: \$5 Drug prescription or refill: \$1 	Allowable copayment amounts would be increased based on the beneficiary's income level and type of service. For people with higher incomes, states could require a beneficiary to pay a portion (e.g., 20%) of what the state agency pays for the service, as long as the beneficiary's total costs within a period do not exceed an aggregate cap (i.e., 5% of family income).
Several groups of beneficiaries are exempt from copayments, including children 18 and younger or living in foster care, and, in general, pregnant women and institutionalized individuals.	States would be allowed to apply cost sharing for nonemergency services received in an emergency room to all individuals, including individuals otherwise exempt from cost sharing.
Copayment amounts do not apply to emergency services or family planning services.	No change is proposed to this rule.

Federal law currently allows nominal cost sharing, with exemptions for certain services and populations. In January 2013, the Centers for Medicare & Medicaid Services (CMS) proposed new rules that would allow greater state flexibility to impose premiums and cost sharing for individuals with higher income.

*For any prescription, refill, visit, service, device, or item for which the program's payment is \$10 or less, providers cannot require copayment.

†Amounts allowed under proposed federal rules.

‡Refusing service is allowed under current federal law. The California legislature has amended state law to implement this option once California's proposal to increase cost sharing is approved by the federal government.

Sources: WIC Code Sections 14132 and 14134 and WIC Codes Sections 24000–24027, www.leginfo.ca.gov. California Department of Health Care Services, *California Medicaid State Plan*, www.dhcs.ca.gov. Department of Health and Human Services, Proposed Rule, *Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing*. 78 Federal Register, (January 22, 2013), p. 4,593–4,724, federalregister.gov.

Medi-Cal Waivers

	1915(B)	1915(C)	1115
Purpose	Allow states to limit an individual's choice of provider	Allow states to provide long term care services in community settings	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)
Examples (number of beneficiaries)	Specialty Mental Health Services (425,710)	Home- and Community-Based Services (HCBS) for Persons with Developmental Disabilities (92,000) In-Home Operations (140) AIDS (2,371) Assisted Living (16,335) Multipurpose Senior Services Program (1,560) Pediatric Palliative Care (70)	Bridge to Reform (4,910,963)

Medi-Cal Facts and Figures

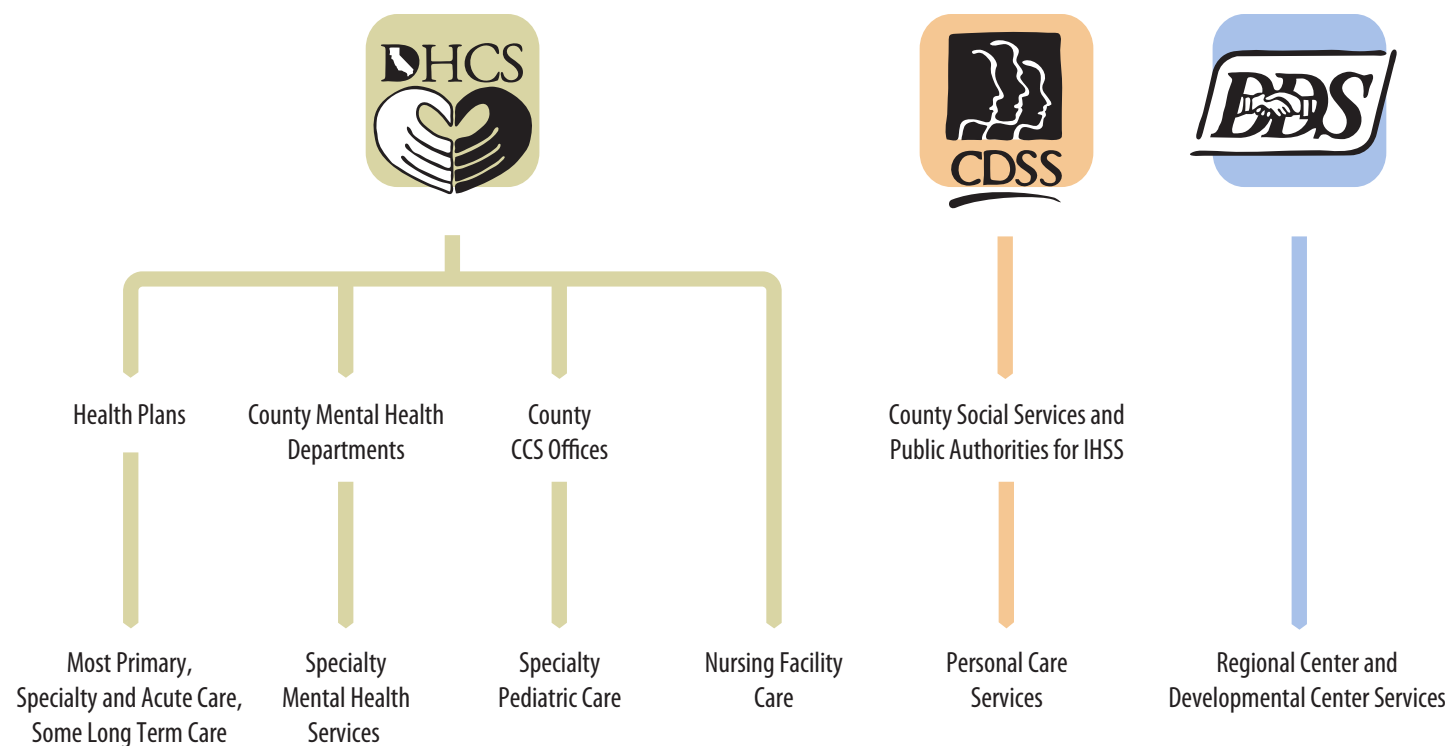
Benefits and Cost Sharing

States may use statutory authority to waive certain Medicaid rules, subject to federal approval.

Medi-Cal operates 11 waiver programs, including the 2010 Bridge to Reform waiver that includes the majority of Medi-Cal enrollees.

Sources: Centers for Medicare & Medicaid Services (CMS), *Medicaid Waivers and Demonstrations List*, www.medicaid.gov. California Department of Health Care Services, Medi-Cal Benefits, Waiver Analysis, and Rates Division, *Semi-Annual Update to the Legislature: Senate Bill (SB) 853, Section 173 (Committee on Budget and Fiscal Review Chapter 717, Statutes of 2010)*, *California's Medicaid Waivers*, March 2012, www.dhcs.ca.gov.

Multiple Delivery Systems



Medi-Cal Facts and Figures

Delivery Systems

Medi-Cal services are financed and administered through an array of state departments and local intermediaries.

Notes: CDSS is the California Department of Social Services. DDS is the California Department of Developmental Services. CCS is California Children's Services program for children with special health care needs. Public Authorities are the employers of record and maintain a provider registry for individuals eligible for personal care services through the In-Home Supportive Services (IHSS) program. Developmental Centers (for facility-based care) and Regional Centers (for community-based care) serve individuals with developmental disabilities. This is not a complete list of services provided by Medi-Cal. The budgets of other departments (e.g., Aging, Corrections, Public Health) also include some general fund spending for Medi-Cal services.

Managed Care vs. Fee-for-Service

	MANAGED CARE	FEE-FOR-SERVICE
Availability	30 counties	All 58 counties
Market Share (March 2013)	69% of all beneficiaries	31% of all beneficiaries
Population	Mandatory enrollment: <ul style="list-style-type: none"> • Children • Pregnant women • Parents • Seniors and people with disabilities not covered by Medicare Voluntary enrollment (in some counties): <ul style="list-style-type: none"> • Seniors and people with disabilities who are dually eligible for Medicare • Foster children 	Counties without managed care (28): All beneficiaries Counties with managed care (30): <ul style="list-style-type: none"> • Family PACT beneficiaries • Other beneficiaries without full-scope Medi-Cal, including those who have Medicare or other insurance • Beneficiaries who have received a medical exemption
Expenditures (FY2011)	26%	74%
Covered Services	Most primary, specialty, and acute care services covered by Medi-Cal, excluding those described under fee-for-service in counties with managed care	Counties without managed care (28): All Medi-Cal services Counties with managed care (30): Most long term care, mental health and dental services, and services provided to children with serious conditions through the California Children's Services (CCS) program [†]
Payment	The state pays plans a fixed monthly capitation rate for each member. Plans negotiate payment rates with most contracted network providers.	The state pays providers according to a fee schedule.
Carve Outs	<ul style="list-style-type: none"> • Mental health • Most long term care • Dental • CCS for the seriously ill and disabled 	N/A

Note: Family PACT is the Family Planning, Access, Care and Treatment Program.

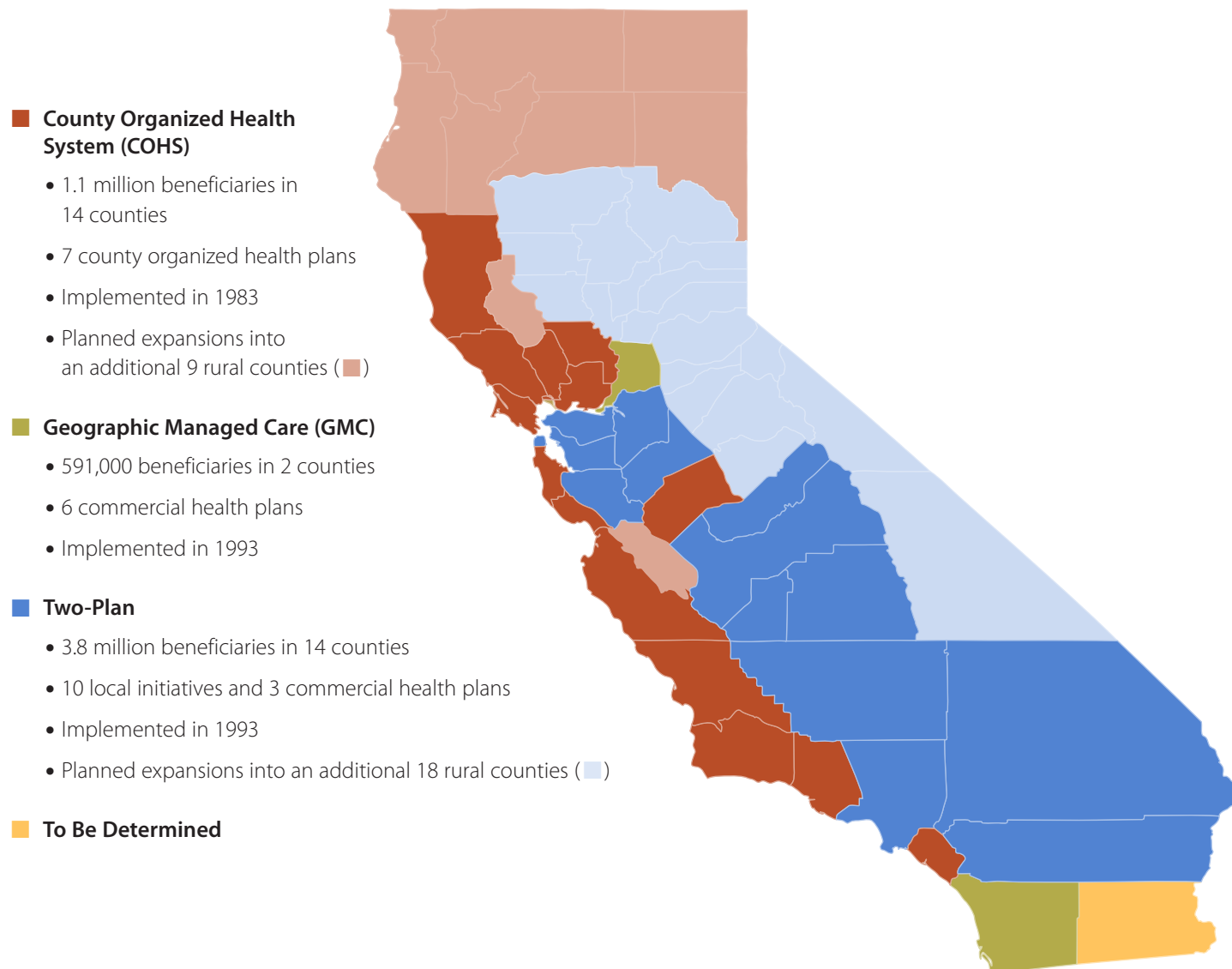
Sources: California Department of Health Care Services (DHCS), *Medi-Cal May 2012 Local Assistance Estimate for FY 2011–2012*, May 2012, www.dhcs.ca.gov. DHCS, *Medi-Cal Managed Care Enrollment Report*, March 2013, www.dhcs.ca.gov. DHCS, *Medi-Cal Managed Care Program Fact Sheet*, October 2012, www.dhcs.ca.gov.

Medi-Cal Facts and Figures

Delivery Systems

Most Medi-Cal beneficiaries are in managed care plans, but managed care spending accounts for only one-quarter of total Medi-Cal service spending, largely because many services are carved out of managed care. In counties with managed care, most seniors and people with disabilities were required to enroll in managed care plans beginning in June 2011.

Managed Care Models, by County, April 2013



Medi-Cal Facts and Figures

Delivery Systems

California has a unique system of managed care, with three different models operating across 30 counties, covering about 65% of the total Medi-Cal population. Beginning in September 2013, the state will expand managed care to the 28 rural counties that currently operate fee-for-service delivery systems using the Two-Plan and County Organized Health System models.

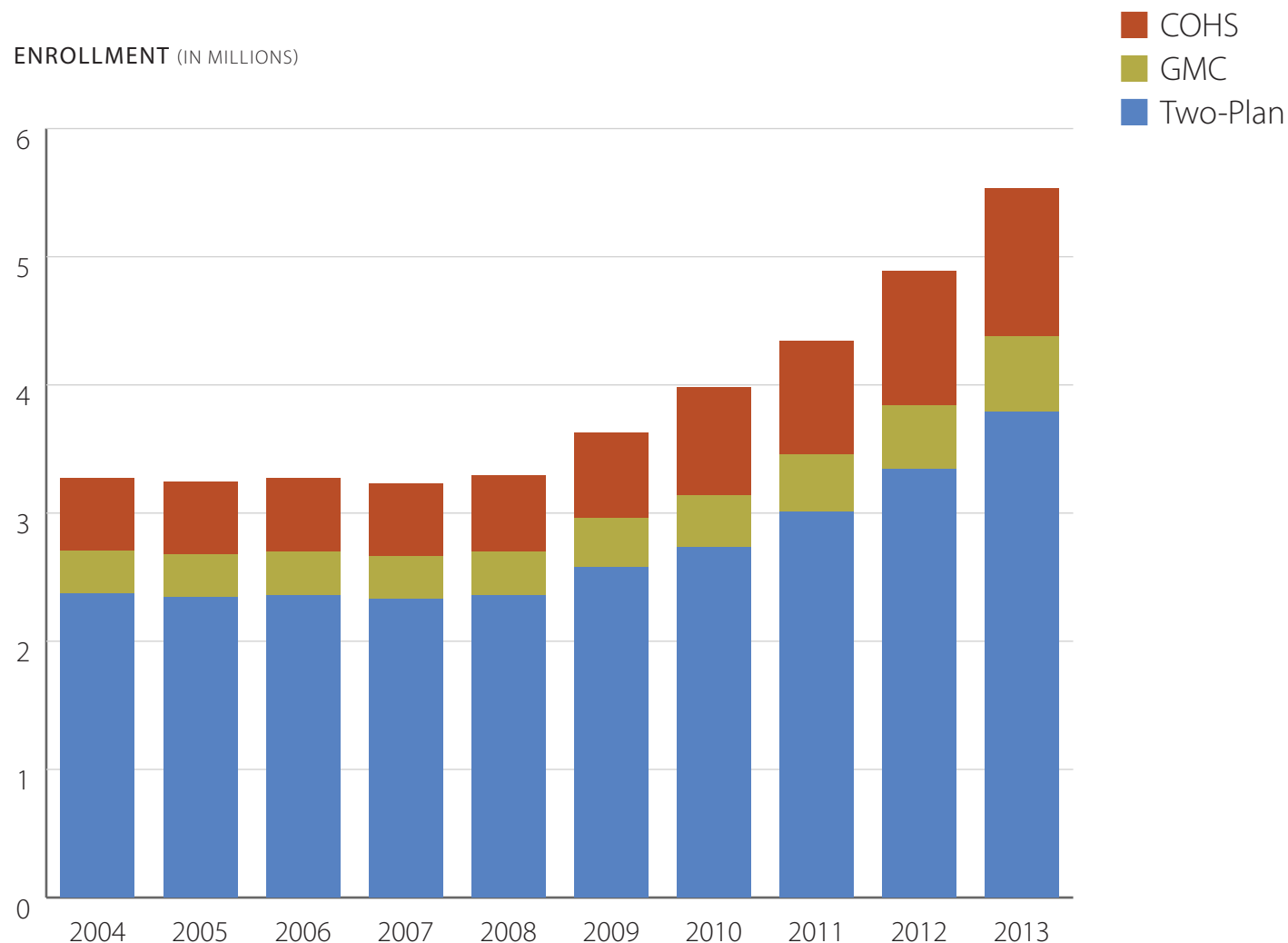
Sources: California Department of Health Care Services (DHCS), *Medi-Cal Managed Care Program Fact Sheet*, October 2012, www.dhcs.ca.gov.
DHCS, *Medi-Cal Managed Care Enrollment Report*, April 2013, www.dhcs.ca.gov.

Managed Care Enrollment Trends, 2004 to 2013

Medi-Cal Facts and Figures

Delivery Systems

ENROLLMENT (IN MILLIONS)



Managed care enrollment has increased 50% over the past five years.

Notes: COHS is County Organized Health System; GMC is Geographic Managed Care.

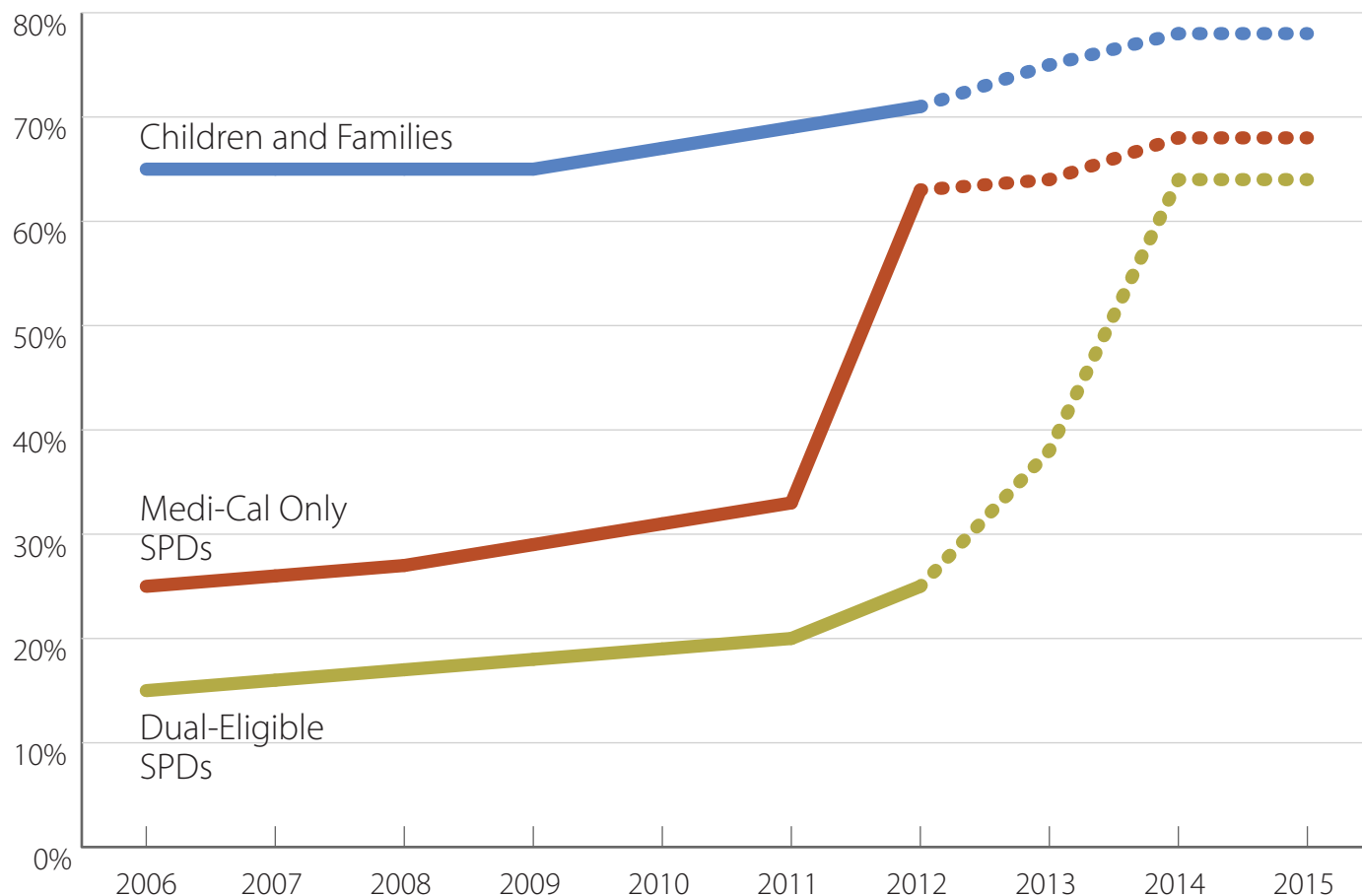
Sources: Data for 2004–2008 figures: Lewin/Ingenix analysis of MIS/DSS data for 12-month periods ending June 30, 2004, through June 30, 2008. Data for 2009–2012 (June) and 2013 (April) figures: California Department of Health Care Services, *Medi-Cal Managed Care Enrollment Reports*, www.dhcs.ca.gov.

Managed Care Enrollment Trends, by Group, 2006 to 2015

Medi-Cal Facts and Figures

Delivery Systems

PERCENTAGE OF BENEFICIARIES ENROLLED IN MEDI-CAL MANAGED CARE



Note: Projections (shown by dotted lines) do not account for expansion of Medi-Cal enrollment beginning in January 2014 as a result of the Affordable Care Act. SPDs are seniors and persons with disabilities.

Source: California Legislative Analyst Office, *Cal Facts 2013*, www.lao.ca.gov.

The proportion of Medi-Cal beneficiaries enrolled in managed care jumped in 2011, as California transitioned many seniors and persons with disabilities from fee-for-service into managed care. Enrollment in Medi-Cal managed care will increase even more as the program expands to 28 rural counties, while California's Coordinated Care Initiative will test new managed care models for people eligible for both Medicare and Medicaid.

Managed Care Penetration, by Medicaid Spending

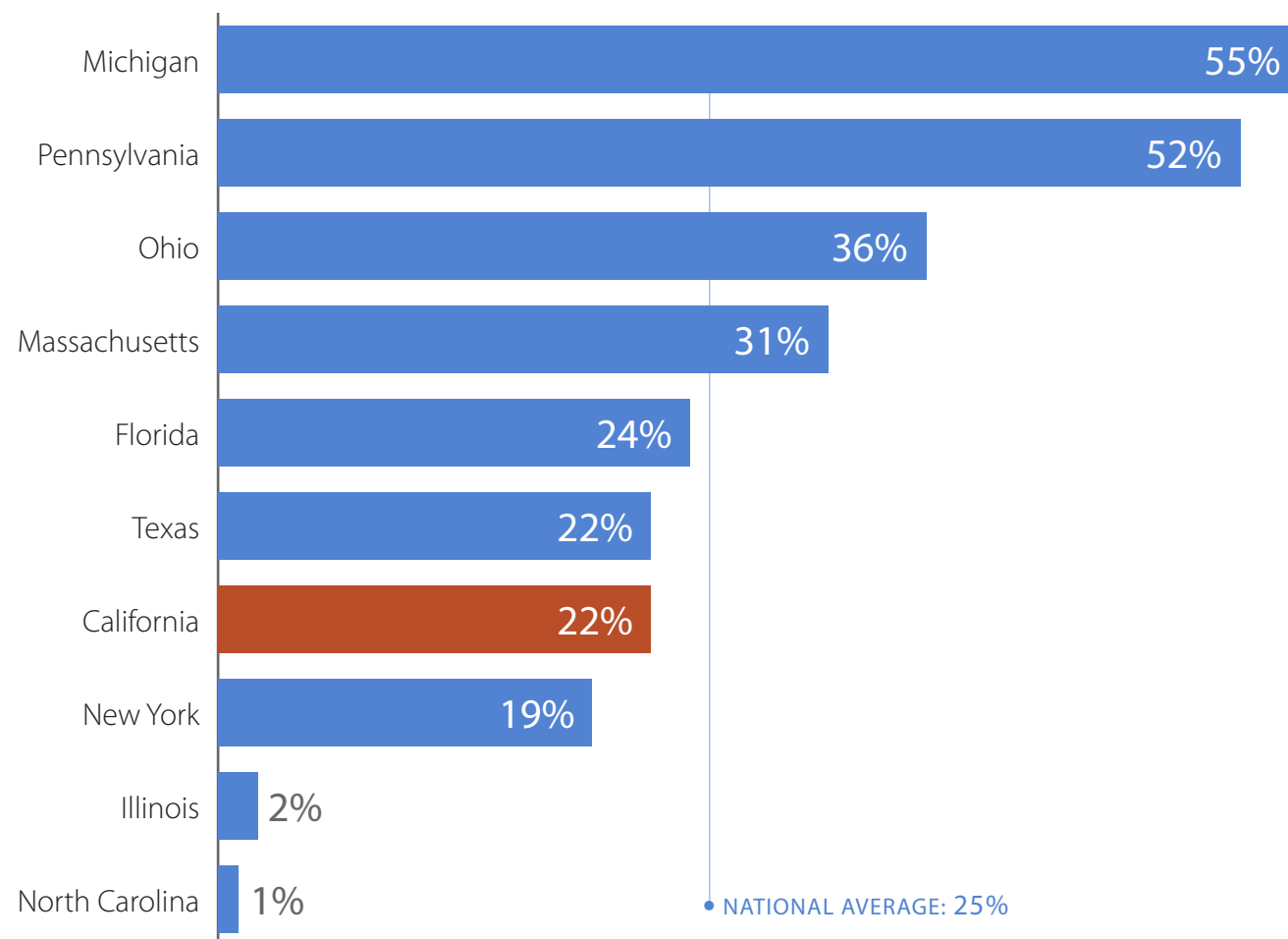
Compared to Other States, FY2009

Medi-Cal Facts and Figures

Delivery Systems

In 2009, 22% of California's Medicaid spending was capitated, which is less than the national average (25%) and the average spending of other large states. These national data, however, do not reflect the expansion of mandatory managed care for Medi-Cal-only seniors and people with disabilities.

CAPITATION AS A PERCENTAGE OF TOTAL SPENDING



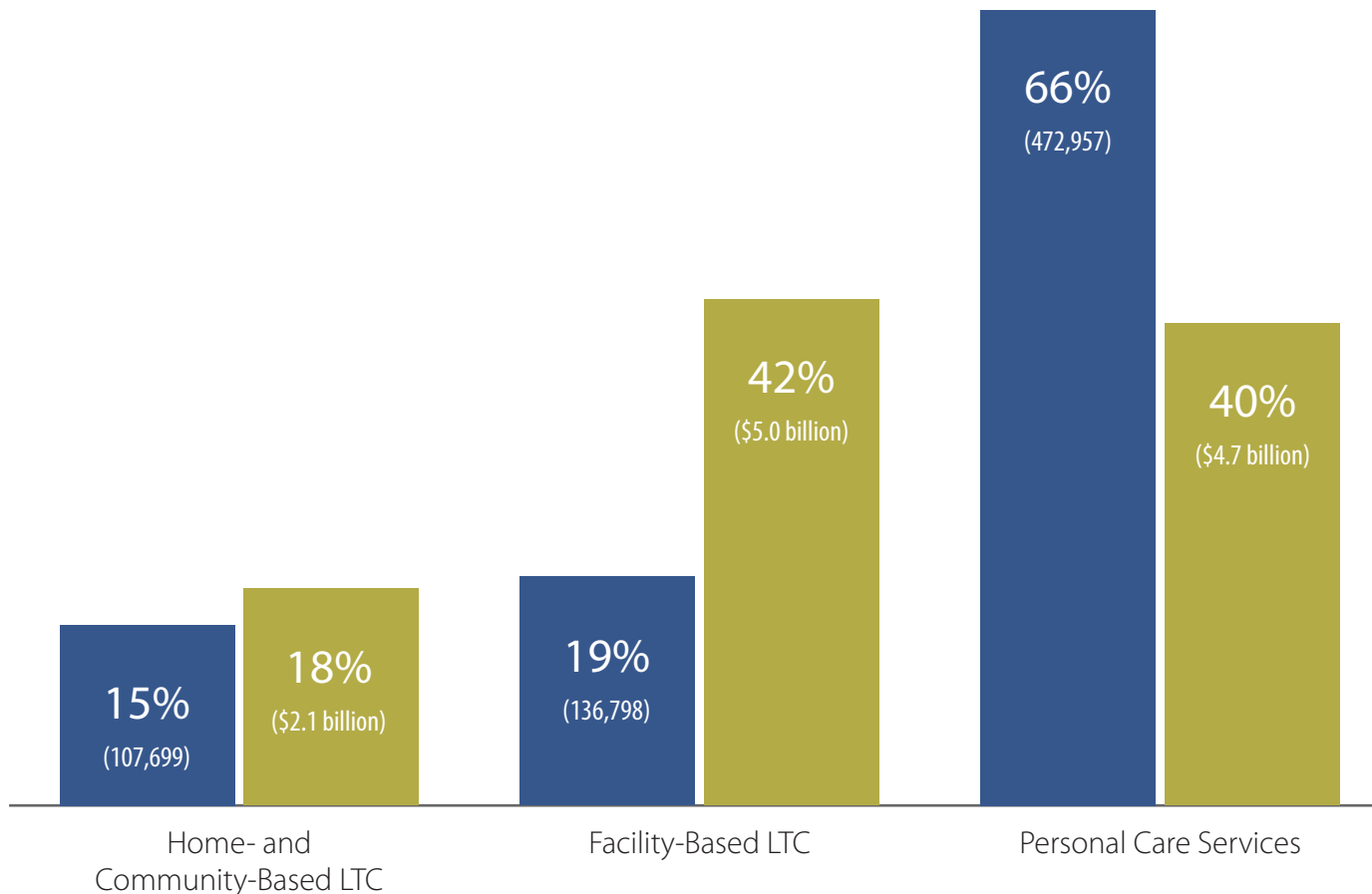
Notes: States with the 10 largest Medicaid programs based on FY2009 expenditures are represented along with the national average. Capitated care refers to a fixed payment per enrollee. Total spending excludes Disproportionate Share Hospital payments, other supplemental payments to providers, Medicaid payments for Medicare premiums, administrative expenses, and accounting adjustments.

Source: Lewin analysis of Medicaid Statistical Information System (MSIS) data for 12-month period ending September 30, 2009.

Long Term Care, FY2011

LTC SPENDING AS A PERCENTAGE OF TOTAL:

■ Users ■ FFS Expenditures



Notes: FFS is fee-for-service. Facility-Based LTC (long term care) includes nursing facilities, and hospitals and intermedicate care facilities serving people with developmental disabilities.

Source: Lewin analysis of Medicaid Statistical Information System (MSIS) data for 12-month period ending September 30, 2011.

Medi-Cal Facts and Figures

Delivery Systems

Nursing facility care and other institutional care account for the largest share of Medi-Cal spending on long term care, followed closely by spending on personal care services. Spending on other long term care services provided in the home or community (e.g., skilled nursing, therapy services, case management) accounts for the remainder.

Other Managed Care Carve Outs

Medi-Cal Facts and Figures

Delivery Systems

MENTAL HEALTH SERVICES

- Medi-Cal beneficiaries with severe mental illness access specialty mental health services (e.g., inpatient hospital services, outpatient mental health treatment, crisis intervention, case management) through a separate county-level managed care delivery system, known as the County Mental Health Plan.*
- Medi-Cal beneficiaries with mild to moderate mental illness can receive more limited services, generally from primary care providers, through their Medi-Cal managed care plan or fee-for-service.
- In 2009, Medi-Cal spent nearly \$3.8 billion providing mental health and substance use services to nearly 565,000 enrollees.

CALIFORNIA CHILDREN'S SERVICES (CCS)

- CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to eligible children under age 21.
- Eligibility is limited to children with certain health conditions, diseases, injuries, or physical limitations who meet specific income standards.†
- CCS currently covers only costs related to the condition that makes the child eligible for the program, making care coordination difficult.
- In FY2010–11, approximately 246,000 children were enrolled, with an annual cost of \$2.5 billion.

*Two COHS counties, San Mateo and Solano, currently integrate mental and physical health in managed care.

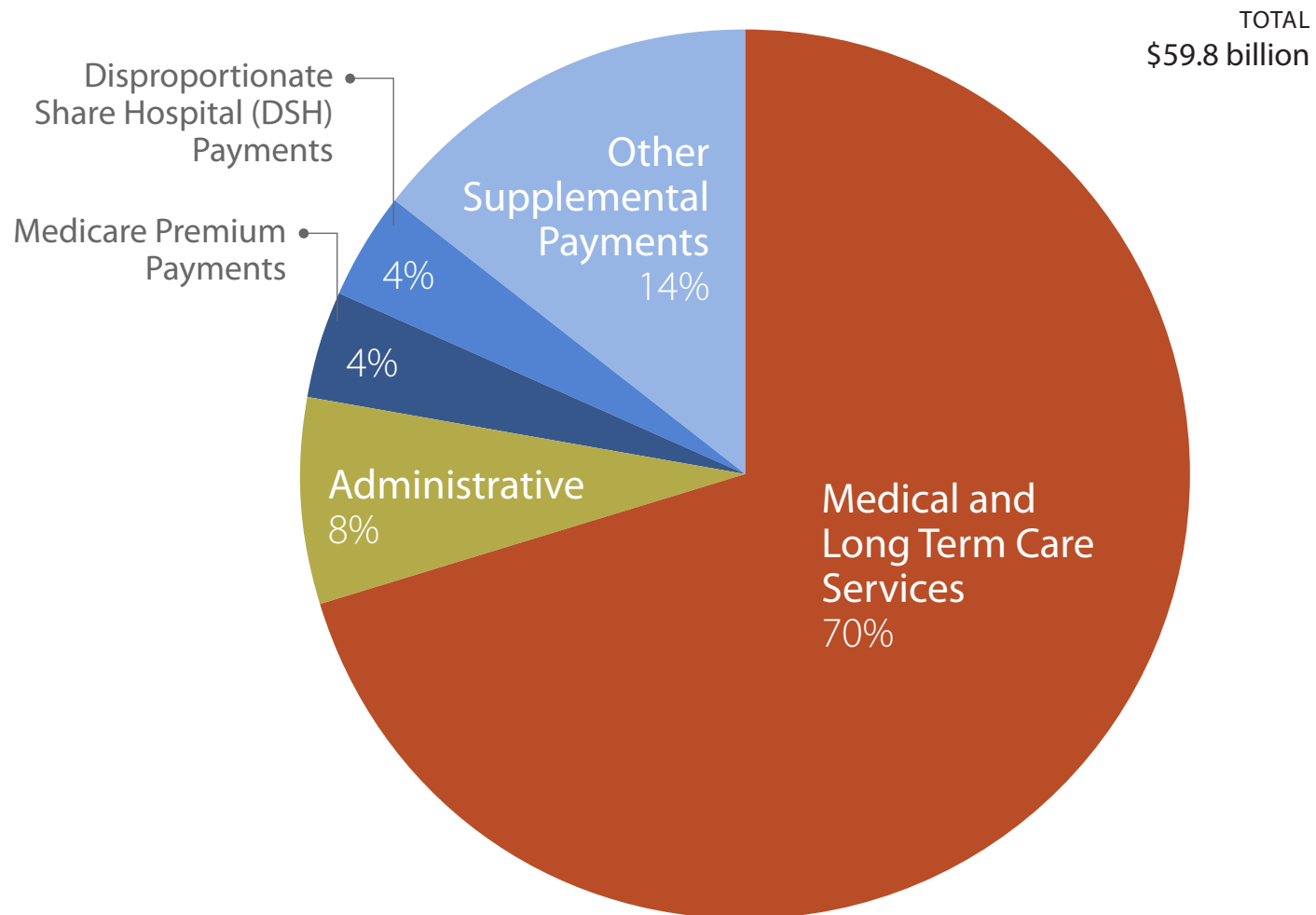
†Families are eligible if they have annual income of less than \$40,000, if out-of-pocket medical costs are expected to exceed 20% of their income, or if child is enrolled in Medi-Cal or Healthy Families.

Note: Dental services, also carved out of Medi-Cal managed care, account for a very small share of Medi-Cal spending and are not discussed in this report.

Sources: California HealthCare Foundation, *The Crucial Role of Counties in the Health of Californians*, March 2011, www.chcf.org. Insure the Uninsured Project, *California's Mental Health System: Aligning California's Physical and Mental Health Services to Strengthen the State's Capacity for Federal Coverage Expansion*, August 2011, www.itup.org. California Department of Health Care Services, *California Mental Health and Substance Use Services Needs Assessment*, February 9, 2012, www.cimh.org. California Department of Health Care Services (DHCS), *California Children's Services*, www.dhcs.ca.gov. DHCS, *California Children's Services Demonstration Projects*, November 2011, www.dhcs.ca.gov. California Department of Public Health, "Form 4" and "Form 7," *Maternal, Child, and Adolescent Health Program: Application/Annual Report*, July 15, 2012, www.cdph.ca.gov.

Along with most long term care, specialty care for individuals with severe mental health conditions and for children in CCS are generally administered and paid for outside of the Medi-Cal managed care system — they are considered carve outs. Coordinating care for enrollees across these systems has been a significant challenge for individuals and their providers.

Expenditure Distribution, FY2011



Notes: This includes both the traditional Medicaid population and the Children's Health Insurance Program (CHIP)-expansion population in Medi-Cal. Analysis does not include costs for services funded solely by state dollars. Medical Services include expenditures for reimbursing providers at the state's standard Medicaid payment rate. States also make supplemental payments to certain providers. Medicare premium payments reflect Medi-Cal payments for Medicare Part A and Part B for qualified individuals. DSH Payments include supplemental payments to providers that provide a disproportionate share of uncompensated care to low-income individuals. Other Supplemental Payments are non-DSH supplemental payments to providers, including payments to hospitals from the Safety Net Care Pool under the Bridge to Reform waiver. Administrative payments include eligibility and enrollment, school-based administration, and other state and local costs.

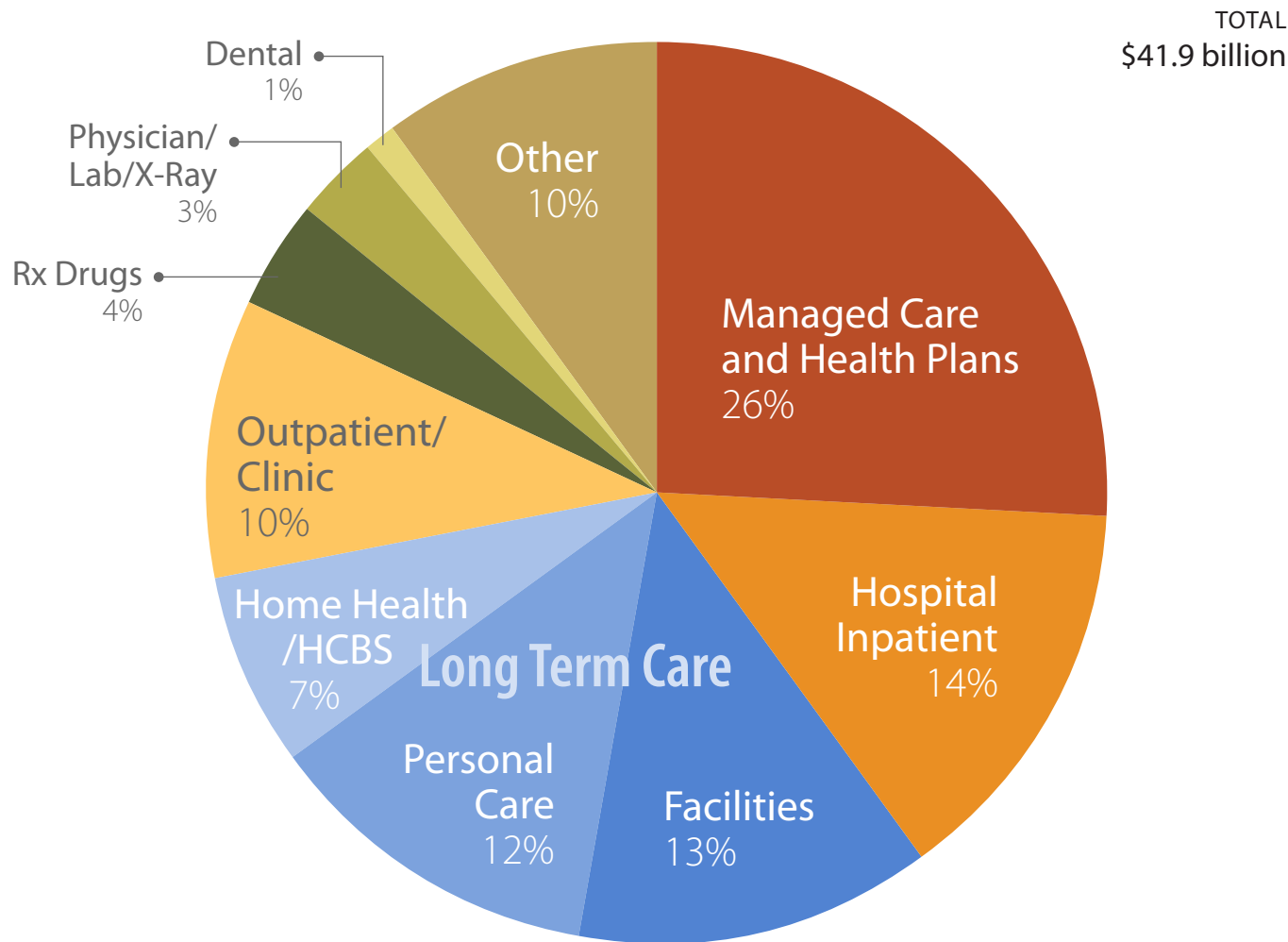
Source: Centers for Medicare & Medicaid Services (CMS), *Financial Management Report for FY2002 through FY2011*, www.medicaid.gov.

Medi-Cal Facts and Figures

Spending

Medical and long term care services account for 70% of Medi-Cal spending. Remaining funds go toward state and local administrative costs, including eligibility determination; to Medicare premium payments; and to supplemental payments to providers.

Distribution of Spending on Services, FY2011



Medi-Cal Facts and Figures

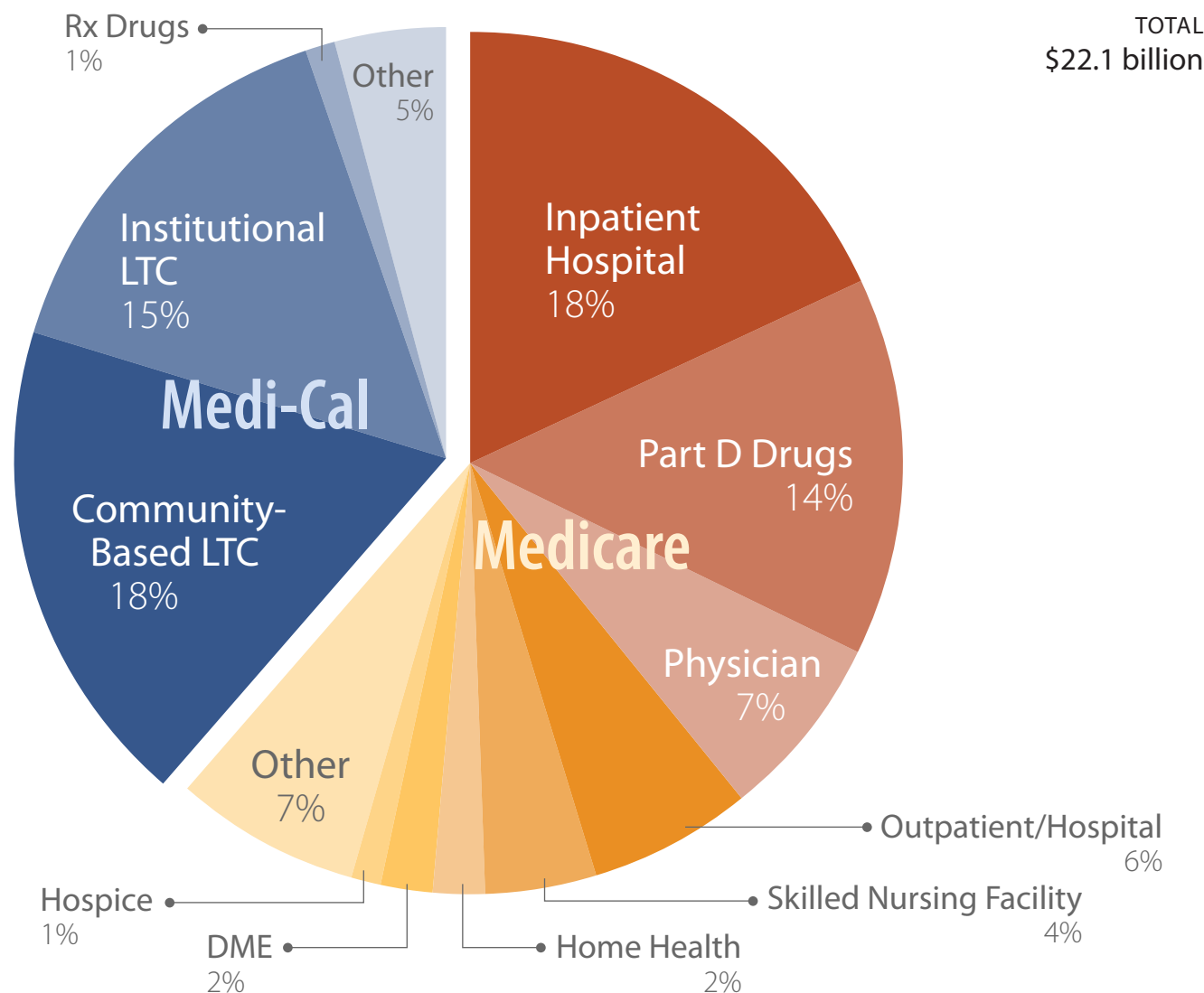
Spending

Payments to managed care plans account for the largest share of Medi-Cal spending on services, followed by spending for inpatient hospital care. One-third of Medi-Cal spending on services is for long term care.

Notes: This includes both the traditional Medicaid population and the Children's Health Insurance Program (CHIP)-expansion population in Medi-Cal. These values include expenditures to reimburse providers at the state's standard Medicaid payment rate and exclude all supplemental payments and administrative costs. The Long Term Care Facilities category includes spending on mental health facilities.

Source: Centers for Medicare & Medicaid Services (CMS), *Financial Management Report for FY2002 through FY2011*, www.medicaid.gov.

FFS Spending for Dual Eligibles, FY2007



Medi-Cal Facts and Figures

Spending

Medi-Cal accounted for 38% of spending on services for full-benefit Medicare-Medicaid enrollees (dual eligibles) in 2007. The largest share of Medicare spending went toward inpatient hospital care, whereas the largest share of Medicaid spending went toward community-based long term care support and services.

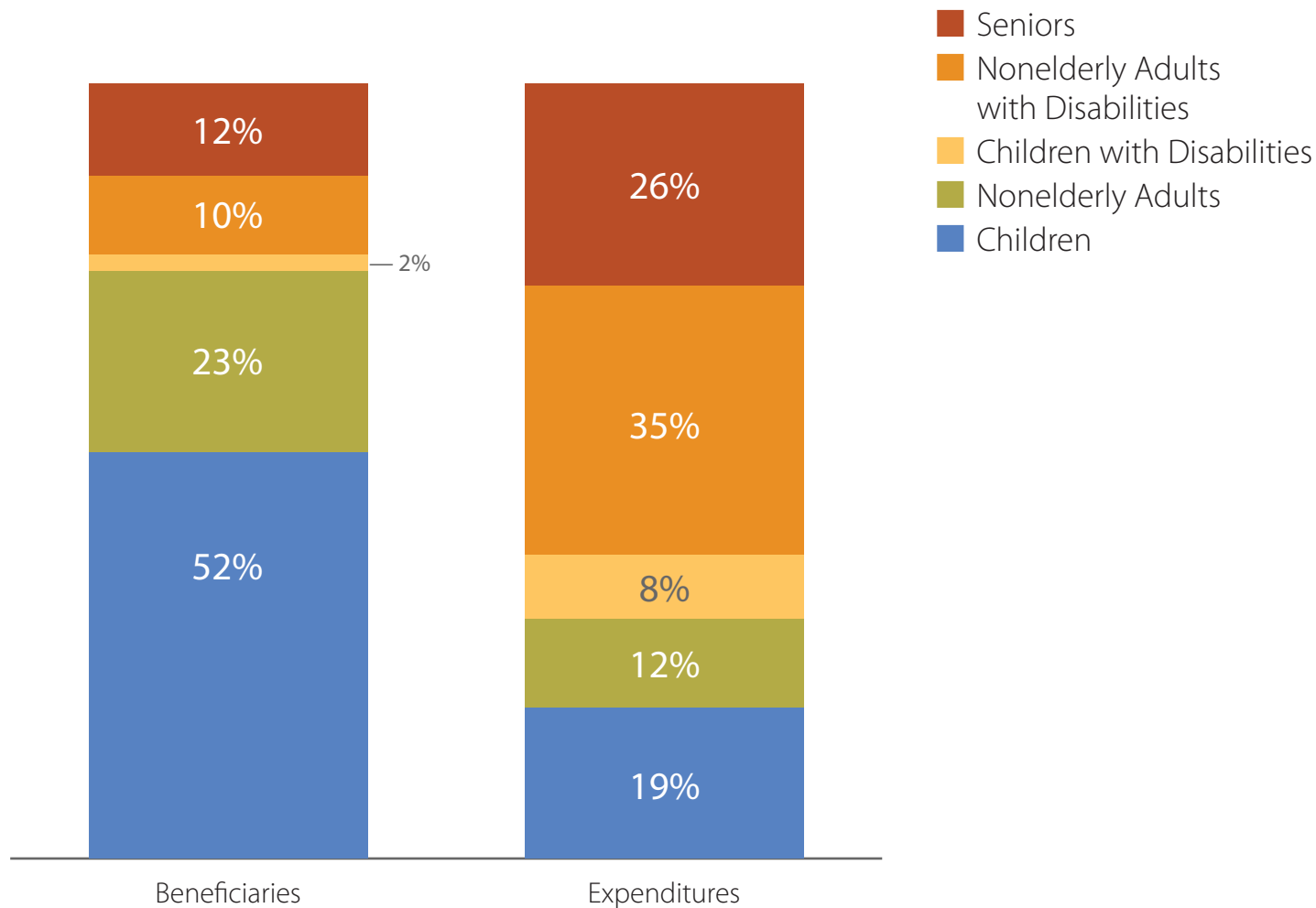
Notes: FFS is fee-for-service. DME is durable medical equipment. LTC is long term care.

Source: Centers for Medicare & Medicaid Services (CMS), California Medicare-Medicaid Enrollee State Profile, www.cms.gov.

Beneficiaries and Spending, by Group, FY2011

Medi-Cal Facts and Figures

Spending



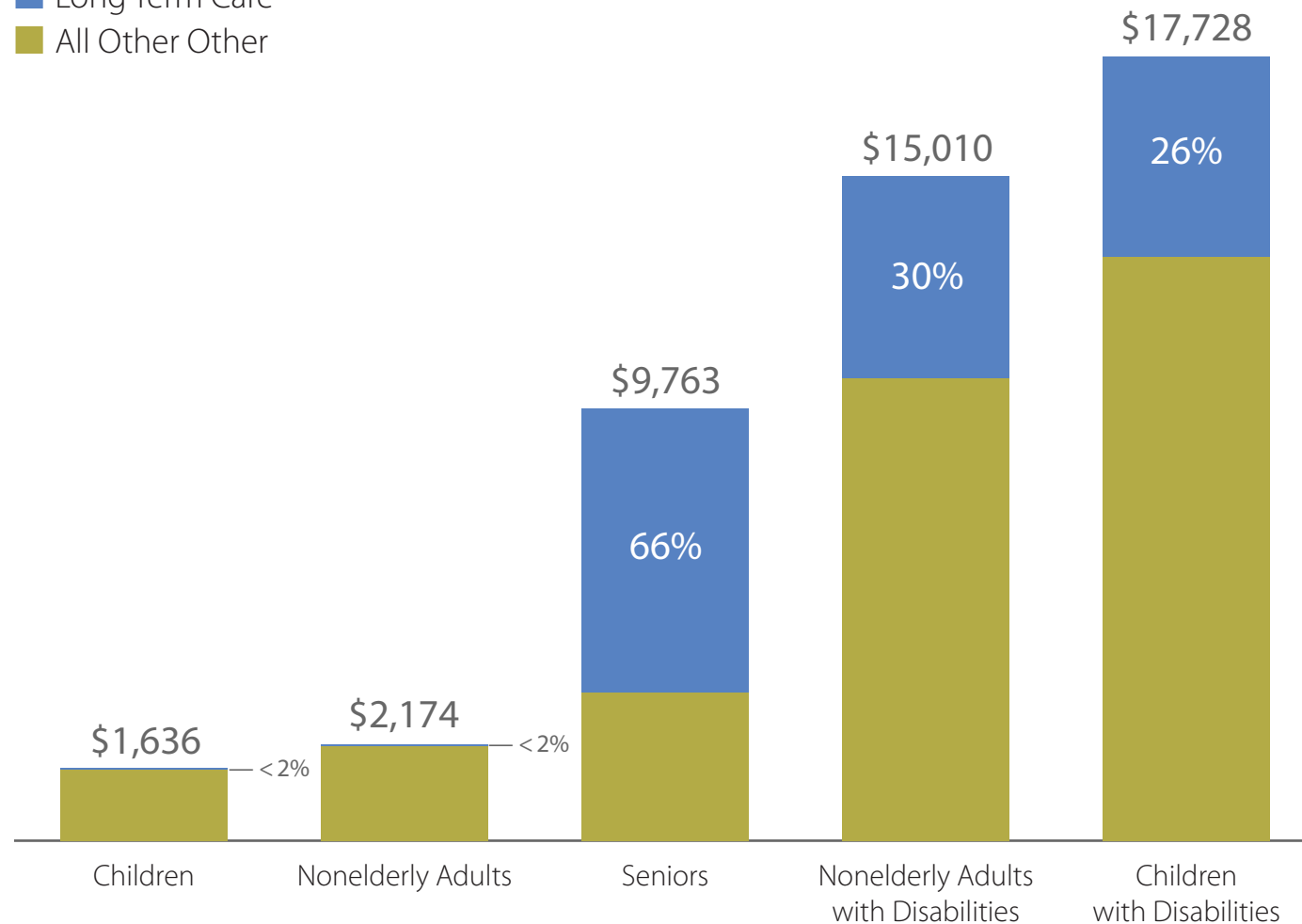
Seniors and people with disabilities account for 24% of beneficiaries but 69% of expenditures.

Notes: Estimates include expenditures and the number of unique beneficiaries for the 12-month period ending September 30, 2011. Estimates include some beneficiaries who are eligible for a limited set of benefits through restricted scope Medi-Cal, including undocumented immigrants but excluding Family Planning, Access, Care, and Treatment (PACT) beneficiaries. Estimates exclude 1.83 million Family PACT beneficiaries and \$612 million in spending on Family PACT services. Enrollment categories are based on age; counts exclude people with unknown age in Medicaid Statistical Information System (MSIS) (less than 2% of expenditures). Segments may not add to 100% due to rounding.

Source: Lewin analysis of MSIS data for the 12-month period ending September 30, 2011.

Annual Cost per Beneficiary, FY2011

■ Long Term Care
■ All Other Other



Notes: Estimates include some beneficiaries who are eligible for a limited set of benefits through restricted-scope Medi-Cal, including undocumented immigrants. Estimates exclude 1.83 million Family Planning, Access, Care, and Treatment (PACT) beneficiaries and \$612 million in spending on Family PACT services. Beneficiary counts exclude those whose eligibility status or age is unknown. People with unknown age represent less than 2% of expenditures. Enrollment categories are based on age and basis of eligibility. Spending categories are based on Medicaid Statistical Information System (MSIS) State Summary Service Categories. Long Term Care is defined as home health, ICF/MR services, nursing facilities, and personal supports services. All Other Care reflects spending on primary, specialty, and acute care services.

Source: Lewin analysis of MSIS data for the 12-month period ending September 30, 2011.

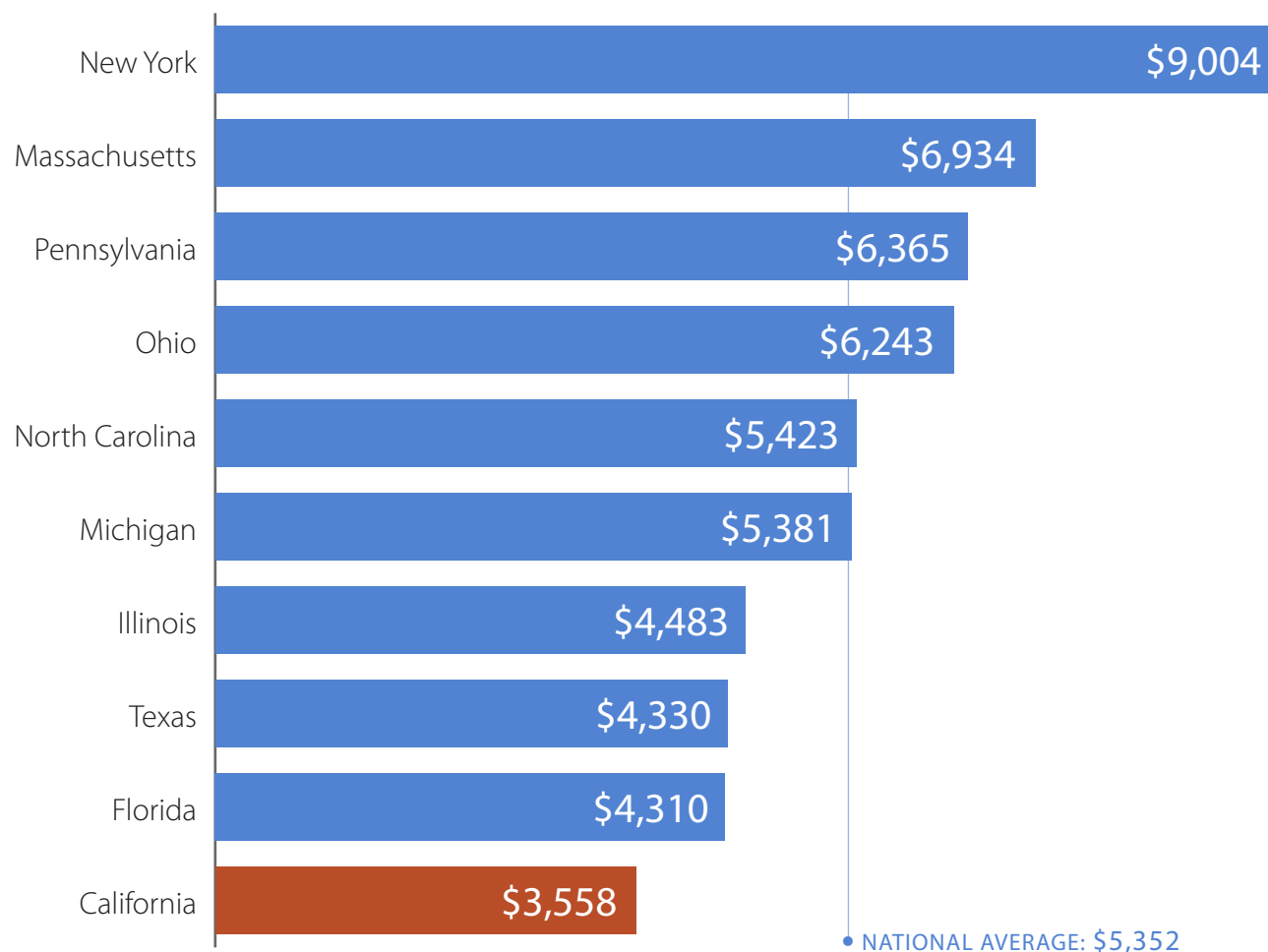
Medi-Cal Facts and Figures

Spending

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

Annual State Spending per Beneficiary

Compared to Other States, FY2009



Notes: States with the 10 largest Medicaid programs based on FY2009 expenditures are represented along with the national average. The Medicaid Statistical Information System (MSIS) Total Medicaid Paid Amount excludes Disproportionate Share Hospital payments, other supplemental payments to providers, Medicare premium payments, administrative expenses, and accounting adjustments. Estimates include some beneficiaries who are eligible for a limited set of benefits through restricted-scope Medi-Cal, including undocumented immigrants but excluding Planning, Access, Care and Treatment (PACT) beneficiaries.

Source: Lewin analysis of MSIS data for 12-month period ending September 30, 2009.

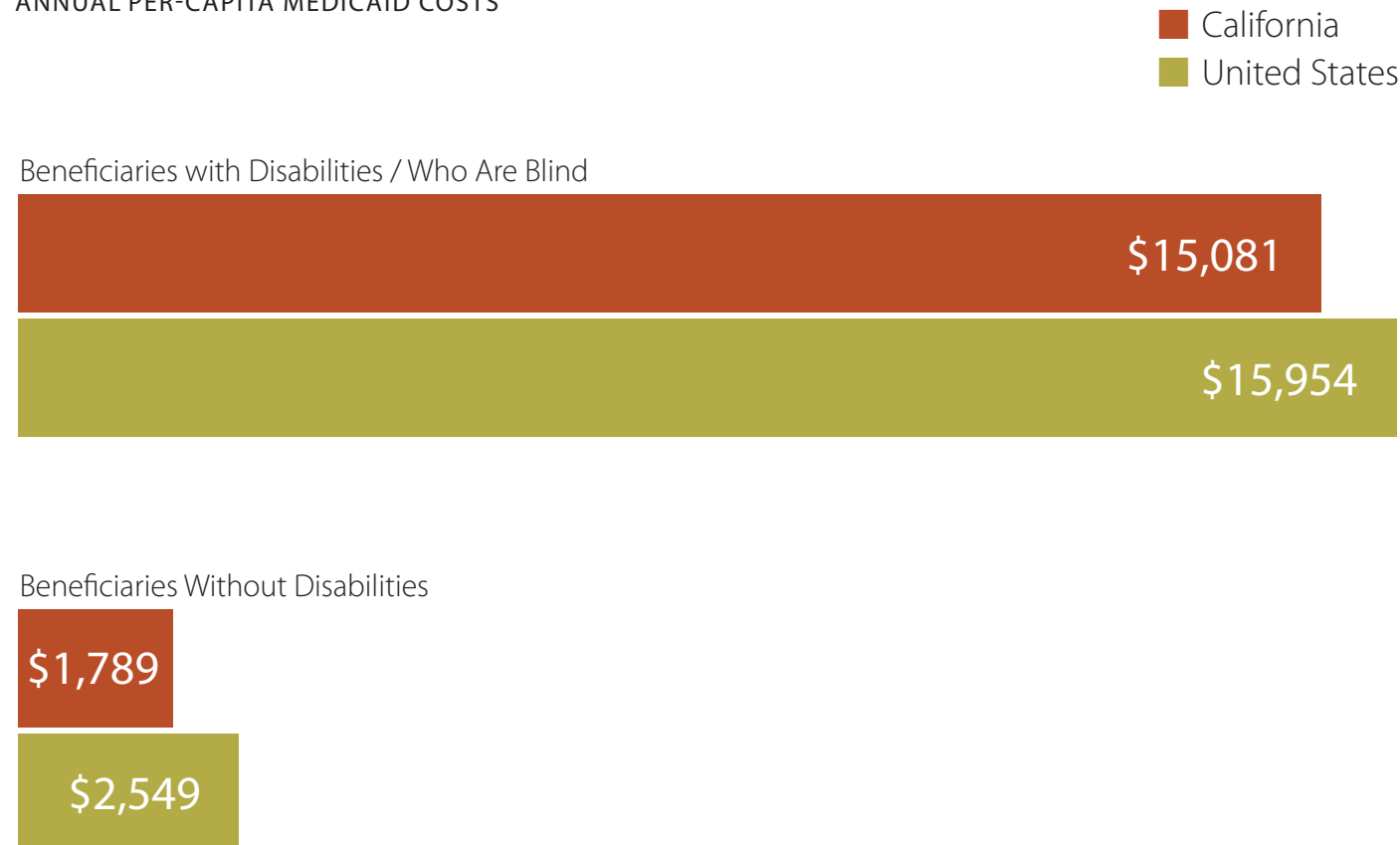
Medi-Cal Facts and Figures

Spending

California spends over 30% less per beneficiary than the national average and the least per beneficiary among the 10 largest states. California's large share of undocumented immigrants, who receive only limited benefits through Medicaid, is partly responsible for this difference.

Spending per Beneficiary, by Group, FY2009

ANNUAL PER-CAPITA MEDICAID COSTS



Notes: Medicaid Statistical Information System (MSIS) data exclude Disproportionate Share Hospital payments, other supplemental payments to providers, Medicare premium payments, administrative expenses, and accounting adjustments. Estimates include some beneficiaries who are eligible for a limited set of benefits through restricted-scope Medi-Cal, including undocumented immigrants but excluding Family Planning, Access, Care, and Treatment (PACT) beneficiaries. Estimates exclude beneficiaries with unknown ages (representing less than 2% of expenditures in California).

Source: Lewin analysis of MSIS data for 12-month period ending September 30, 2009.

Medi-Cal Facts and Figures

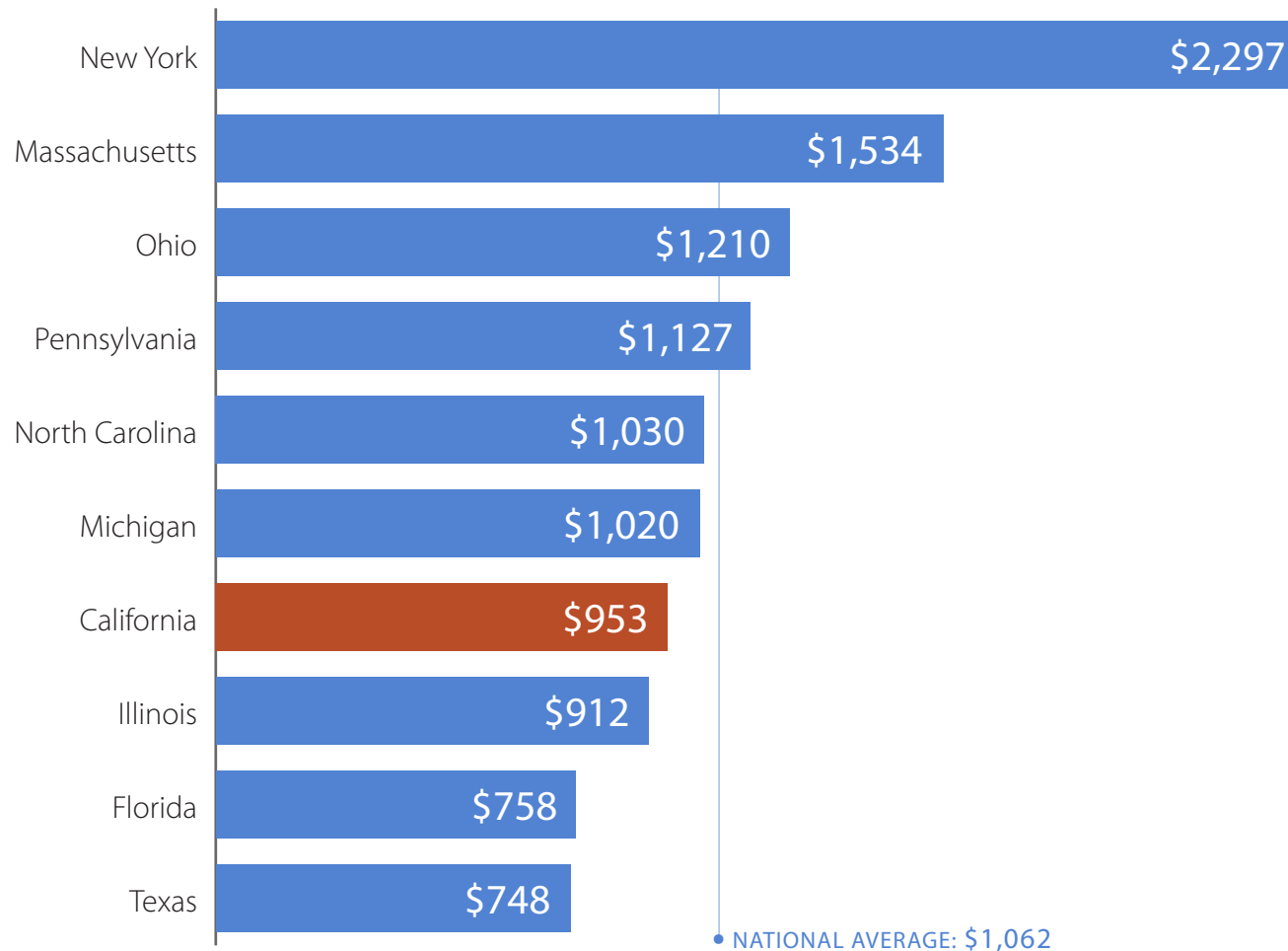
Spending

Among the 50 states and Washington, DC, California is ranked 30th in per-beneficiary spending for nonelderly beneficiaries with disabilities, and 51st for nonelderly beneficiaries without disabilities.

California's lower spending for Medicaid beneficiaries without disabilities (mostly children and parents) reflects a higher proportion of undocumented immigrants with restricted-scope coverage than the nation.

Spending Per Resident

Compared to Other States, FY2009



Notes: States with the 10 largest Medicaid programs based on FY2009 expenditures are represented along with the national average. Medicaid Statistical Information System (MSIS) spending data exclude Disproportionate Share Hospital payments, other supplemental payments to providers, Medicare premium payments, administrative expenses, and accounting adjustments.

Sources: Lewin analysis of MSIS data for 12-month period ending September 30, 2009. US Census Bureau, "Cumulative Estimates of Resident Population Change for the United States, Regions, States, and Puerto Rico and Region and State Rankings: April 1, 2000 to July 1, 2009," *State Totals: Vintage 2009*, www.census.gov.

Medi-Cal Facts and Figures

Spending

California is 10% below the national average in Medicaid spending per resident, which reflects both the share of residents enrolled in Medicaid and spending per beneficiary.

Medi-Cal's Crucial Role

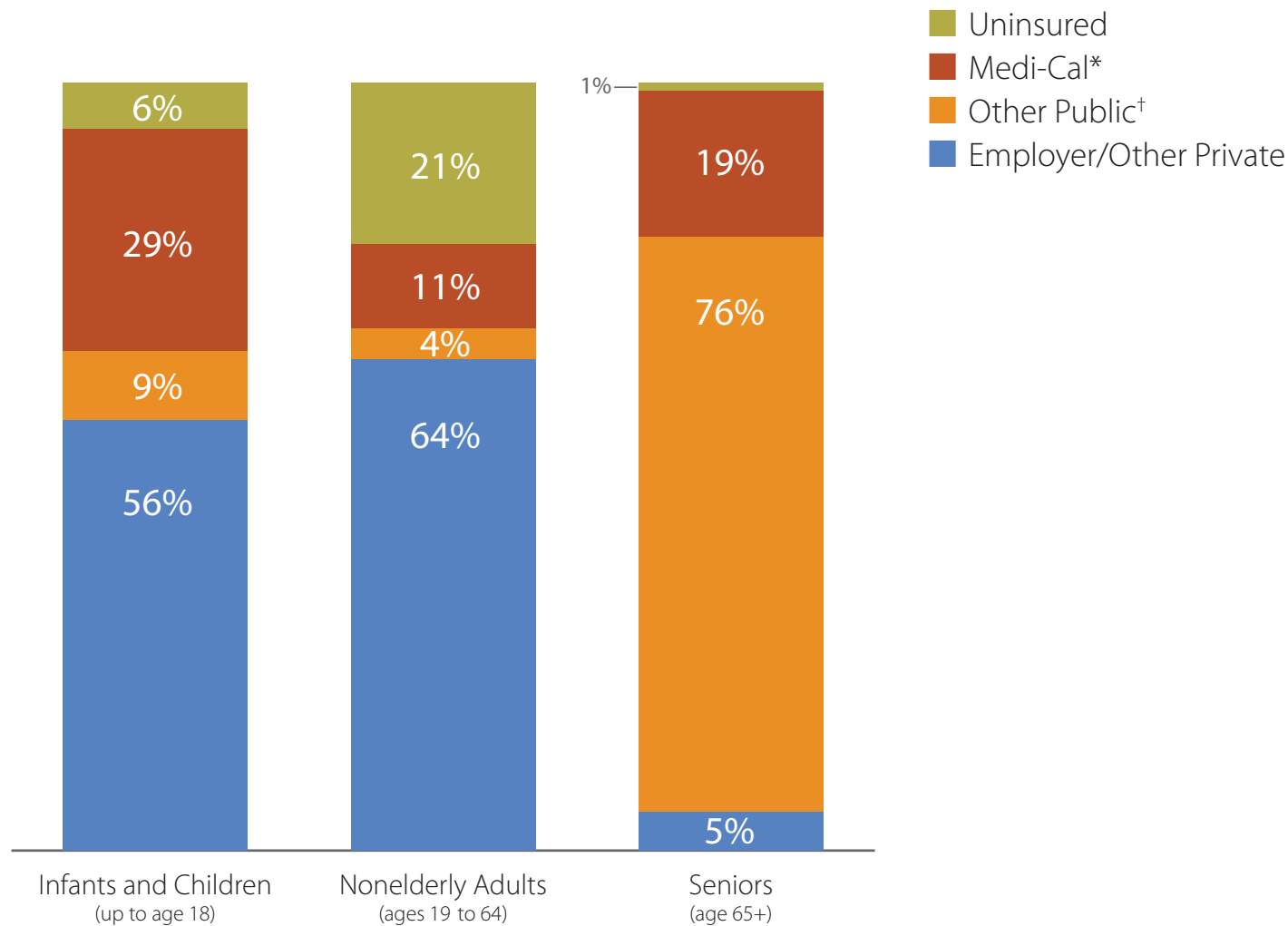
- Provides affordable coverage to low-income children and adults
- Pays for a broad array of services for people with disabilities that are not available through the commercial market
- Fills gaps in coverage for low-income Medicare beneficiaries
- Helps keep commercial premiums affordable for Californians with private coverage 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 Facts and Figures

Role in the System

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

Sources of Coverage, 2009



*Includes individuals who reported that they have both Medi-Cal and Medicare coverage (dual eligibles). This is most common among seniors with Medi-Cal (94%), less common among nonelderly adults with Medi-Cal (11%), and uncommon among children with Medi-Cal (<1%).

†Predominantly Healthy Families (among infants and children), Medicare (among seniors), and coverage for military personnel, retirees, and dependents (among nonelderly adults).

Notes: Insurance status at the time of the survey. Segments may not add to 100% due to rounding.

Source: California Health Interview Survey, 2009, www.chis.ucla.edu.

Medi-Cal Facts and Figures

Role in the System

Medi-Cal provides coverage to 29% of children, 11% of nonelderly adults, and 19% of seniors in California.

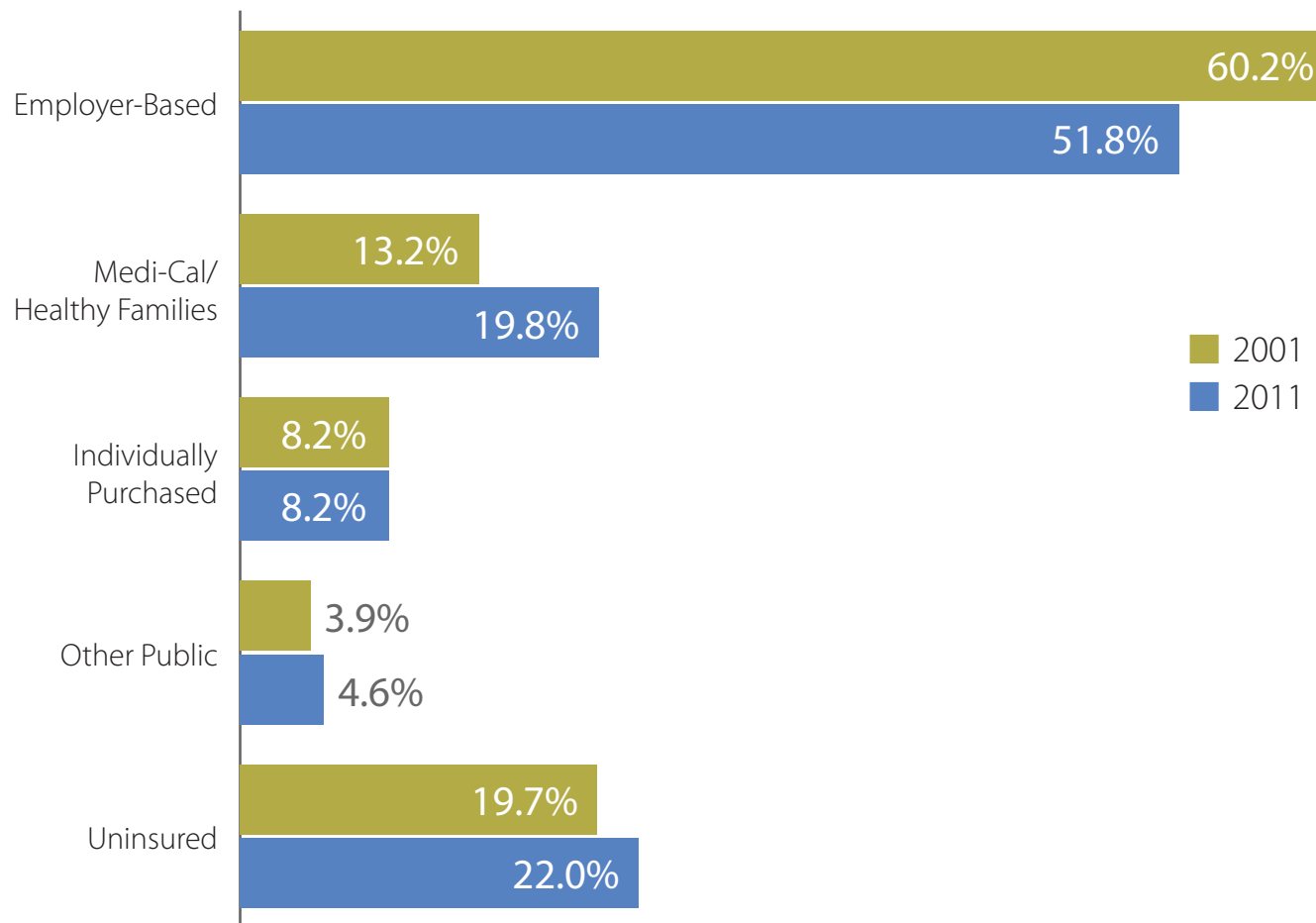
Health Insurance Source Trends, 2001 vs. 2011

Medi-Cal Facts and Figures

Role in the System

From 2001 to 2011, much of the decline in employer-based coverage was offset by increases in Medi-Cal coverage.

PERCENTAGE OF CALIFORNIA NONELDERLY RESIDENTS WITH THE FOLLOWING COVERAGE



Notes: All numbers reflect the nonelderly population, under age 65. Other Public includes Medicare coverage and coverage for military personnel, retirees, and dependents. Numbers do not total 100% because some individuals have more than one type of coverage.

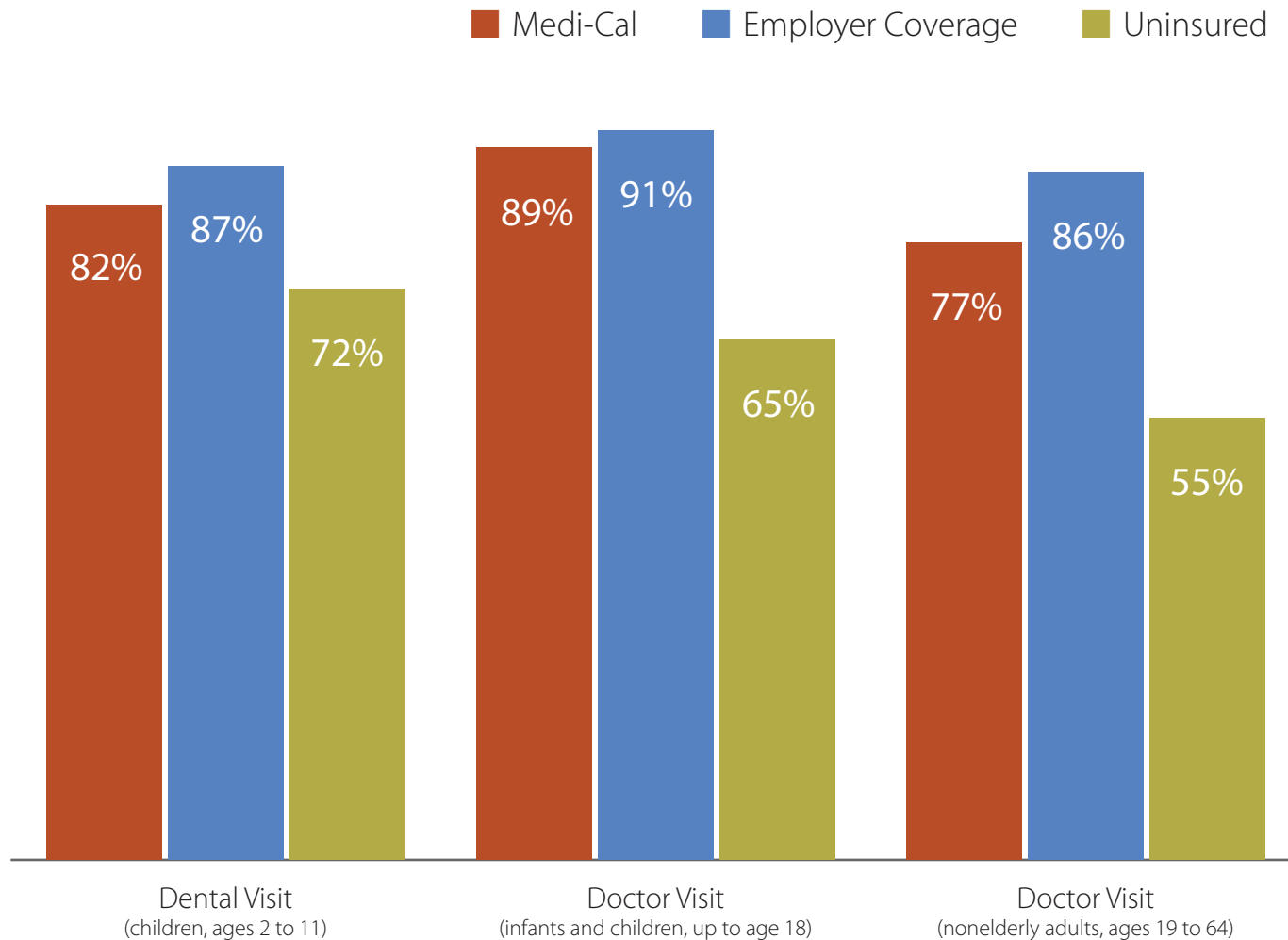
Source: Employee Benefit Research Institute estimates of the Current Population Survey, 2002 and 2012 March Supplements.

Access to Primary Care, 2009

Medi-Cal Facts and Figures

Role in the System

PERCENTAGE OF BENEFICIARIES WHO HAD A MEDICAL VISIT WITHIN THE PAST YEAR



Medi-Cal coverage improves access to care. Children and adults enrolled in Medi-Cal report use of primary care services at rates that are much higher than those who are uninsured, but somewhat lower than those with employer coverage.

Source: California Health Interview Survey, 2009, www.chis.ucla.edu.

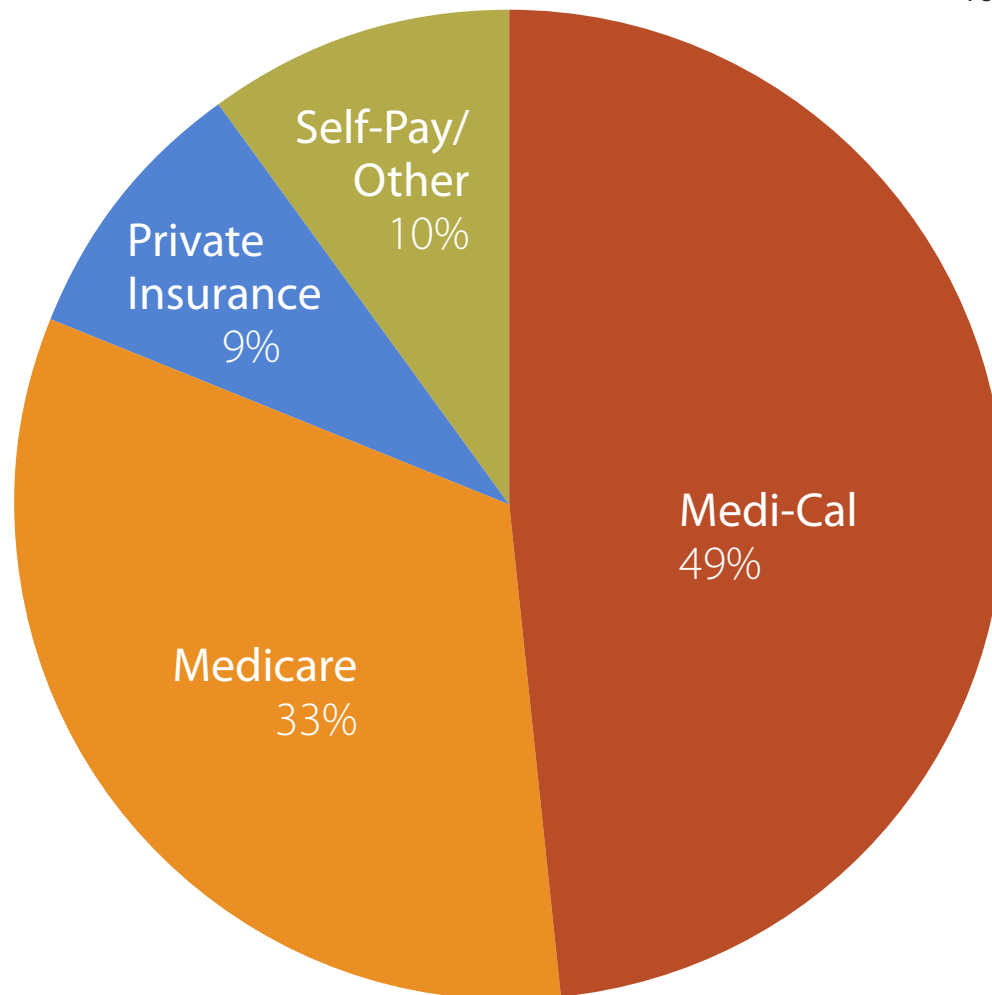
Nursing Facility Revenues, 2010

Medi-Cal Facts and Figures

Role in the System

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

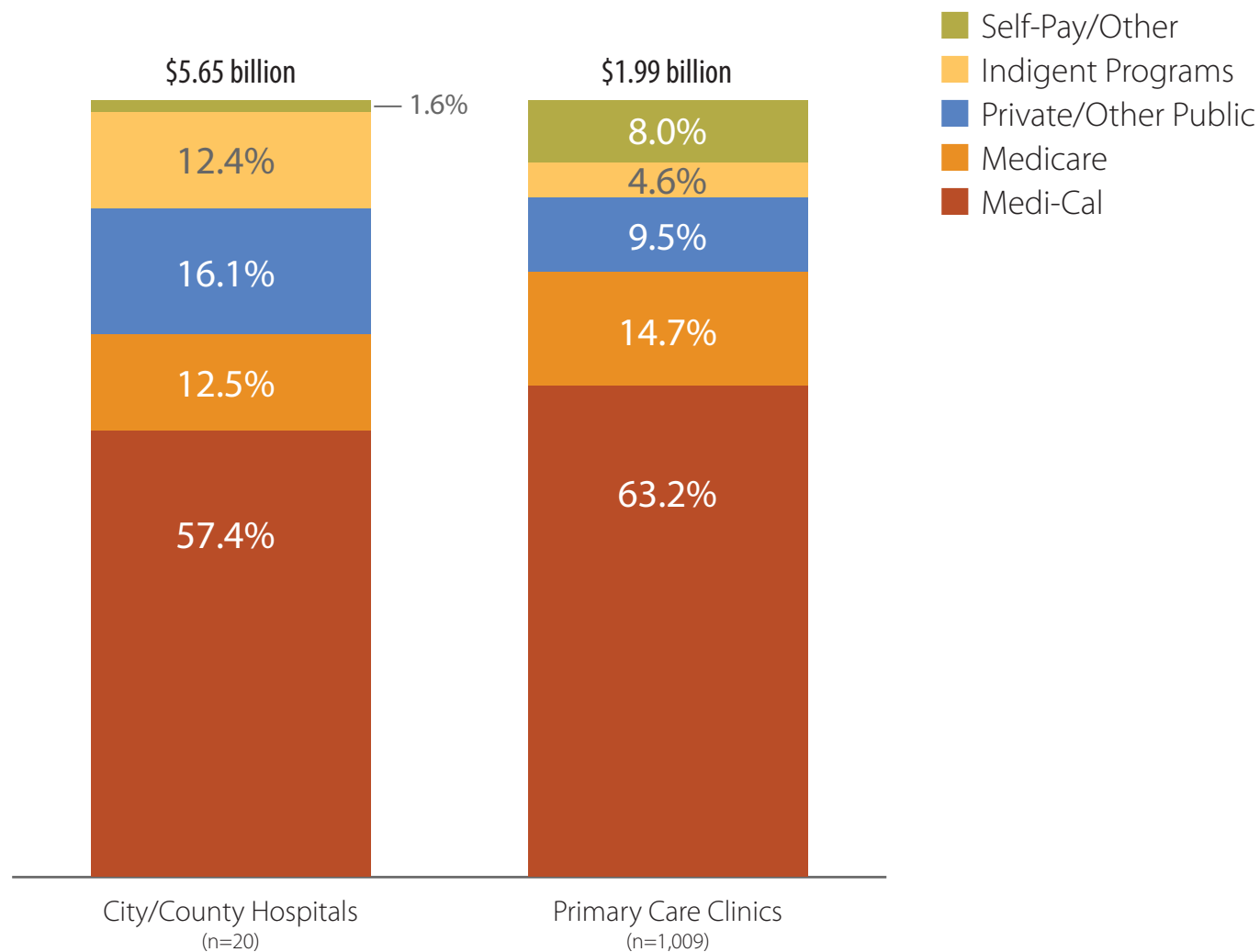
TOTAL NET PATIENT REVENUE
\$8.4 billion



Notes: Net patient revenue includes gross inpatient and outpatient revenue after accounting for the difference between the established rate and the amount paid by patients and third-party payers and capitation premium revenues, prior to expenses. Private insurance as reported for nursing facilities data includes managed care. Self-Pay, in the category Self-Pay/Other, represents 60% of patients and 63% of revenues. In 2010 there were 1,156 skilled nursing facilities and 12 intermediate care facilities that submitted long term care facility financial reports to California Office of Statewide Health Planning and Development (OSHPD). Segments may not total 100% due to rounding.

Source: OSHPD, Healthcare Information Division, *Long-Term Care Facilities Annual Financial Data*, 2010, www.oshpd.ca.gov.

Safety-Net Revenues, 2011



Notes: Includes gross inpatient and outpatient revenue after accounting for deductions from revenue and capitation premium revenue but prior to expenses. Medi-Cal as reported for primary care clinics includes traditional fee-for-service, managed care, Breast and Cervical Cancer Treatment Program, Alameda Alliance for Health, and Family Planning, Access, Care, and Treatment (PACT) programs. Indigent Programs for primary care clinics include County Medical Services Program/Medically Indigent Services Program, LA County Partnership, and other county programs. Private/Other Public includes Healthy Families and Child Health and Disability Prevention. Primary Care Clinics that failed to provide their utilization data and/or were not in operation in 2011 are excluded.

Sources: California Office of Statewide Health Planning and Development (OSHPD), Healthcare Information Division, *Annual Financial Data*, 2011, www.oshpd.ca.gov. OSHPD, Healthcare Information Division, *Primary Clinics Annual Financial Data (Section 6–8)*, 2011, www.oshpd.ca.gov.

Medi-Cal Facts and Figures

Role in the System

Medi-Cal is a key source of funding for major providers of care to the uninsured. It accounts for nearly 60% of patient revenues to city and county hospitals, and over 60% of patient revenues to primary care clinics.

Supplemental Hospital Payments

- Safety-net hospitals are public hospitals that make up just 6% of hospitals statewide, but provide almost half of all hospital care to the state's uninsured population.
- Medi-Cal pays additional (or supplemental) reimbursement to safety-net hospitals that care for a disproportionate share of Medi-Cal and uninsured patients.
- The Bridge to Reform waiver provides federal funding to public hospital systems through October 31, 2015, for quality and efficiency improvements through the Delivery System Reform Incentive Pool (up to \$3.3 billion) and for uncompensated medical services provided to the uninsured (up to \$3.8 billion).

Medi-Cal Facts and Figures

Role in the System

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

Sources: California Association of Public Hospitals and Health Systems (CAPH), *California's Essential Public Hospitals*, February 2010, www.caph.org.
CAPH, *The New Section 1115 Medicaid Waiver: Key Issues for California's Public Hospital Systems*, November 2010, www.caph.org.

Bridge to Reform Section 1115 Medicaid Waiver

Medi-Cal Facts and Figures

Medi-Cal and Health Reform

KEY ELEMENTS

- **Low Income Health Program (LIHP).** Extends county-based coverage to low-income adults ages 19 to 64 through county and federal Medicaid matching funds.*
- **Delivery System Reform Incentive Pool (DSRIP).** Provides federal incentive payments to safety-net hospitals that meet specific performance goals for delivery system improvements.
- **Uncompensated Care.** Provides federal matching funds for uncompensated care to the uninsured and designated state health programs.
- **Organized Systems of Care.** Authorizes mandatory enrollment of seniors and persons with disabilities into managed care and pilots to better coordinate care for children with special health care needs.†

In November 2010, CMS approved California's plan to expand coverage, strengthen the delivery system, and pilot new delivery models in preparation for federal health reform with the Section 1115 waiver, known as the Bridge to Reform waiver. The waiver will provide an estimated \$10 billion in federal funding for these initiatives through October 31, 2015.

*Counties have the option to participate in the program, set lower income thresholds, and set enrollment caps.

†California's Medi-Cal managed care programs were previously authorized under 1915(b) waivers, but now operate under the authority of the 1115 waiver.

Sources: Centers for Medicare & Medicaid Services (CMS), California Bridge to Reform Demonstration Special Terms and Conditions, November 2010, www.dhcs.ca.gov. Department of Health Care Services, Low Income Health Program Monthly Enrollment, June 2012, www.dhcs.ca.gov.

Low Income Health Program*

Medi-Cal Facts and Figures

Medi-Cal and Health Reform

MEDICAID COVERAGE EXPANSION (MCE)

- Extends coverage to adults with incomes <133% FPL
- Offers more limited benefits than traditional Medi-Cal
- Federal funding uncapped
- Automatically enrolls individuals in Medi-Cal in 2014 upon implementation of ACA-based coverage expansions

HEALTH CARE COVERAGE INITIATIVE (HCCI)

- Extends coverage to adults with incomes 133% to 200% FPL
- Offers more limited benefits than MCE
- Federal funding is capped at \$630 million over four years
- Offers eligibility to individuals for federal subsidies for purchasing coverage through California's health insurance exchange

As of November 2012, more than 515,000 adults were enrolled in low-income health programs in 51 California counties.

*Counties have the option to participate in the program, set lower income thresholds, and set enrollment caps.

Note: FPL is federal poverty level.

Sources: Centers for Medicare & Medicaid Services (CMS), *California Bridge to Reform Demonstration Special Terms and Conditions*, November 2010, www.dhcs.ca.gov. Department of Health Care Services (DHCS), *Low Income Health Program Monthly Enrollment*, November 2012, www.dhcs.ca.gov. Peter Harbage and Meredith Ledford King, *A Bridge to Reform: California's Medicaid Section 1115 Waiver*, California HealthCare Foundation, October 2012, www.chcf.org.

Coordinated Care Initiative for Dual Eligibles

Medi-Cal Facts and Figures

Medi-Cal and Health Reform

PROGRAM OVERVIEW

- In May 2012, California submitted a proposal to CMS to participate in the Financial Alignment Demonstration, which aims to align and integrate Medicare and Medicaid financing and services for full-benefit Medicare-Medicaid enrollees (dual eligibles).
- Participating health plans will receive Medicaid capitation payments from the state and Medicare capitation payments from the federal government. Plans will be responsible for delivering a full continuum of Medicare and Medi-Cal health services, including long term care services and supports and behavioral health services.
- Long term care services and supports will include nursing facility care and a variety of home and community-based services, including services provided through California's In-Home Supportive Services program, the Community Based Adult Services program, and the Multipurpose Senior Services Program.
- DHCS intends to implement the demonstration in eight counties in 2014.

Eight California counties are expected to begin the demonstration in 2014: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

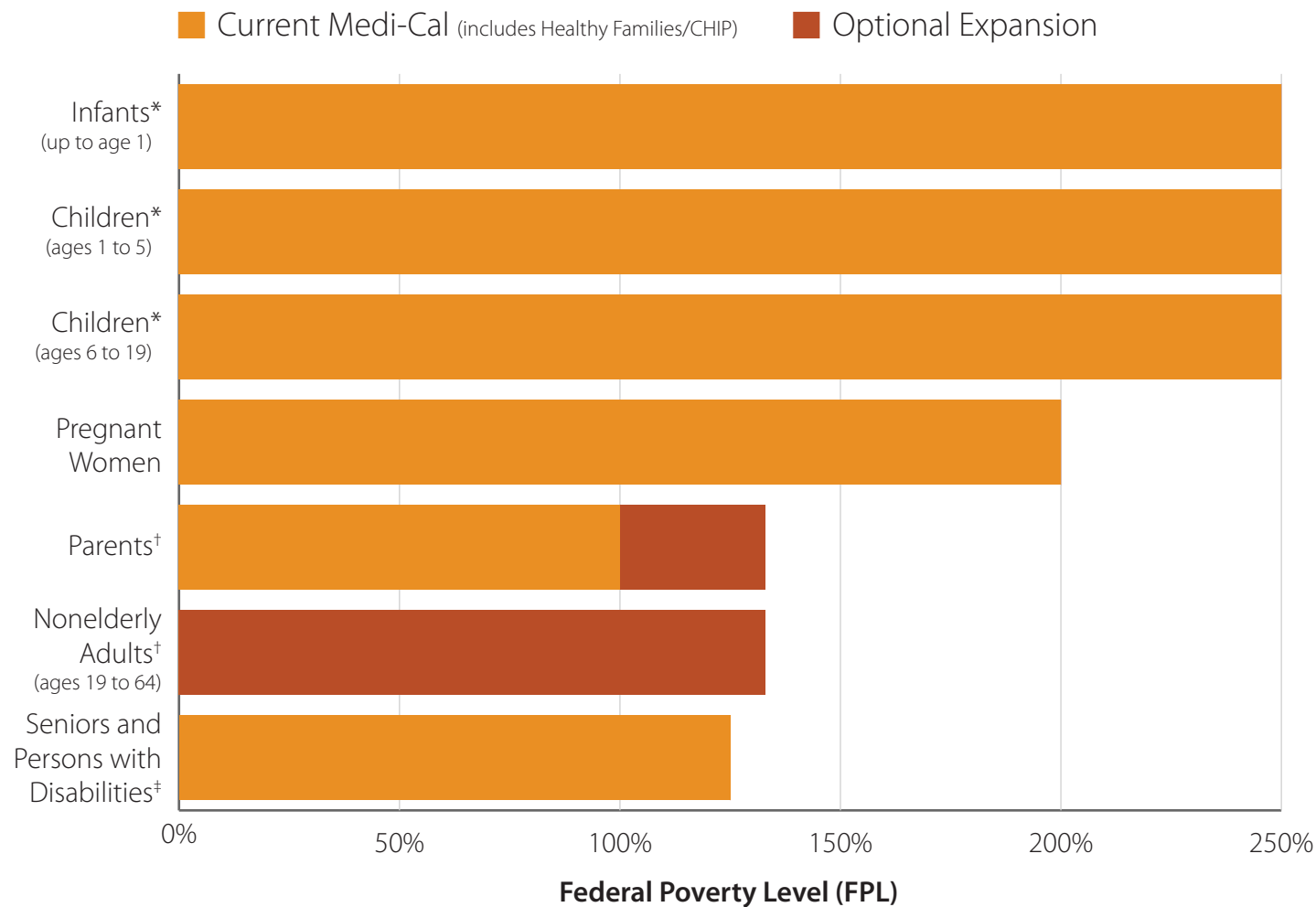
Note: CMS is Centers for Medicare & Medicaid Services (CMS).

Source: California Department of Health Care Services (DHCS), *Dual Eligibles Coordinated Care Demonstration*, 2012, www.dhcs.ca.gov.

Income Limits After 2014

Medi-Cal Facts and Figures

Medi-Cal and Health Reform



The ACA authorizes states to expand coverage to nonelderly adults, including those without dependent children, with incomes up to 133% FPL, beginning January 1, 2014. The federal government will pay 100% of the cost of coverage for newly eligible enrollees from 2014 through 2016, then reduce its share to 90% in 2020.

*ACA maintenance of effort requirements have states applying the same eligibility rules for children under Medicaid and Children's Health Insurance Program (CHIP) through October 1, 2019.

†Under current Medi-Cal rules, working parents may automatically deduct 6% of earnings, bringing their effective limit to 106% FPL. Under the ACA, application of a standard 5% income disregard for all enrollees brings the effective income limit to 138% FPL.

‡ACA does not change the eligibility rules for persons qualifying for Medicaid on the basis of disability.

Sources: Centers for Medicare & Medicaid Services (CMS), Eligibility, www.medicaid.gov. Health Consumer Alliance, *Medi-Cal/Healthy Families Income Levels*, www.healthconsumer.org. Department of Health and Human Services, *Federal Poverty Guidelines*, 2012, aspe.hhs.gov/poverty. Social Security Administration, *OASDI and SSI Program Rates and Limits*, 2011, www.ssa.gov. Access for Infants and Mothers Program, *Income Guidelines*, www.aim.ca.gov. CMS, *Informational Bulletin on Updates on Medicaid/CHIP*, August 31, 2011, www.cms.gov.

Enrollment and the Exchange

- Beginning in 2014, the ACA requires states to simplify Medicaid eligibility rules and enrollment, including determination of family income and eliminating the asset test for most enrollees, among other changes.
- The ACA also requires states to make health insurance exchanges available to consumers. California's exchange, Covered California, will offer qualified health plans for non-Medi-Cal eligible individuals and small businesses, with subsidies available for individuals up to 400% FPL.
- The ACA requires that states create a "no wrong door" environment, so that applicants can access insurance coverage in a variety of ways: online, in person, by mail, or by phone.
- California is developing the California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) to support enrollment functions for the Exchange and Medi-Cal. CalHEERS will screen individuals for Medi-Cal eligibility and refer them to counties for enrollment. Covered California will coordinate with DHCS and counties to help transition Medi-Cal enrollees between coverage programs if their eligibility changes.

Medi-Cal Facts and Figures

Medi-Cal and Health Reform

Under the ACA, states are required to provide a single enrollment point for the Exchange, Medicaid, and CHIP. California is building the CalHEERS portal to meet this requirement.

Notes: CHIP is the Children's Health Insurance Program. FPL is federal poverty level. DHCS is the California Department of Health Care Services.

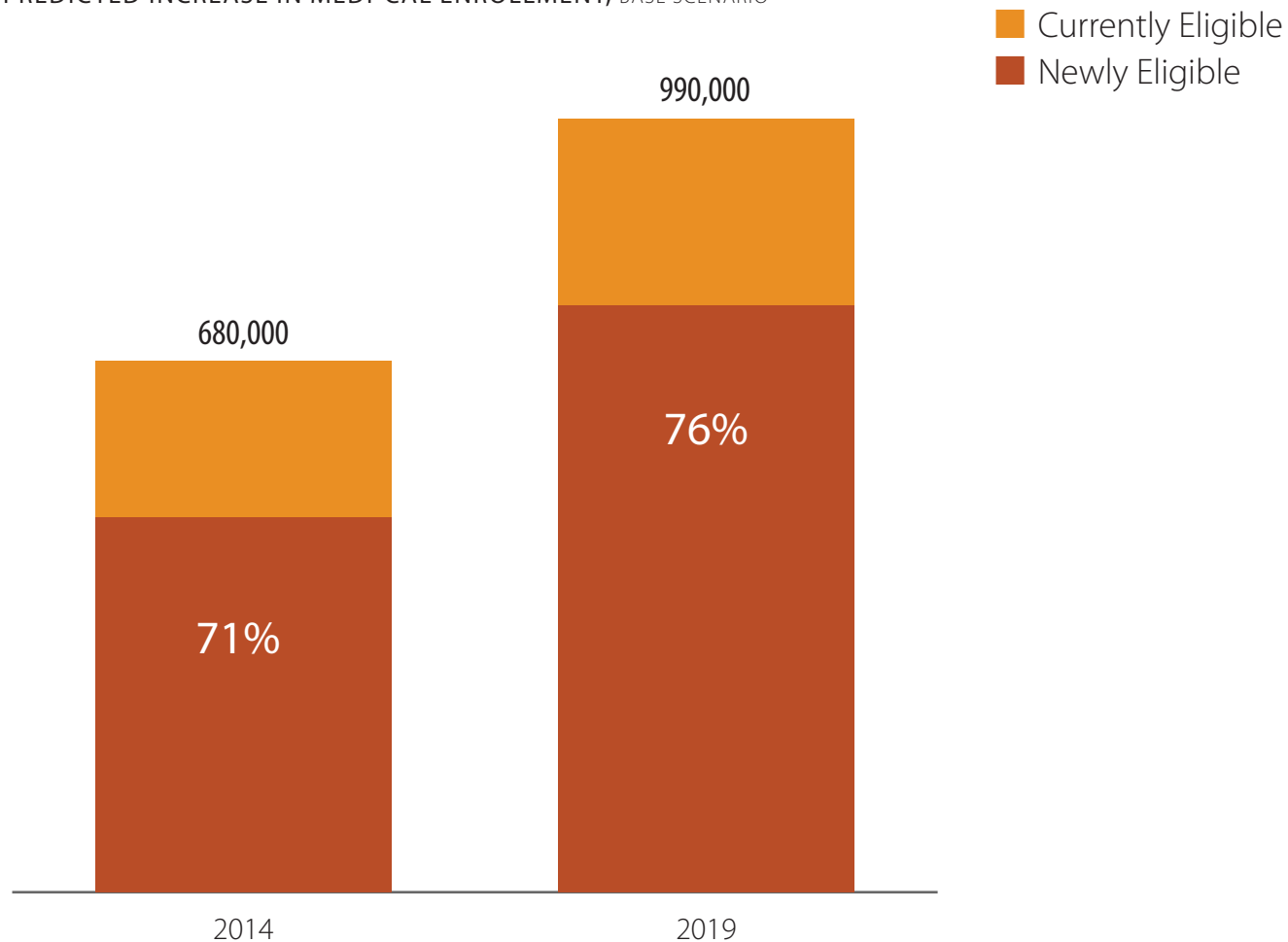
Sources: California Health Benefit Exchange, *Key Questions and Answers on the Impact of Potential Supreme Court Decision on California*, June 26, 2012, www.healthexchange.ca.gov. California Health Benefit Exchange, *California Health Benefit Exchange*, 2012, www.healthexchange.ca.gov. California Health Benefit Exchange, *California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) Development and Operations Services Solicitation*, 2012, www.healthexchange.ca.gov.

Impact on Enrollment, 2014 and 2019

Medi-Cal Facts and Figures

Medi-Cal and Health Reform

PREDICTED INCREASE IN MEDI-CAL ENROLLMENT, BASE SCENARIO



By 2019, the number of people enrolled in Medi-Cal is projected to increase by nearly one million or more due to the ACA. About 25% of those projected to enroll in Medi-Cal after the expansion are already eligible under current rules.

Notes: Base scenario reflects take-up rates (i.e., share of those eligible who will enroll) in 2018 of 61% among those newly eligible for Medi-Cal and 10% among those currently eligible but unenrolled. Enhanced scenario (not shown) reflects take-up rates of 75% and 40%, respectively. Under the enhanced scenario, Medi-Cal enrollment gain due to the ACA is projected to be 1.4 million by 2019.

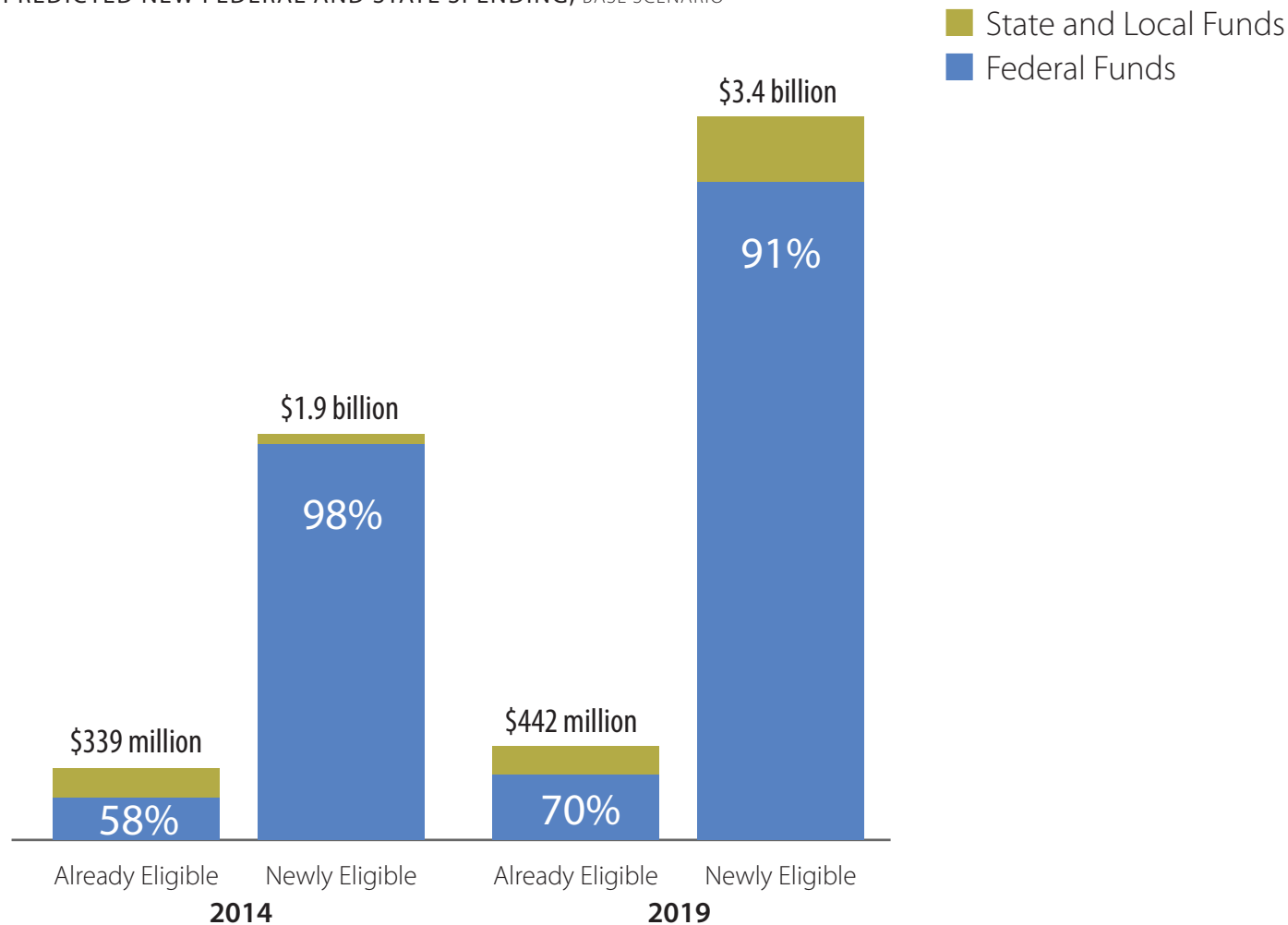
Source: UCLA Center for Health Policy and UC Berkeley Labor Center, *Medi-Cal Expansion Under the Affordable Care Act: Significant Increase in Coverage with Minimal Cost to the State*, January 2013, laborcenter.berkeley.edu.

Impact on Spending, 2014 and 2019

Medi-Cal Facts and Figures

Medi-Cal and Health Reform

PREDICTED NEW FEDERAL AND STATE SPENDING, BASE SCENARIO



The federal government is projected to pay for at least 85% (not shown) of total new Medi-Cal spending between 2014 and 2019.

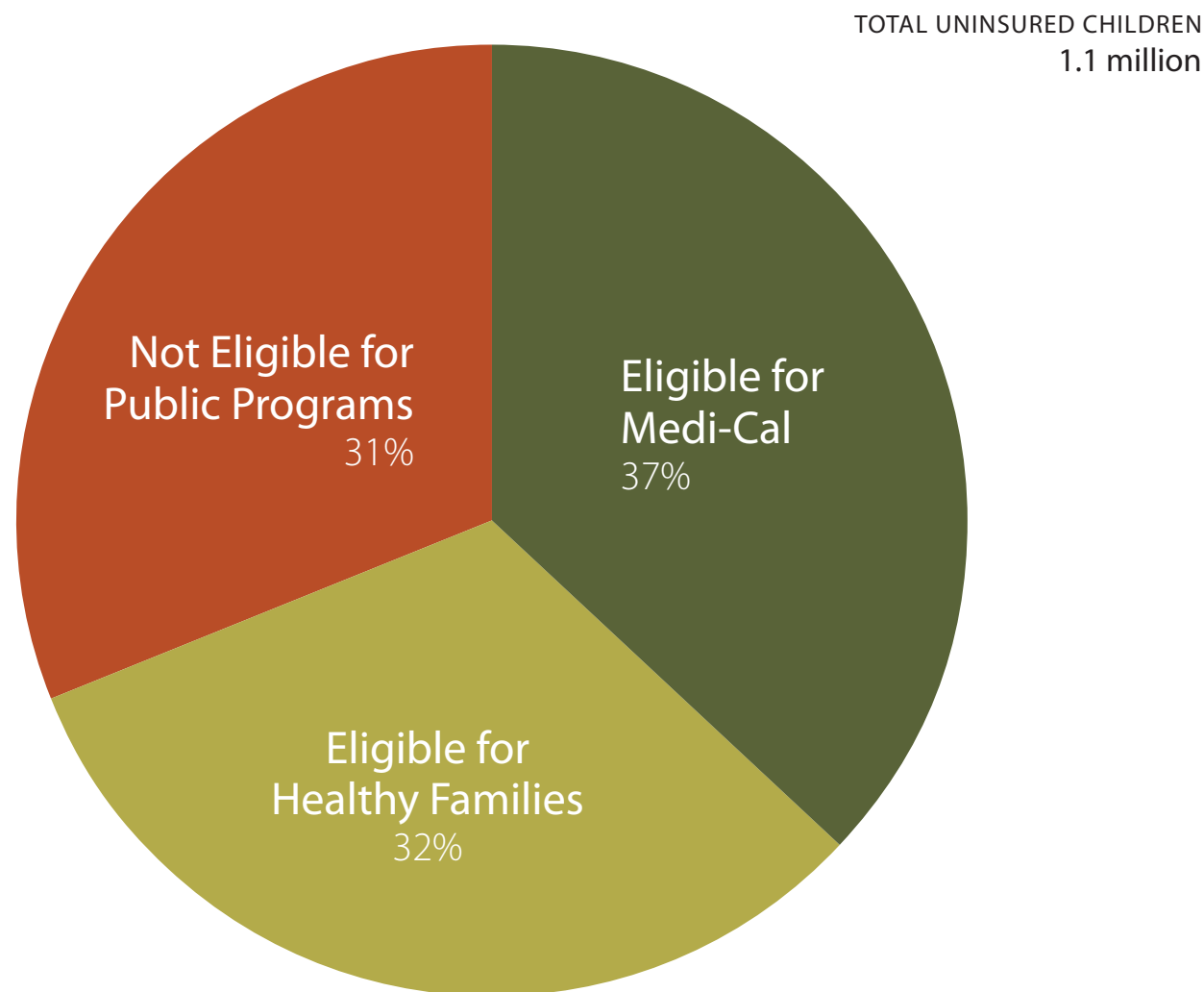
Note: Spending estimates reflect the base scenario for the California Simulation of Insurance Markets model and include administrative costs for both newly eligible and already eligible groups.

Source: UCLA Center for Health Policy and UC Berkeley Labor Center, Medi-Cal Expansion Under the Affordable Care Act: *Significant Increase in Coverage with Minimal Cost to the State*, January 2013, laborcenter.berkeley.edu.

Children Eligible but Not Enrolled, 2012

Medi-Cal Facts and Figures

Challenge: Enrollment



According to recent estimates, more than two-thirds of uninsured children in California are eligible for Medi-Cal, including those who had been eligible for Healthy Families.

Note: Estimates of the percentage of uninsured children eligible but not enrolled in Medi-Cal or Healthy Families from the 2009 California Health Interview Survey are similar to the Current Population Survey (CPS), although the total numbers of uninsured children differ significantly.

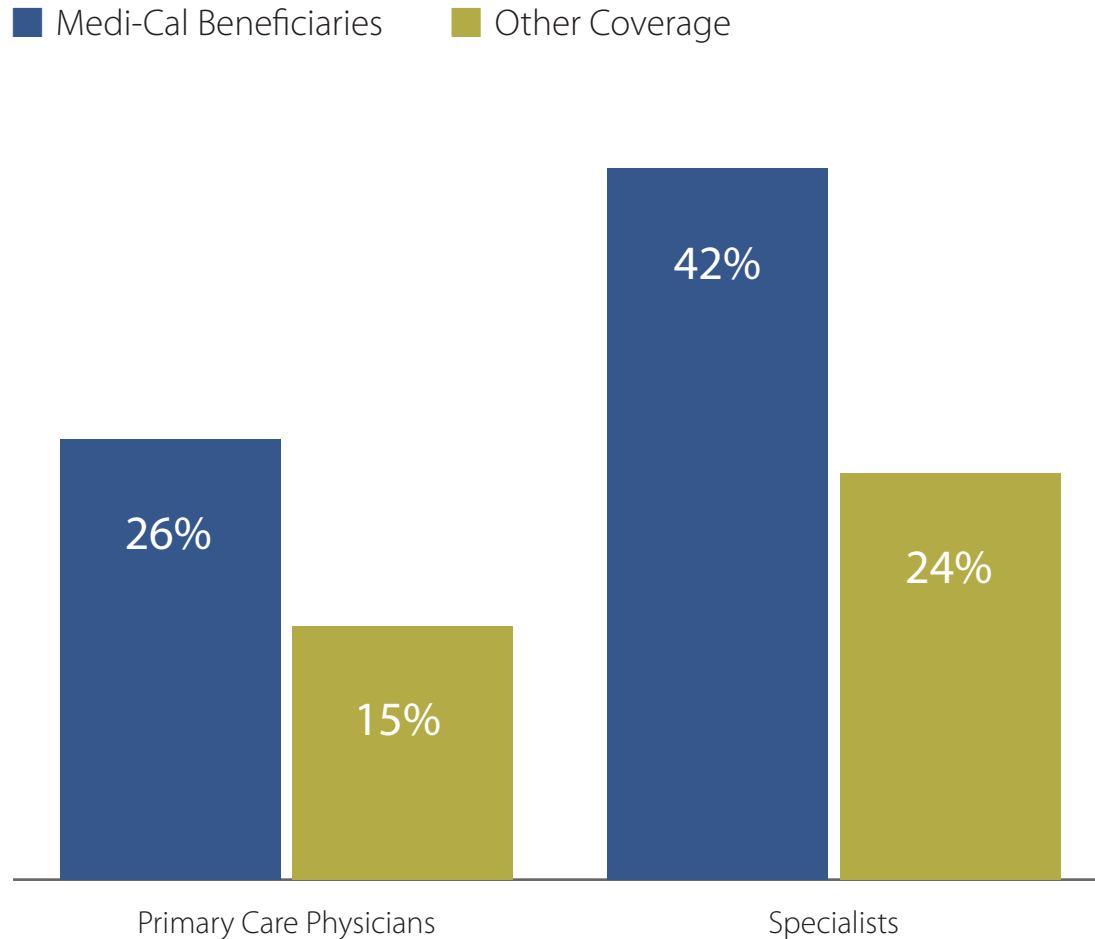
Source: Employee Benefit Research Institute estimates of the CPS, 2012 March Supplement. CPS collects data on citizenship but not immigrant status; the values shown here underestimate children eligible for Medi-Cal because it is restricted to citizens. See California HealthCare Foundation, *California's Uninsured: Treading Water* for more information, www.chcf.org.

Access to Providers, 2012

Medi-Cal Facts and Figures

Challenge: Access

PERCENTAGE REPORTING DIFFICULTY GETTING APPOINTMENTS



Adults with Medi-Cal are nearly twice as likely to report difficulty getting a doctor appointment than other insured adults in California.

Notes: Other Coverage includes employer-purchased plans, self-purchased plans, and Medicare. Adults with other types of health insurance includes adults of all income levels. Excludes Medicare-Medicaid enrollees and enrollees unable to participate in telephone survey.

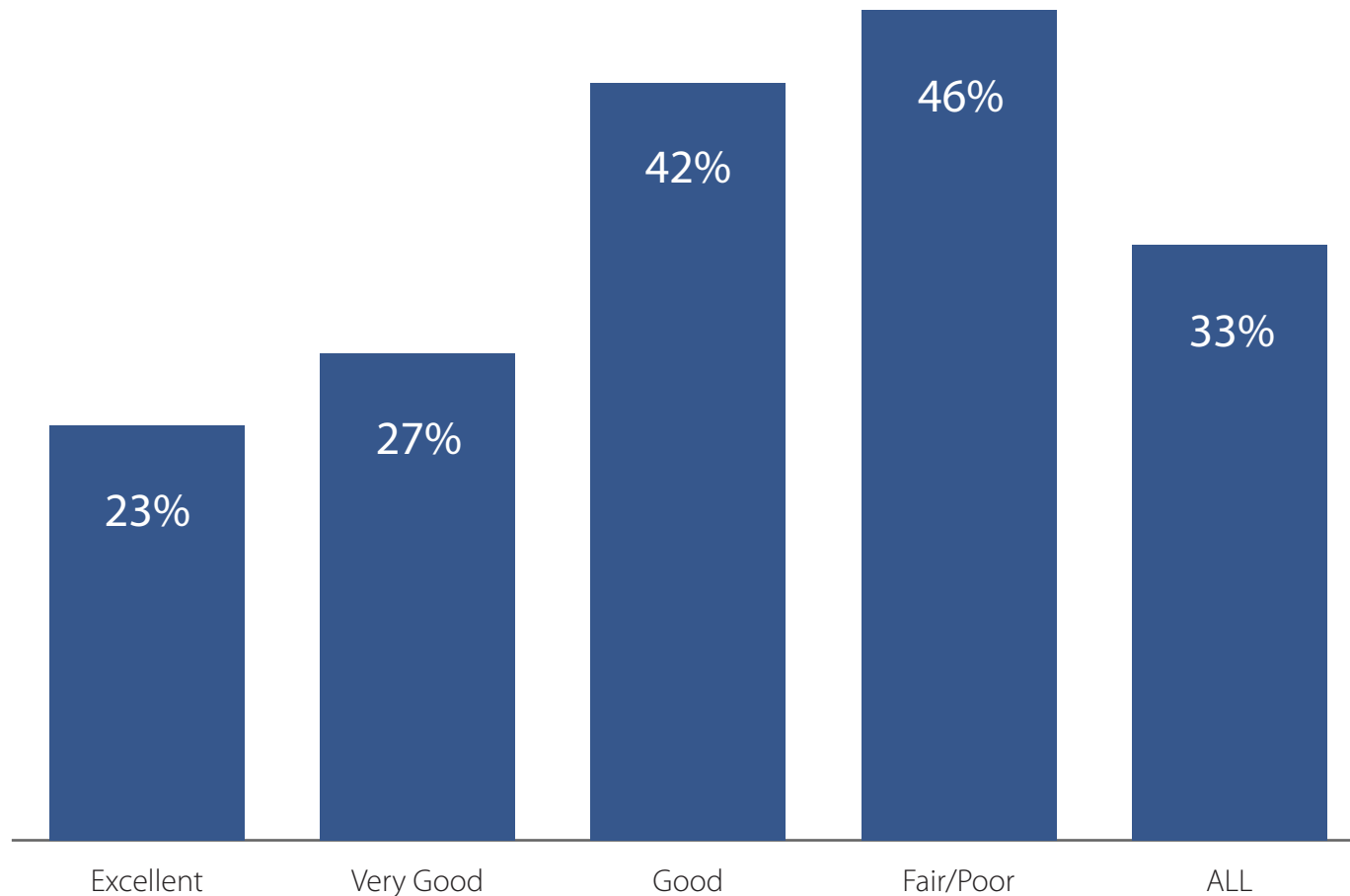
Source: California HealthCare Foundation, *Medi-Cal at a Crossroads: What Enrollees Say About the Program*, research conducted by Lake Research Partners, May 2012, www.chcf.org.

Access to Specialists, by Health Status, 2012

Medi-Cal Facts and Figures

Challenge: Access

PERCENTAGE REPORTING DIFFICULTY GETTING APPOINTMENTS



One-third of all Medi-Cal enrollees reported difficulty getting an appointment with a specialist. Enrollees in fair or poor health were twice as likely to report having trouble getting an appointment as enrollees in excellent health.

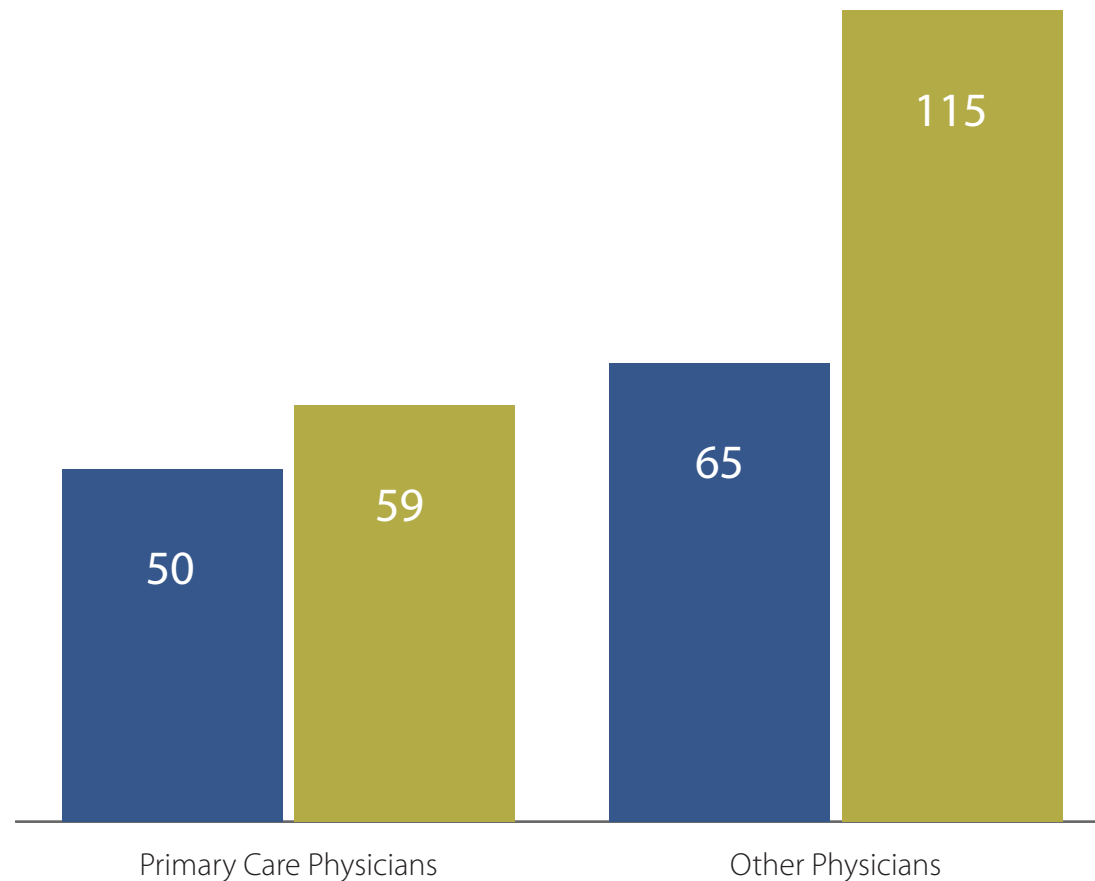
Notes: Excludes Medicare-Medicaid enrollees and enrollees unable to participate in telephone survey. Includes parents responding about their enrolled children.

Source: California HealthCare Foundation, *Medi-Cal at a Crossroads: What Enrollees Say About the Program*, research conducted by Lake Research Partners, May 2012, www.chcf.org.

Physician Participation, 2008

PER 100,000 PEOPLE

■ Medi-Cal Beneficiaries ■ Overall



Note: Numbers based on physicians providing patient care at least 20 hours per week.

Source: California HealthCare Foundation, *Physician Participation in Medi-Cal, 2008*, July 2010, www.chcf.org.

Medi-Cal Facts and Figures

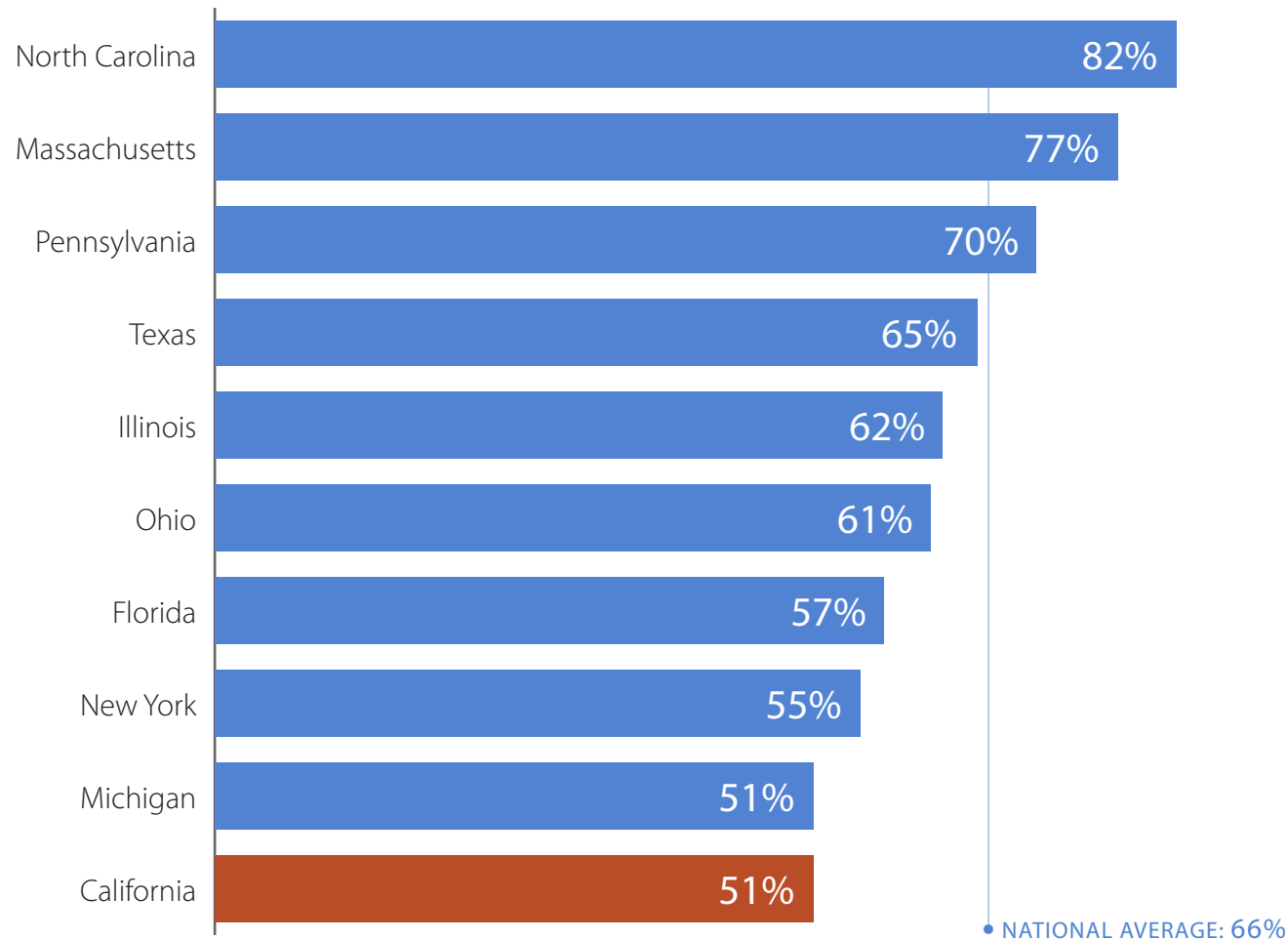
Challenge: Access

In 2008, there were only 50 primary care providers for every 100,000 Medi-Cal beneficiaries in California, well below the federal guidelines of 60 to 80 per 100,000. For other physicians, the physician-to-population ratio is 43% lower for Medi-Cal enrollees than for the California population overall.

Physician Payment Rates

Compared to Other States, FY2012

MEDICAID RATES AS A PERCENTAGE OF MEDICARE



Note: States with the 10 largest Medicaid programs based on FY2009 expenditures are represented along with the national average.

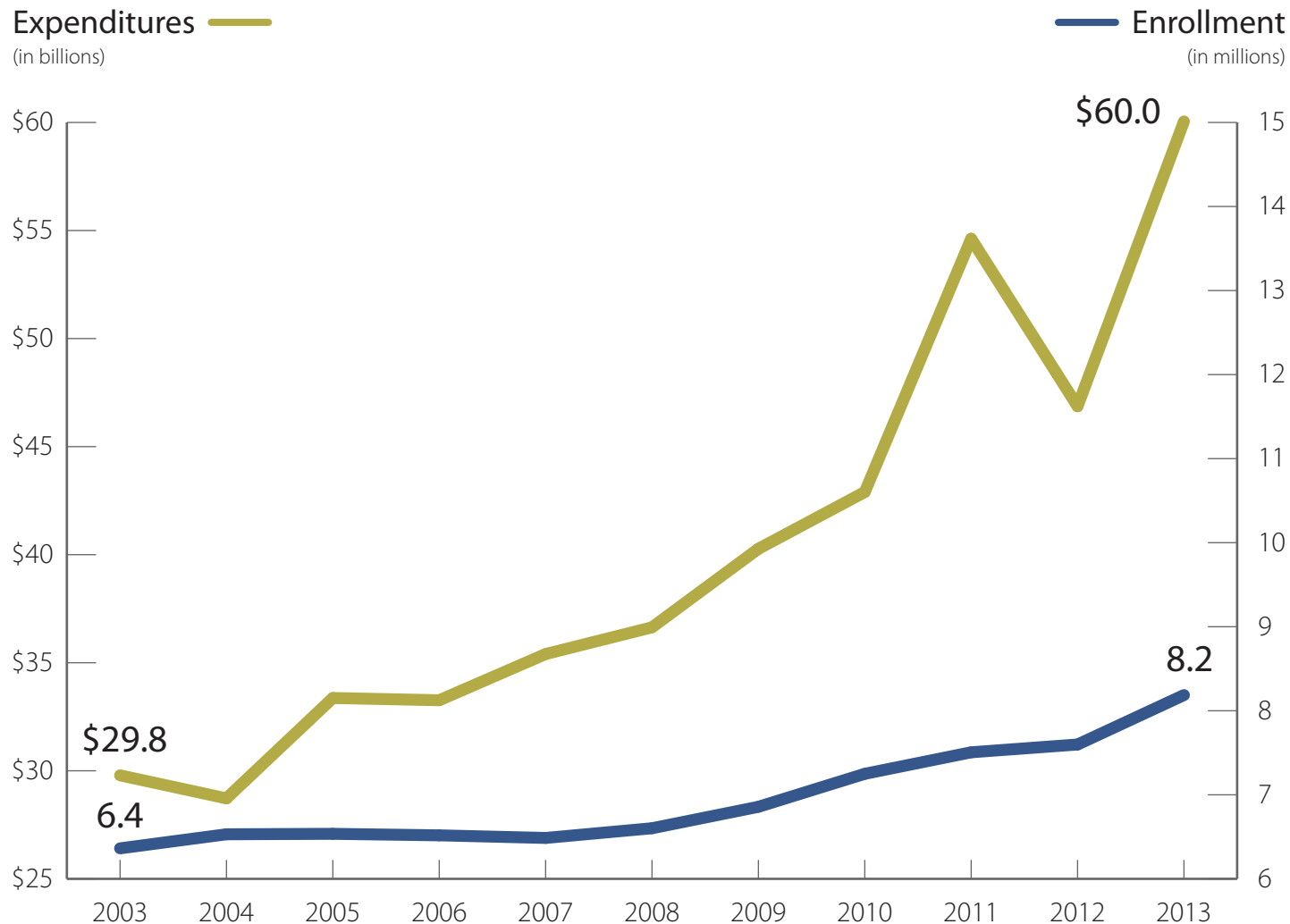
Source: Stephen Zuckerman and Dana Goin, *How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees*, Urban Institute and Kaiser Family Foundation, December 2012, www.kff.org.

Medi-Cal Facts and Figures

Challenge: Access

Medi-Cal pays physicians 51% of Medicare rates for the same service, an amount below the national average. The ACA will require states to increase Medicaid payments in 2013 and 2014 for primary care physicians to reach parity with Medicare; 100% of the costs will be met through federal funding.

Spending and Enrollment Trends, 2003 to 2013



Notes: Expenditures include total Medi-Cal spending. For FY2002–03 to FY2011–12, enrollment estimates are for the month of January for the corresponding fiscal year. The enrollment estimate for FY2012–13 is a projection based on the November 2012 Local Assistance Estimate from the California Department of Health Care Services (DHCS).

Sources: DHCS, *Medical Certified Eligibles, Summary Pivot Table, Most Recent 24 Months*, January 2012, www.dhcs.ca.gov. DHCS, Fiscal Forecasting and Data Management Branch, *Medi-Cal Local Assistance Estimates, FY2002–03 through FY2011–12*, www.dhcs.ca.gov, and FY2012–2013, www.dhcs.ca.gov. DHCS, Research and Analytical Studies Branch, *Trend in Total Medi-Cal Certified Eligibles: 2000–2011*, www.dhcs.ca.gov.

Medi-Cal Facts and Figures

Challenge: Rising Costs

Over the past decade, total Medi-Cal spending has grown at an average annual rate of 7%, reaching a new peak in FY2012–13 due in part to the transition of Healthy Families enrollees into Medi-Cal. Enrollment has accounted for about one-third of the growth in Medi-Cal spending over the decade. Spending in recent years has fluctuated dramatically.*

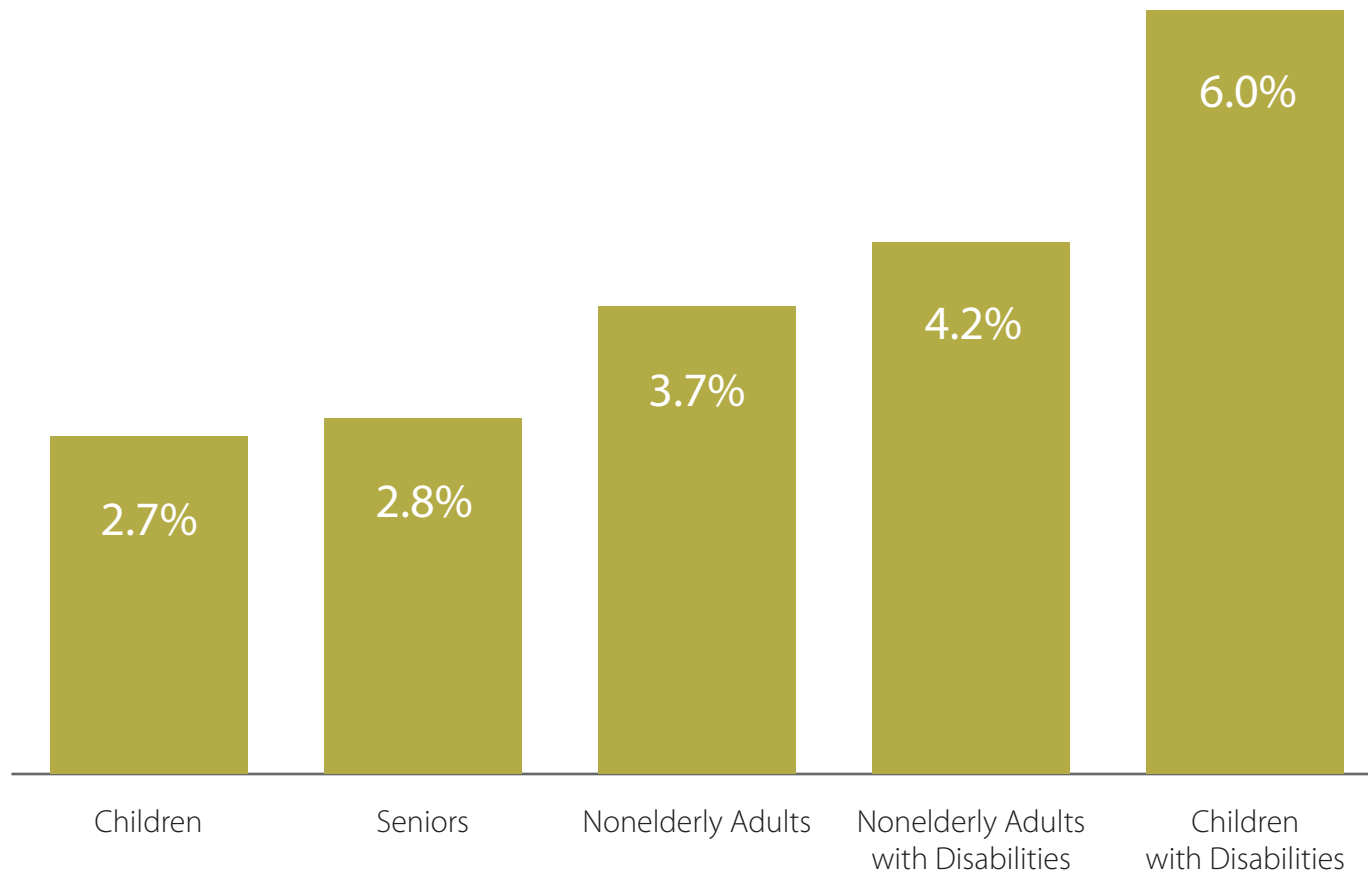
*Expenditures reflect cash basis. Large fluctuations in recent years reflect delays in payment due to pending federal approval, shifting payments from one year to the next, and policy changes, among other factors.

Change in per-Person Spending, 2001 to 2011

Medi-Cal Facts and Figures

Challenge: Rising Costs

AVERAGE ANNUAL GROWTH RATES



Between 2001 and 2011, the average cost per Medi-Cal beneficiary grew for every aid group, although it grew fastest for enrollees with disabilities.

Notes: Excludes Family Planning, Access, Care, and Treatment (PACT) beneficiaries from enrollment counts (1.3 million in 2001 and 1.8 million in 2011) and spending (\$324 million in 2001 and \$612 million in 2011). Also excludes enrollees for whom age and eligibility category are unknown (1.3 million in 2001 and 1.5 million in 2011) and corresponding spending.

Source: Lewin analysis of Medicaid Statistical Information System (MSIS) data for 12-month periods ending September 30, 2001, and September 30, 2011.

Spending Trends in Long Term Care Services, 2006 to 2011

AVERAGE ANNUAL GROWTH

Personal Care Services



Home- and Community-Based Services



Long Term Care Facilities



Notes: FFS is fee-for-service. Long Term Care Facilities include intermediate care facilities for individuals with intellectual disabilities and nursing facilities. Home- and Community-Based Services (HCBS) includes spending and beneficiaries for HCBS waiver services.

Source: Lewin analysis of Medicaid Statistical Information System (MSIS) data for 12-month periods ending September 30, 2006 and September 30, 2011.

Medi-Cal Facts and Figures

Challenge: Rising Costs

Use of and spending for long term care among Medi-Cal beneficiaries have grown significantly since 2006. Growth in users and spending has been fastest for home- and community-based services and personal care services. The number of beneficiaries in long term care facilities has remained flat, while expenditures for their care have risen.

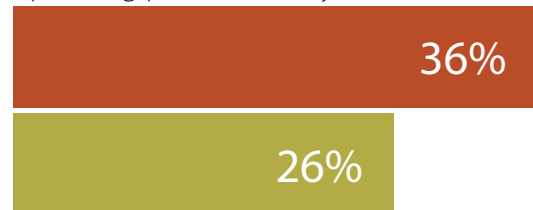
Enrollment and Spending Comparison, 2001 to 2009

INCREASE IN:

Enrollment



Spending per Beneficiary



Total Spending



Notes: For both California and the US, enrollment estimates exclude 1.3 million Family Planning, Access, Care, and Treatment (PACT) beneficiaries from 2001 enrollment counts and 1.8 million Family PACT beneficiaries from 2009 enrollment counts. Estimated spending also excludes the expenditures associated with these beneficiaries (\$324 million in 2001 and \$526 million in 2009).

Source: Lewin analysis of Medicaid Statistical Information System (MSIS) data for 12-month periods ending September 30, 2001 and September 30, 2009.

Medi-Cal Facts and Figures

Challenge: Rising Costs

Between 2001 and 2009, Medi-Cal spending per beneficiary grew faster than Medicaid nationwide, while enrollment grew at a slower pace. The result: a larger percentage increase in total spending for California than for the US as a whole.

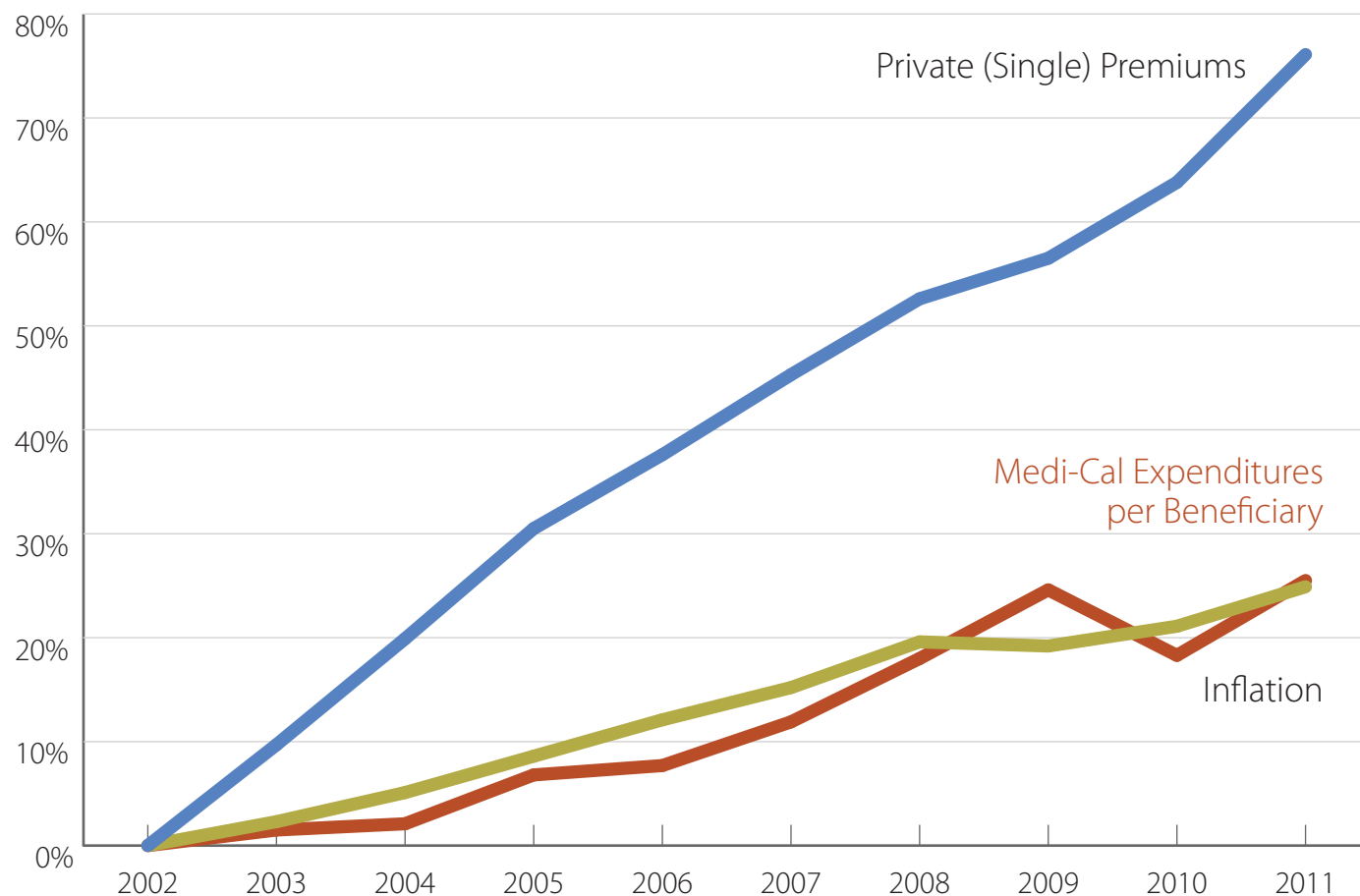
Health Care Cost Trends, 2002 to 2011

Medi-Cal Facts and Figures

Challenge: Rising Costs

Over the past decade, the rate of growth of Medi-Cal spending per beneficiary has been much lower than that of private health insurance premiums.

CUMULATIVE CHANGE



Sources: US Department of Labor, Bureau of Labor Statistics, *Table Containing History of CPI-U U.S. All Items Indexes and Annual Percent Changes from 1913 to Present*, www.bls.gov. Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits 2012 Annual Survey*, ehbs.kff.org. Lewin analysis of Medicaid Statistical Information System (MSIS) data for the 12-month period ending September 30, 2011.

Looking Ahead

Medi-Cal is in the midst of a major transformation. Most apparent are changes in enrollment, both underway and planned, from the transition of children from Healthy Families to Medi-Cal and from eligibility simplifications and expansions under the Affordable Care Act. No less profound is Medi-Cal's rapid change from a program in which care is paid on a fee-for-service basis to one dominated by fully capitated managed care.

These changes offer an important opportunity to improve the enrollee experience by simplifying eligibility determination, enhancing the quality of care, and improving coordination of care across a range of health, mental health and long term care providers.

However, Medi-Cal faces numerous challenges. Chief among these are the continuing rise of health care costs and the difficulty many beneficiaries report getting timely access to care. Moreover, if Medi-Cal's transformation is to be successful, beneficiaries and their health care providers must have the information and tools they need to be successful.

MEDI-CAL'S PRIORITIES INCLUDE:

- Implementing the Affordable Care Act by enrolling a million or more newly eligible individuals and ensuring they have appropriate access to care
- Ensuring that children in Healthy Families, seniors, and people with disabilities have a successful transition to Medi-Cal managed care
- Fostering improvements in care through payment reform, effective contracting, and oversight of plan and provider performance
- Slowing the continuing rise of Medi-Cal spending

Medi-Cal Facts and Figures

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Much of the information and data for this presentation was prepared by The Lewin Group. 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.

FOR MORE INFORMATION



CALIFORNIA
HEALTHCARE
FOUNDATION

California HealthCare Foundation
1438 Webster Street, Suite 400
Oakland, CA 94612
510.238.1040
www.chcf.org