Introduction

After nearly a decade of unprecedented economic growth, California now faces a multi-billion dollar budget deficit. In response, Governor Davis recently announced a package of current and upcoming fiscal year spending cuts totaling $5.2 billion. As the second-largest component of the state general fund, Medi-Cal will undoubtedly be impacted by these budget cuts. This issue brief provides an overview of the Medi-Cal budget and its cost drivers, and discusses the four elements that shape Medi-Cal spending: eligibility/enrollment, benefits, service use, and provider rates.

Overview of Medi-Cal Expenditures

Medi-Cal expenditures are expected to total $26.9 billion in FY 2002-03; $10.1 billion of that amount will come from the state’s General Fund, while the remainder will be financed by federal matching payments and intergovernmental transfers. More than half of Medi-Cal expenditures are for direct fee-for-service (FFS) payments to physicians, hospitals, pharmacy providers, and long-term care facilities (Figure 1). An additional 16 percent of expenditures go to health plans, which are responsible for reimbursing providers for services delivered through the Medi-Cal managed care program. Administrative costs account for approximately $1.5 billion, or roughly 6 percent of the Med-Cal budget; the vast majority of this expense is $1.2 billion in payments to counties to support eligibility determination and other county activities.1
Cost Drivers

Medi-Cal expenditures have increased by 56 percent in the past decade, increasing from $17.2 billion in FY 1993-94 to a projected $26.9 billion in FY 2002-03 (Figure 2).\(^1,2\) A portion of this growth can be explained by a 23 percent increase in Medi-Cal enrollment over the same period (from 5.3 million beneficiaries in FY 1993-94 to an estimated 6.5 million in FY 2002-03).\(^3,4\)

Another contributing factor is the growth of total program expenditures per Medi-Cal enrollee, which increased by nearly 60 percent between FY 1994-95 and FY 2000-01. A large portion of this growth can be attributed to increases in spending on pharmaceuticals, nursing facilities, and inpatient hospital services in the same time period. Pharmacy expenditures, for example, accounted for one-third of the total growth in Medi-Cal FFS per capita provider

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* Figure 1: Medi-Cal Expenditures by Service Category, FY 2000-01

* Figure 2: Medi-Cal Expenditure and Beneficiary Trends, FY 1993-94 to FY 2002-03

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* Projected

Sources:
2. California Department of Health Services. Counts of Medi-Cal Beneficiaries by County, Aid Code and Month.
3. California Department of Finance. 2002-03 Governor’s Budget Summary.
payments, increasing from $1 billion in FY 1994-95 to $2.2 billion in FY 2000-01.\(^6\) Nursing facility payments accounted for more than 20 percent of the per capita increase, and inpatient hospital services were responsible for 15 percent of the growth. Despite these recent increases, however, California spends on average 32 percent less per beneficiary than the nationwide average ($2,573 per enrollee in CY 1998, compared to a nationwide average of $3,822). As a result, California ranks 51st out of 51 Medicaid programs in per capita expenditures.\(^7\)

Although Medi-Cal is often thought of as a health insurance program for low-income mothers and children, a significant proportion of the program’s budget is spent on services for elderly and disabled individuals. The elderly and disabled populations, which tend to be higher users of costly services like long-term care and pharmaceuticals, are on average much more expensive to care for than children and non-disabled adults. While the elderly and disabled comprise only 23 percent of the total Medi-Cal caseload, the majority of Medi-Cal expenditures (66 percent) are spent on these beneficiaries. In calendar year 1998, Medi-Cal spent an average of $940 for each child enrolled compared to $7,789 for each non-elderly disabled adult and $6,396 for each elderly enrollee (Figure 3).\(^8\)

### Policy Considerations

State policymakers and program officials can alter future Medi-Cal spending in four ways:

1. change the rules that determine who is eligible for Medi-Cal and the practices that affect who enrolls;
2. modify the benefits package available to those who enroll;
3. impose or reduce restrictions that affect the use of services; and/or
4. adjust provider payment rates.

### Eligibility and Enrollment

An average of 28.5 percent of California’s low-income residents (those with incomes less than 200 percent of the Federal Poverty Level) were enrolled in Medi-Cal in the period 1997 to 1999, compared to a national average of 26.4 percent.\(^9\) Federal law requires Medi-Cal and all other state Medicaid programs to provide coverage to “mandatory” eligibility categories, including individuals who would have qualified for cash assistance (AFDC) prior to welfare reform and those receiving Supplemental Security Income (SSI). In addition, states are given the option to provide Medicaid coverage to additional “optional” categories. Nationally, nearly one in three Medicaid enrollees is in one of these optional eligibility categories. These enrollees, many of whom are elderly and/or disabled, account for 44 percent of Medicaid expenditures.\(^10\)

Medi-Cal has chosen to include many of these optional categories, including coverage for individuals who may have too much income to qualify under the mandatory categories but who have “spent down” to Medicaid eligibility by incurring...
medical expenses that offset their excess income. In recent years, California has expanded eligibility to parents in families with incomes below 100 percent of the Federal Poverty Level (FPL), to the working disabled with incomes below 250 percent of FPL, and to seniors and disabled individuals with incomes below 133 percent of FPL.

Federal law offers additional options related to the duration of beneficiaries’ eligibility for Medicaid coverage. The Balanced Budget Act of 1997 gave states the option to provide extended coverage for children, regardless of changes in family income or resources. California, along with 17 other states, elected this option and, in January 2001, implemented 12 months of continuous eligibility for children in Medi-Cal.11 The proposed budget for FY 2002-03 includes $312 million to provide continuous eligibility to an estimated 450,000 children.12

Finally, efforts to simplify the enrollment and eligibility re-determination processes and to provide outreach to potential eligibles may impact the size of the Medi-Cal caseload. In 2000, California simplified the process for staying enrolled in Medi-Cal by eliminating the requirement that beneficiaries submit quarterly eligibility status reports. This change will allow an estimated 218,000 adults who would have otherwise lost their eligibility to retain Medi-Cal coverage.13 In addition, California has undertaken a series of outreach activities with the goal of increasing enrollment. In FY 2001-02, the state spent nearly $40 million on outreach activities aimed at increasing enrollment in Healthy Families and Medi-Cal for children.14

Benefits
All Medicaid programs are required to provide a core set of services, including doctor visits, hospital inpatient and outpatient care, nursing home care, laboratory tests, and x-rays. In addition, states have the option to offer 34 extra categories of services in their Medicaid programs. The Medi-Cal program includes 32 of the 34 optional categories, including dental and vision care for adults, as well as coverage of outpatient prescription drugs. More than one-third of Medi-Cal FFS payments in 1997 were spent on these optional benefits.15

The 1915(c) Medicaid waiver is an option that offers states some additional flexibility in designing their benefits packages. Known as the Home and Community-Based Services (HCBS) waiver, it allows states to go beyond the scope of traditional Medicaid benefits to cover additional medical and non-medical services. HCBS waivers enable states to treat certain Medicaid populations at home or in community-based settings rather than in institutional settings such as hospitals or nursing homes. California has six HCBS waivers that serve roughly 45,000 individuals who are frail elderly, developmentally disabled, physically disabled, or who have HIV/AIDS.16

The federal Department of Health and Human Services recently announced a new waiver option, the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative, which offers states the flexibility to make budgetary trade-offs between benefits and eligibility. HIFA will allow states to reduce benefits for optional categories of Medicaid enrollees and use those savings to extend eligibility to additional people (see text box).

Service Use
Service use is managed in Medi-Cal FFS by requiring prior authorization for some services through a Treatment Authorization Request (TAR). All inpatient hospital and long-term care services require TARs before Medi-Cal will pay for treatment. Other services that may require TARs include prescription drugs, medical equipment/supplies, and physical, occupational, and speech therapy. In addition to TARs, a number of states are implementing pharmacy utilization and/or disease management programs in their FFS programs to control costs.
Managed care, which has been implemented in some form by all state Medicaid programs, allows states to ensure predictable costs by instituting a predetermined, fixed payment that is not tied to the number of services utilized by an individual beneficiary. To date, California has limited mandatory Medi-Cal managed care enrollment in most counties primarily to non-disabled children and their parents. A significant number of other states require enrollment in managed care for disabled children (31 states), disabled adults (30 states), and the elderly (26 states).17

Service use can also be influenced by requiring beneficiary cost sharing such as copayments. The Governor’s proposed FY 2002-03 budget calls for increases in Medi-Cal copayments for prescription drugs, dental services, physician services, and home health. The copayments will be deducted from the providers’ payment rates, and it will be the responsibility of providers to collect them directly from Medi-Cal beneficiaries. Consequently, the impact of this proposal may be to reduce provider payments rather than to control utilization.

**Provider Payments**

Decisions about the level of payment rates for Medi-Cal providers can have a significant impact on the Medi-Cal budget. In FY 2000-01, rate

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**Recent Changes at the Federal Level**

- **FMAP Reduction.** Roughly half of all Medi-Cal expenditures come from matching federal funds that are derived from what is known as the Federal Medical Assistance Percentage (FMAP). In FY 2002-03, California’s FMAP will be reduced from 51.4 percent to 50 percent, resulting in a projected loss of $222 million in federal funding for the Medi-Cal program.19 Although California is home to 14 percent of the nation’s residents who live in poverty, it will now only receive 11 percent of total federal funds for Medicaid.19 The formula is based on a state’s average income rather than the number of low-income residents.

- **Revision to Medicaid Payments for Hospitals.** In January 2002, the Bush administration reduced the Medicaid Upper Payment Limit for public hospitals (the maximum amount the federal government will pay groups of providers) from 150 to 100 percent of the Medicare rate. This change will begin to be phased-in in California in FY 2003-04, and will be fully implemented by 2010. It is expected that safety net hospitals will lose approximately $1 billion in federal Medicaid payments during the phase-in period, and $300 million in each fiscal year thereafter.20 In addition, hospitals participating in the Disproportionate Share Hospital (DSH) program will receive approximately $184 million less in federal DSH funding in FY 2002-03, due to spending reductions established by the Balanced Budget Act of 1997.21

- **Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative.** In August 2001, the U.S. Department of Health and Human Services unveiled a new option that will allow states to increase the number of individuals who are insured within their current Medicaid and SCHIP budgets. This option allows states to trade-off reductions in benefits in order to expand eligibility in a budget-neutral way. Under HIFA, states can implement a reduced benefits package and cost-sharing requirements for optional categories of beneficiaries who are currently enrolled, and use those savings to enroll additional people who would not otherwise be eligible.

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increases for physicians, dentists, long-term care facilities and health plans totaled $800 million, or roughly 30 percent of the Medi-Cal program’s budget increase for that year. Governor Davis’s FY 2002-03 budget proposes to partially rescind approximately $155 million of those increases.

Payment rate adjustments can also impact access to care, as they may influence a provider’s decision to participate in the program. Despite the FY 2000-01 increases, California’s FFS physician payment rates rank 42nd out of 51 Medicaid programs in the country when adjusted for cost of living differences, and Medi-Cal rates average only 65 percent of what Medicare pays for the same services.

Fraudulent billing by providers can also drive up Medi-Cal spending. Between July 1999 and March 2001, California increased spending to detect and prevent fraudulent Medi-Cal provider claims by $18 million. The Department of Health Services estimates that its fraud prevention efforts saved $288 million (including cost avoidance) during this period, and that those savings are expected to increase to $500 million by 2003.

Looking Ahead

The call for state budget cuts comes at a time when the need for health coverage through the Medi-Cal program is growing. The program’s caseload has grown by nearly 20 percent in the last year, increasing from 5.2 million in January 2001 to 6.1 million in January 2002. As the unemployment rate in California approaches 6 percent, the number of people who depend on the Medi-Cal program for access to health care services will likely increase even further.

A number of additional challenges face the Medi-Cal budget in upcoming years, including:

- Medicare’s FFS program does not offer a pharmacy benefit, and many seniors enrolled in Medicare HMOs are losing their drug coverage. Consequently, a growing number of low-income seniors with high pharmacy costs are likely to enroll in Medi-Cal for its drug benefit. Alternatively, Medi-Cal spending for prescription drugs could fall if a pharmacy benefit is added to Medicare.
- California currently benefits from a waiver of standard Medicaid rules (known as the 1115 waiver), which will bring a total of $900 million in federal funds into the state between 2000 and 2005. The goals of this waiver are to increase the availability of ambulatory care services for the uninsured in Los Angeles County, and to restructure the county’s health system. The federal government has informed California that it will not renew this waiver when it expires in 2005.
- California’s growing senior population, which is expected to nearly double over the next 25 years, will translate into a growing number of elderly Medi-Cal beneficiaries. Many of these seniors will require long-term care and other high-cost services not currently covered by Medicare.

As policymakers weigh options for reducing Medi-Cal costs, it will be important to consider the unintended consequences their decisions may have. For every dollar of state funds cut from the Medi-Cal budget, the state loses another dollar in federal matching funds. Further, the provision of health care services has far-reaching implications, including an impact on worker productivity, the capacity of children to learn, and the success of individual efforts to transition from welfare to work.
**Endnotes**


8 Ibid.

9 Ibid.


11 Survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured.


13 Ibid.


16 For more information on California’s HCBS waivers, see *Understanding Medi-Cal: Long-Term Care*, Medi-Cal Policy Institute, 2001 (www.medi-cal.org).


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24 California Department of Health Services, Audits and Investigations. Personal communication with Diana Ducay, January 17, 2002.


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**About the Institute**

The Medi-Cal Policy Institute, established in 1997 by a grant from the California HealthCare Foundation, is an independent source of information on the Medi-Cal and Healthy Families programs. The Institute seeks to facilitate and enhance the development of effective policy solutions guided by the interests of the programs’ consumers. The Institute conducts and commissions research, distributes information about the programs and the people they serve, highlights the programs’ successes, and identifies the challenges ahead. It collaborates with a broad spectrum of policymakers, researchers, providers, consumer representatives, and other stakeholders who are working to create higher-quality, more efficient Medi-Cal and Healthy Families programs.