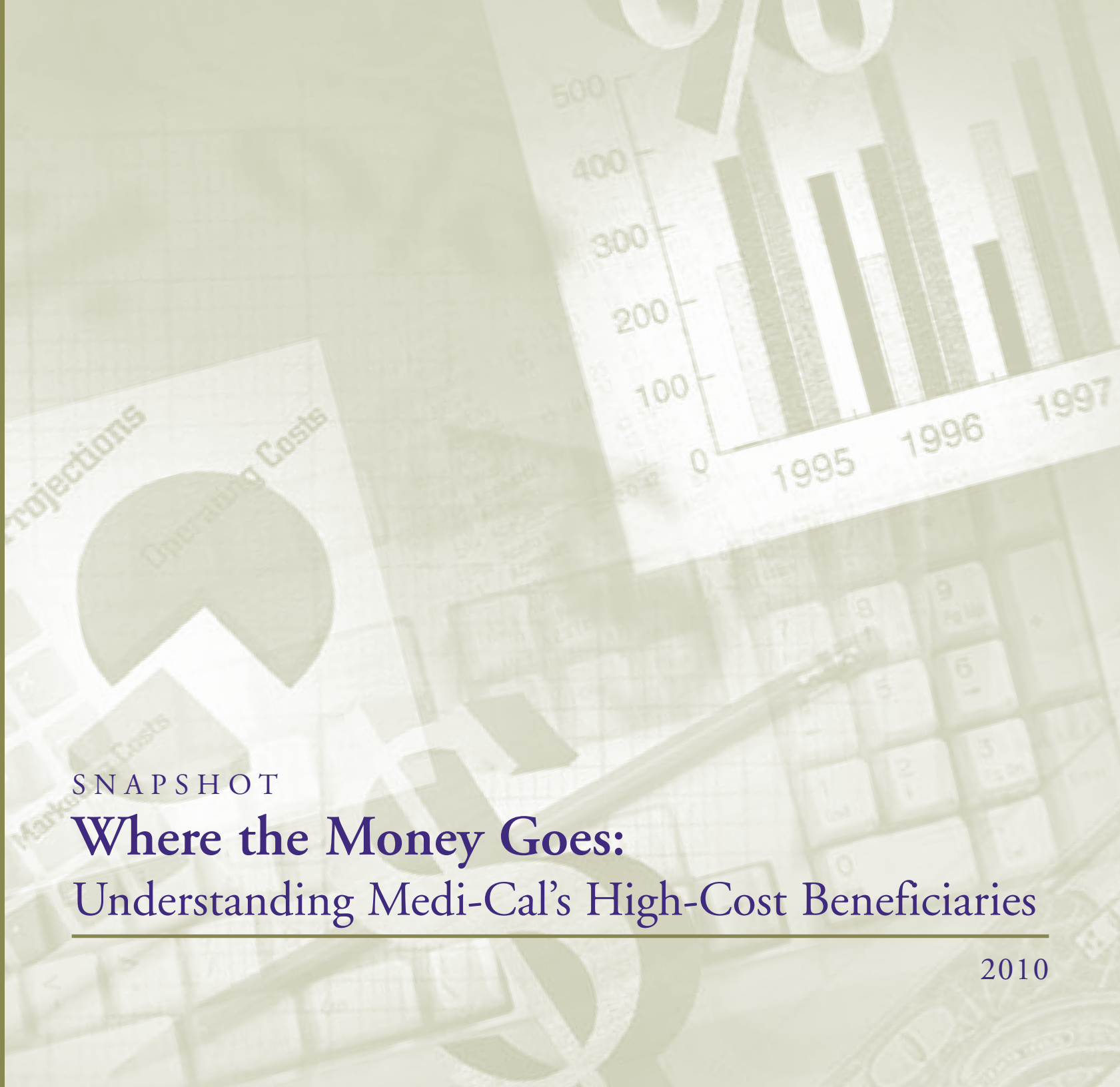

California HealthCare Foundation

SNAPSHOT

Where the Money Goes:

Understanding Medi-Cal's High-Cost Beneficiaries

2010

Introduction

In fiscal year (FY) 2009, California spent a total of $47 billion on Medi-Cal, the state's Medicaid program.* Seventy-three percent of that amount was spent on health care services and the remainder funded payments to disproportionate share hospitals (DSH), the Safety Net Care Pool, Medicare, program administration, and other expenses. As is common with other states' Medicaid programs and health insurance generally, spending was highly concentrated among a small number of beneficiaries: Seven percent of Medi-Cal beneficiaries accounted for more than three-quarters of fee-for-service (FFS) program expenditures in FY 2008.

Understanding this small but expensive group of beneficiaries is essential if California is to slow the growth of Medi-Cal spending, which accounts for an increasing share of the state budget. Although there is no single definition of a high-cost beneficiary, this analysis considers high-cost beneficiaries as individuals with Medi-Cal fee-for-service claims costs of $10,000 or more during FY 2008.

The findings in this presentation can inform the state's current programs and proposed initiatives targeting high-cost beneficiaries. It is clear that new approaches must better integrate physical health, mental health, and long term care services, and that Medi-Cal and Medicare must be better coordinated. Although there are numerous challenges to address, including the diversity of the high-cost population in terms of age, conditions, institutional status, and other characteristics, the continuity of coverage and persistence of costs among high-cost Medi-Cal beneficiaries means that there is an opportunity to improve health outcomes and control spending with programs specifically designed to manage care and coordinate services more effectively.

*California uses a July through June fiscal year. FY 2009 is the 12-month period beginning in July 2008 and extending through June 2009.

Sources: California HealthCare Foundation, *Medi-Cal Facts and Figures 2009*. Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008. California Department of Health Care Services (DHCS) Management Summary, Medi-Cal May 2009 Local Assistance Estimate for Fiscal Years 2007–2008 and 2008–2009, www.dhcs.ca.gov. Coughlin, T. and S. Long, "Health Care Spending and Service Use Among High-Cost Medicaid Beneficiaries 2002–2004," Inquiry 46: 405–417 (Winter 2009/2010).

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Summary of Key Findings

- High-cost beneficiaries are a diverse group, spanning the age spectrum and presenting a wide array of physical and mental health conditions.
- Most cases are not a function of episodic or catastrophic care.
- High-cost beneficiaries tend to have continuous Medi-Cal coverage and incur high claims for at least three years.
- Among those with costs greater than $10,000, nearly two-thirds have multiple conditions and more than one-third have co-occurring physical and mental health conditions.
- Nearly half of high-cost Medi-Cal beneficiaries have Medicare coverage.
- Long term care is a primary cost driver for high-cost Medi-Cal beneficiaries with Medicare coverage, whereas inpatient hospital admissions drive expenditures for those without Medicare coverage.
- Annual expenditures for the 1,000 most costly beneficiaries averaged $502,465 per person.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

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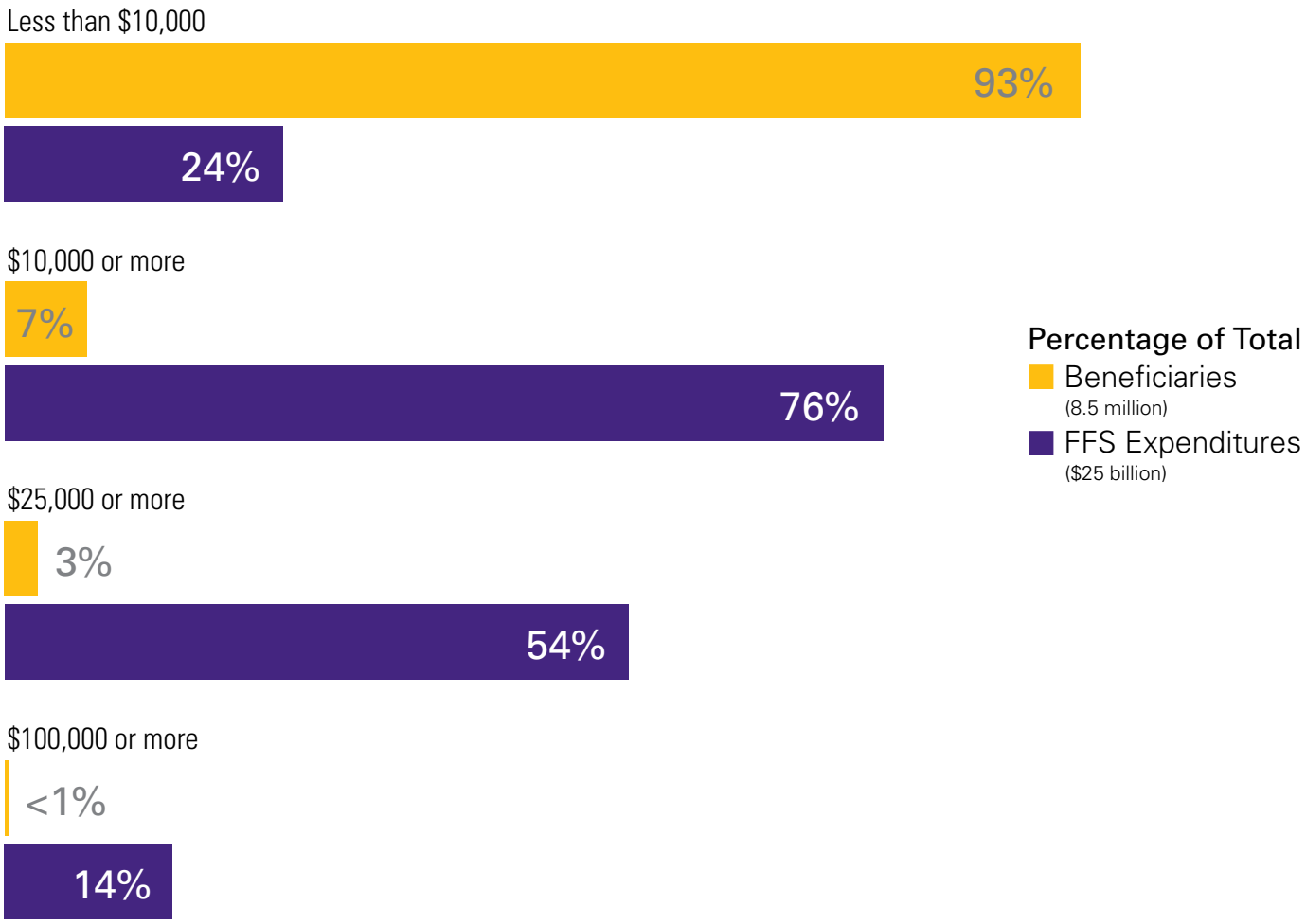
Medi-Cal Expenditures and Beneficiaries,
by Cost of Care, FY 2008



Notes: Statewide beneficiary total includes all individuals with at least one month of Medi-Cal coverage at some point during FY 2008. Individuals with only non-certified months of eligibility were excluded.

Sources: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009). Beneficiary counts in other states obtained from Centers for Medicare & Medicaid Services (CMS), msis.cms.hhs.gov (FY 2007 Quarterly Cube).

In FY 2008, 605,013 Medi-Cal beneficiaries generated $10,000 or more in FFS costs. This group of high-cost beneficiaries represented only 7 percent of Medi-Cal's total enrollment, yet accounted for 76 percent of total FFS expenditures.

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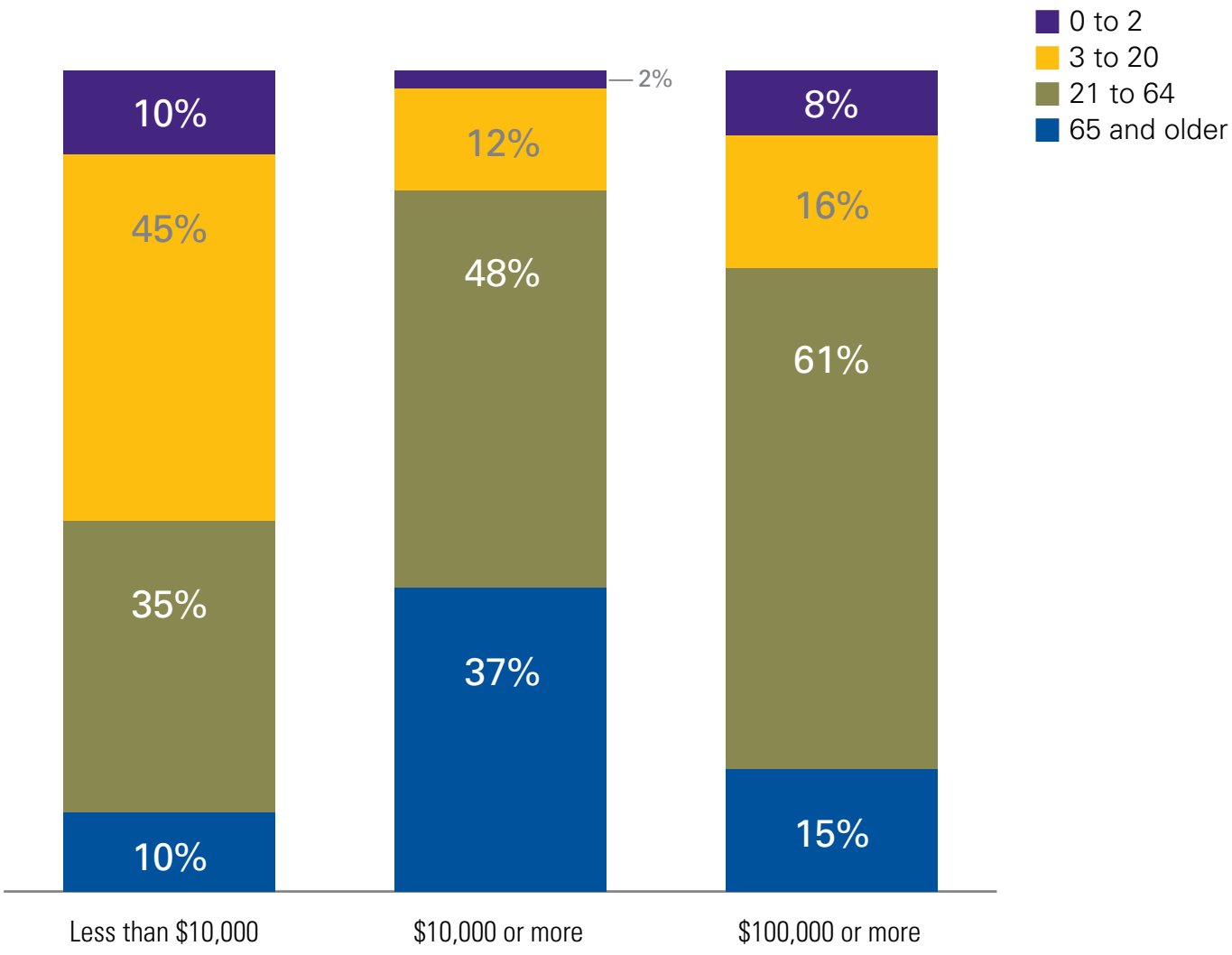
Age Group of Medi-Cal Beneficiaries,
by Cost of Care, FY 2008



Notes: Reflects fee-for-service expenditures only. Segments may not add to 100 percent due to rounding.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

Medi-Cal's high-cost beneficiaries are distributed across the age spectrum. Children are less likely than other age groups to incur FFS costs exceeding $10,000, as many are healthy and most are enrolled in capitated managed care plans.

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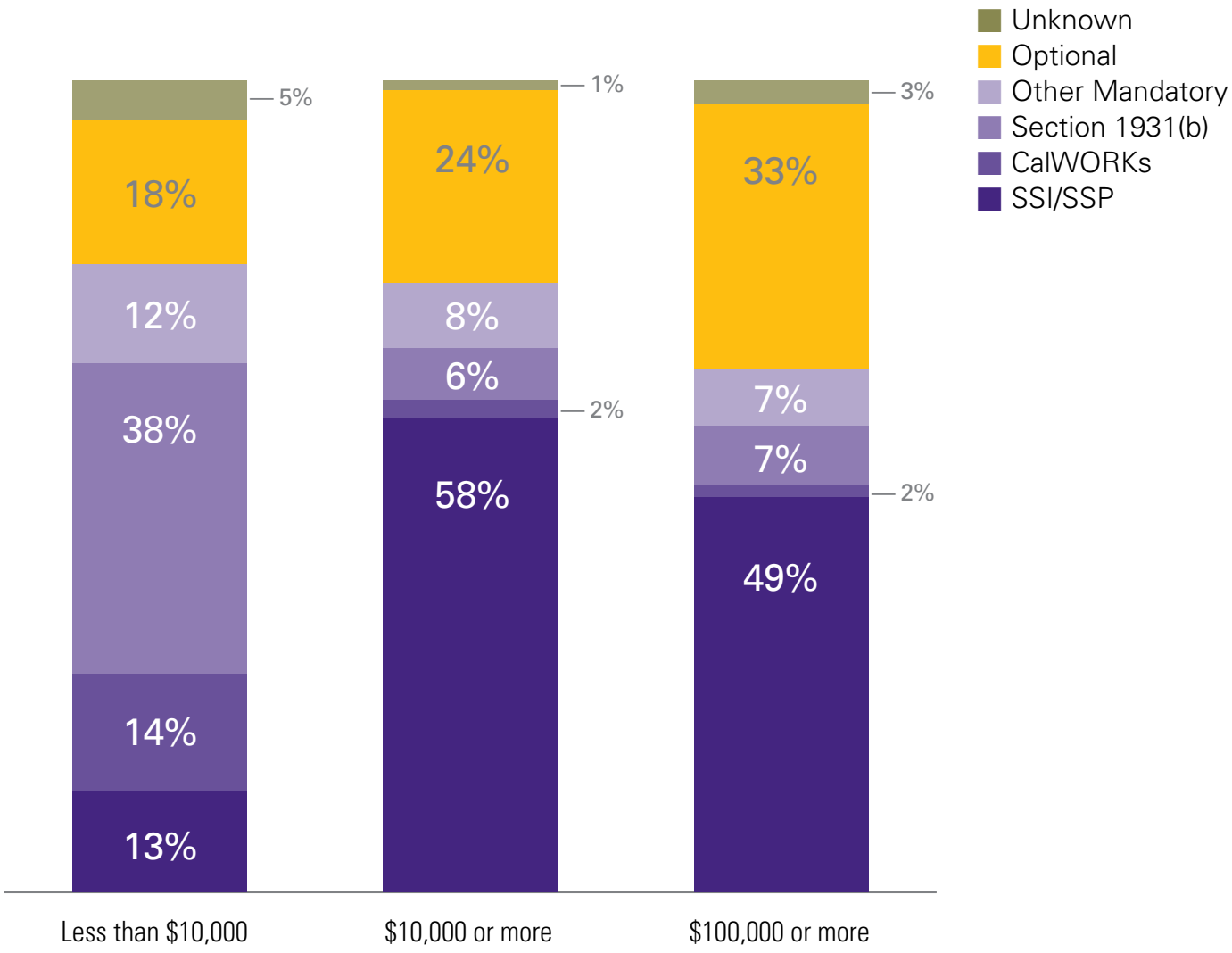
Medi-Cal Program Eligibility,
by Cost of Care, FY 2008



Note: Segments may not add to 100 percent due to rounding.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

Medi-Cal High-Cost Beneficiaries
Characteristics

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Most high-cost beneficiaries (58 percent) are enrolled in Medi-Cal because they qualify for federal cash assistance payments for low-income individuals who have a disability or are age 65 and older. The Optional group includes beneficiaries in Medi-Cal's medically needy programs, some of whom qualify for Medi-Cal following admission to a long term care facility.

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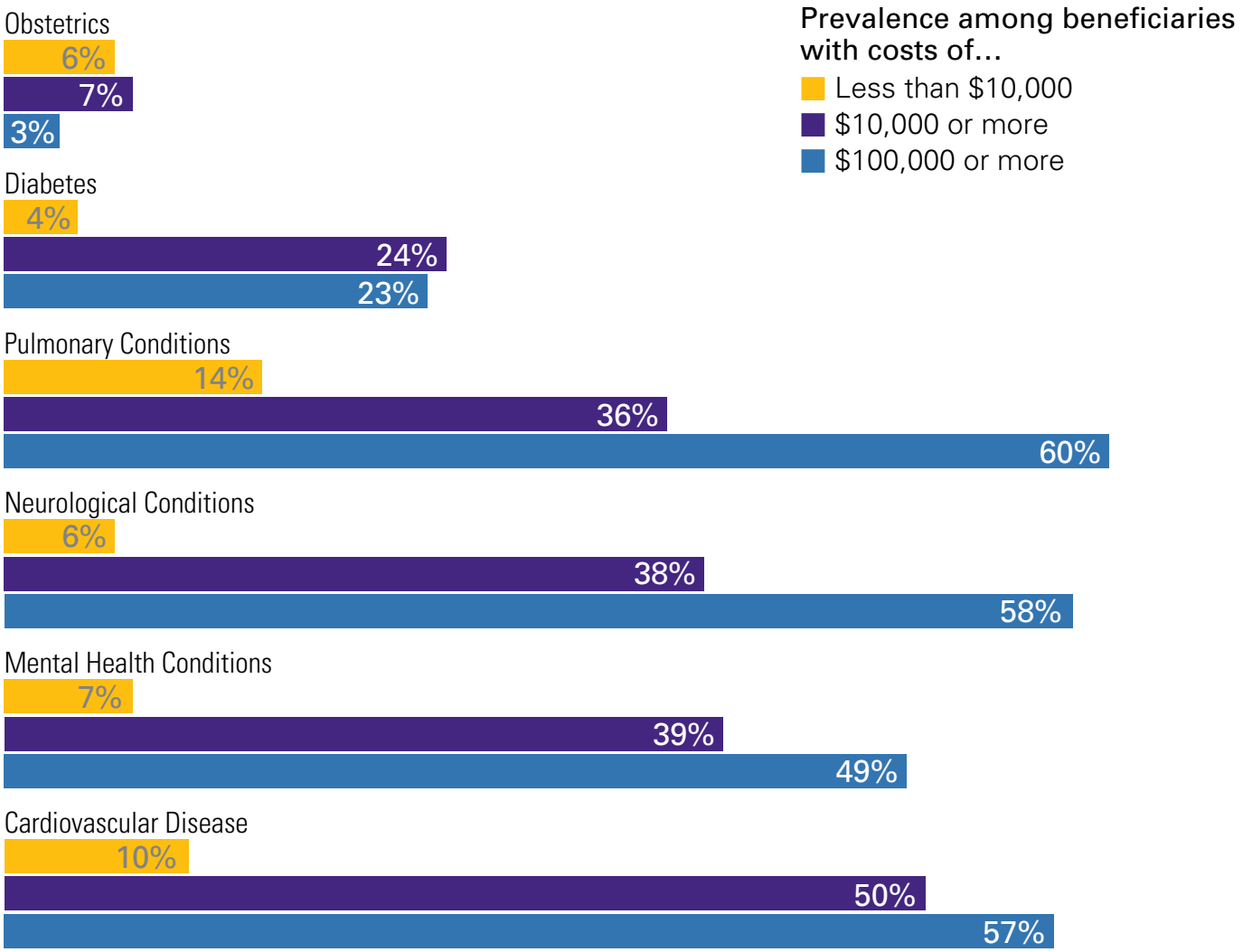
Prevalence of Selected Conditions,
by Cost of Care, FY 2008



Notes: Reflects fee-for-service expenditures only. The number of beneficiaries with each condition is based on claims and/or encounters indicating the condition. Percentages do not total 100 percent due to comorbidity. See Methodology section for description of selected conditions.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

High-cost beneficiaries have a wide array of conditions. The most common among the conditions analyzed were cardiovascular, mental health, neurological, and pulmonary conditions. One-half of high-cost beneficiaries have cardiovascular disease.

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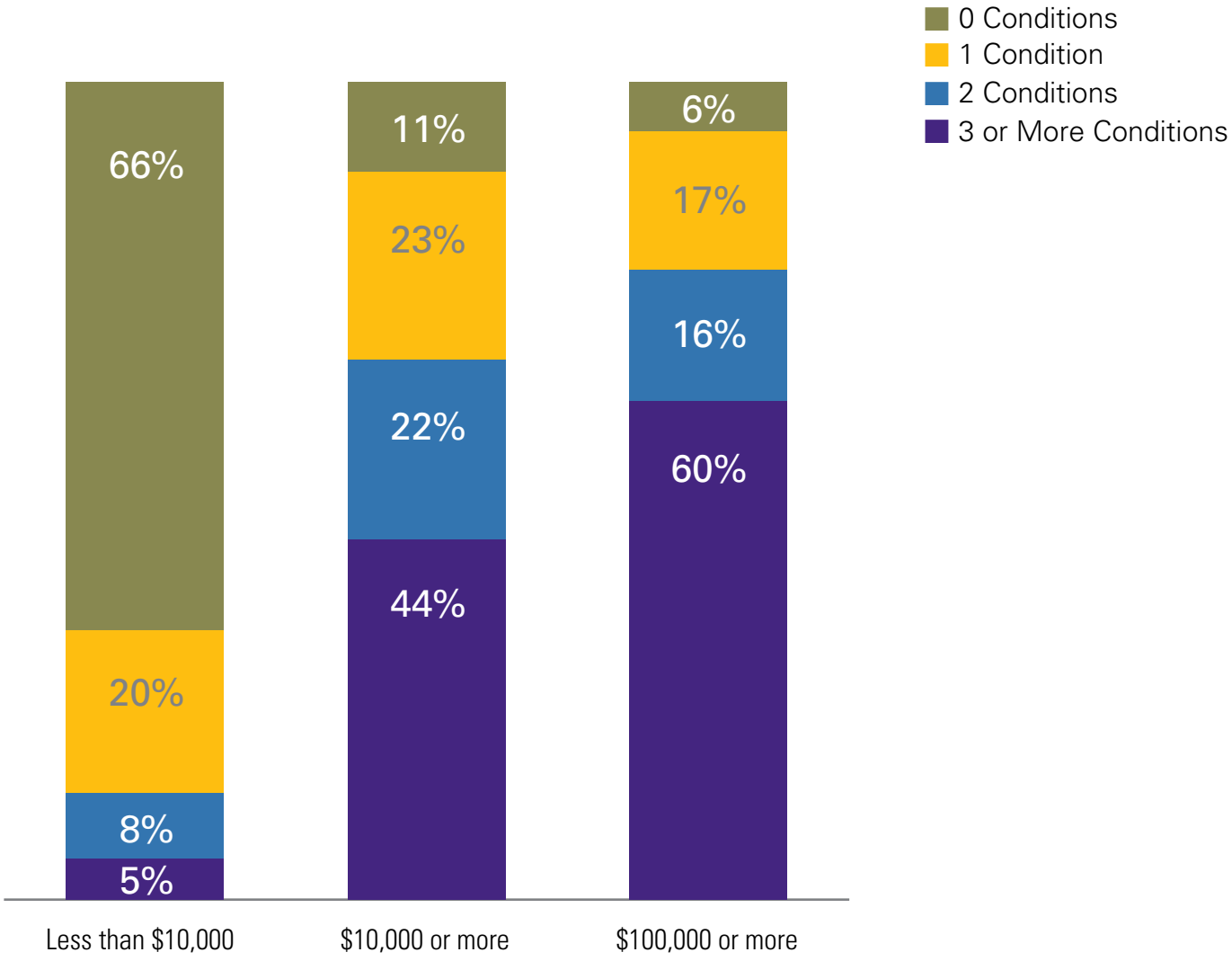
Comorbidity,
by Cost of Care, FY 2008



Notes: Reflects fee-for-service expenditures only. Segments may not add to 100 percent due to rounding.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

Two-thirds of high-cost beneficiaries had multiple health conditions; nearly half (44 percent) had three or more conditions.

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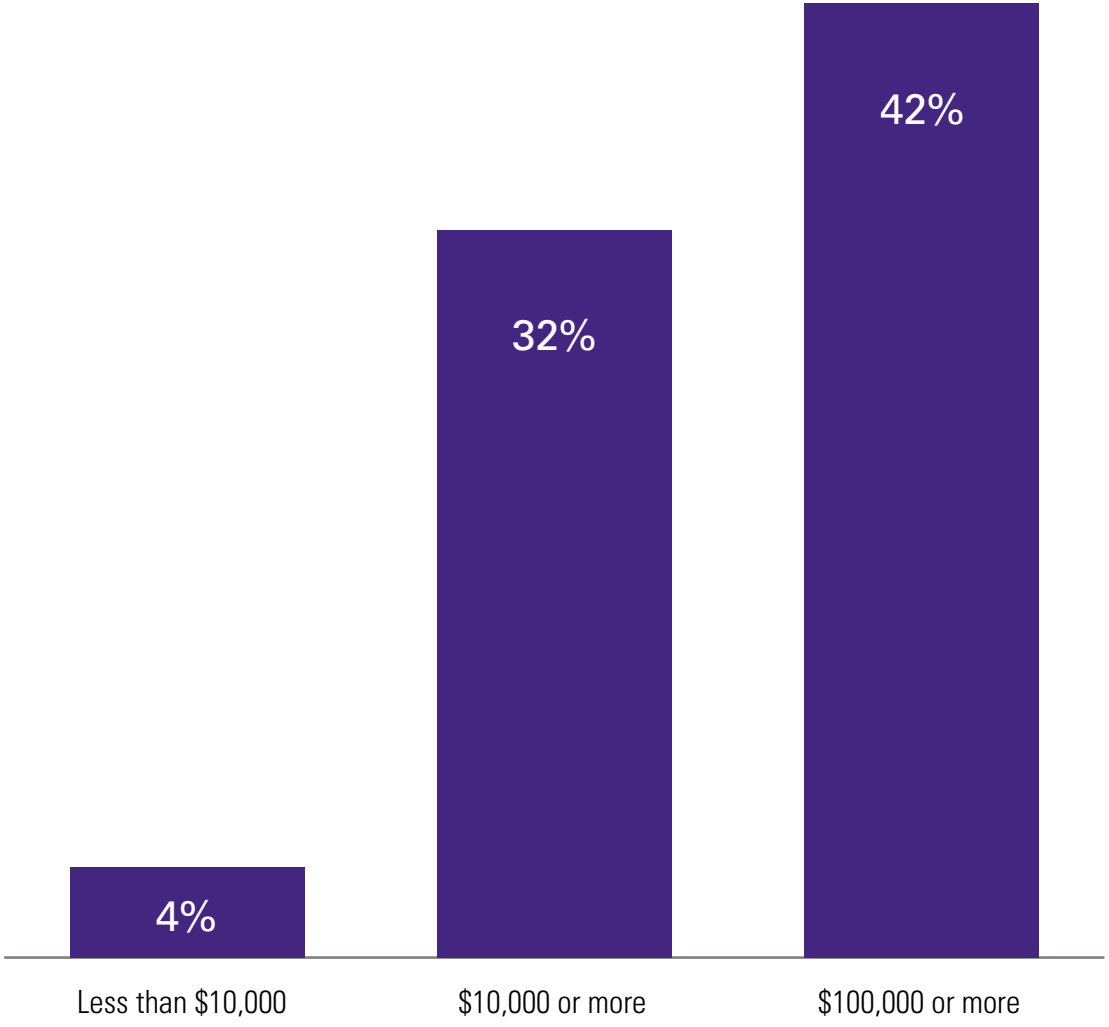
Physical and Mental Health Comorbidity,
by Cost of Care, FY 2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

Nearly one-third of high-cost beneficiaries had co-occuring mental health and physical health disorders.

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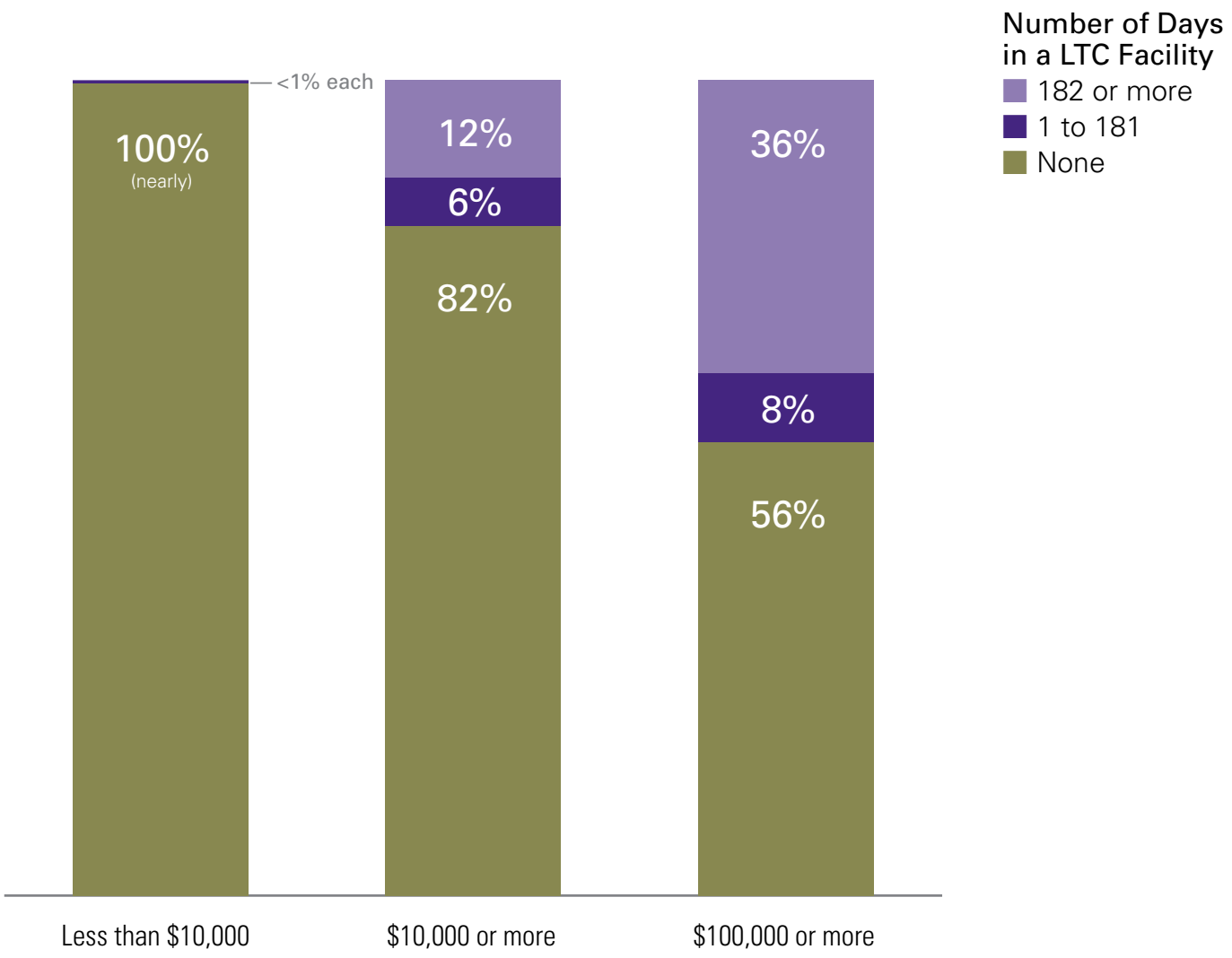
Long Term Care Facility Use,
by Cost of Care, FY 2008



Notes: Among those who resided in a long term care facility for 182 days or more with expenditures below $10,000, nearly all were enrolled in a capitated health plan and/or Medicare; managed care and Medicare expenditures were not captured in this analysis. Reflects fee-for-service expenditures only. Segments may not add to 100 percent due to rounding.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

Among high-cost beneficiaries, fewer than one-fifth had one or more days of long term care facility use paid by Medi-Cal. However, 77 percent of Medi-Cal beneficiaries with one or more days in a long term care facility had Medi-Cal fee-for-service expenditures of $10,000 or more.

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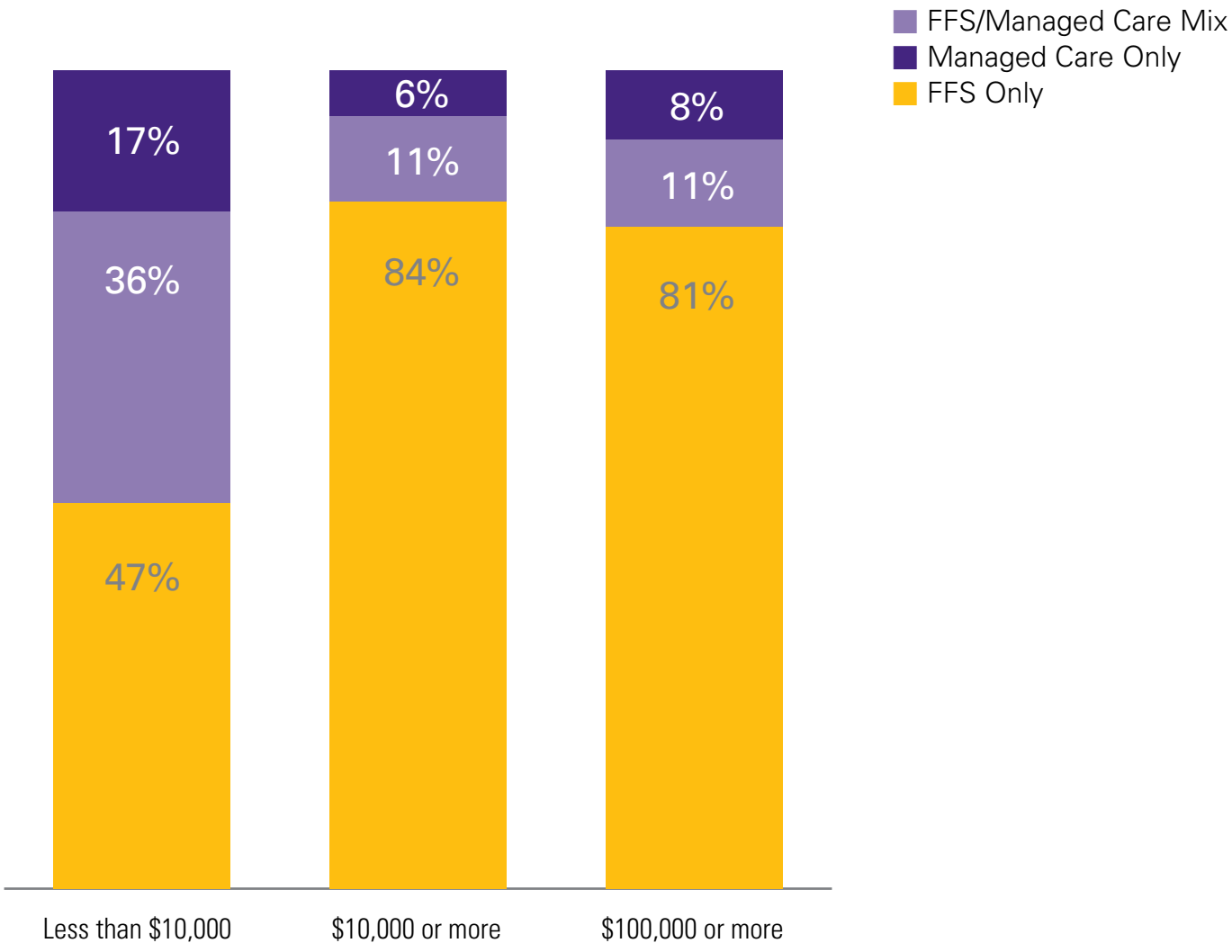
FFS and Managed Care Enrollment,
by Cost of Care, FY 2008



Notes: FFS/Managed Care Mix category represents beneficiaries with at least one month of fee-for-service coverage and one month of Medi-Cal managed care in FY 2008. Segments may not add to 100 percent due to rounding.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

Almost 100,000 beneficiaries, representing 17 percent of Medi-Cal's high-cost population, were enrolled in a capitated managed care plan for all or part of 2008. For these beneficiaries, FFS expenditures reflect drugs and services carved out* of payments to managed care plans, as well as all Medi-Cal services provided during non-managed care covered months.

*Carved-out services are those not included in capitated payments to managed care plans such as treatment for mental health conditions or conditions that qualify under the California Children's Services program. Pharmaceuticals carved out of payments include HIV/AIDS drugs and antipsychotic medications.

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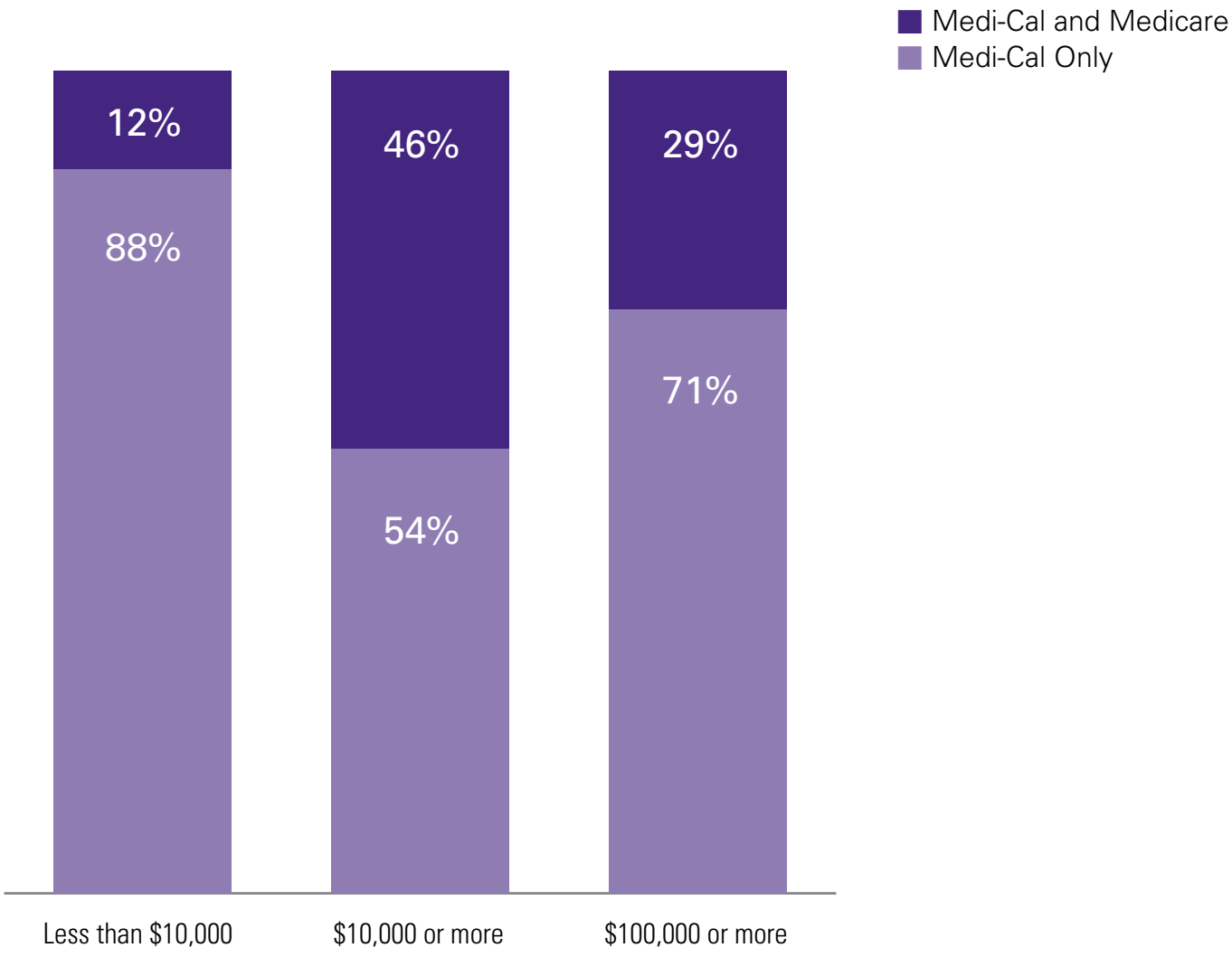
Eligibility for Medi-Cal and Medicare,
by Cost of Care, FY 2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

Beneficiaries with both Medi-Cal and Medicare coverage accounted for nearly half (46 percent) of Medi-Cal's high-cost population, although these "dual eligibles" made up only 15 percent of the overall Medicaid population.

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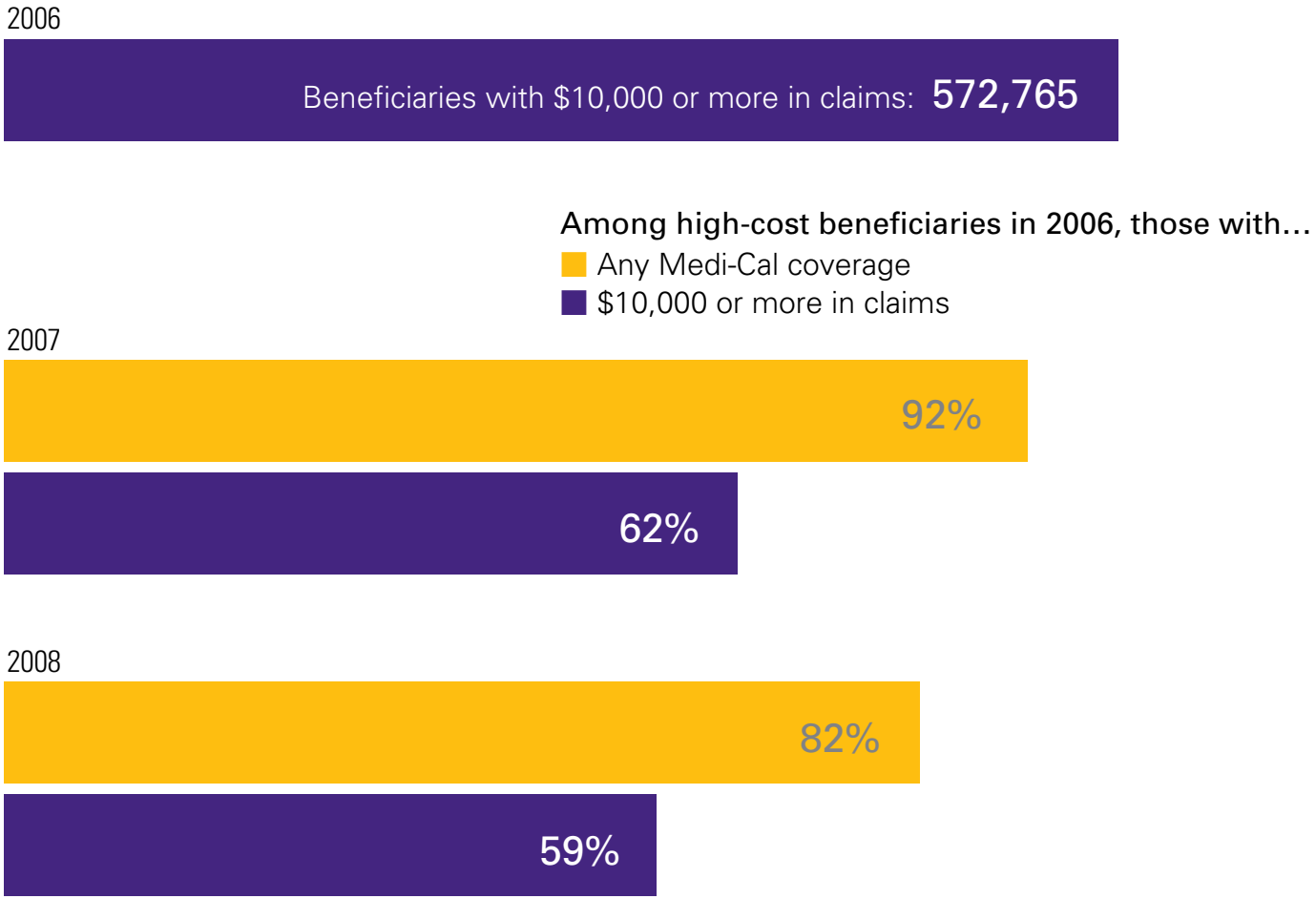
Enrollment Continuity and High-Cost Persistence, FY 2006–2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 and claims from FY 2006 and FY 2007 (extracted May 2009).

Most high-cost beneficiaries continue to have high costs for at least two years. Among Medi-Cal beneficiaries classified as high-cost in FY 2006, 82 percent were still enrolled in Medi-Cal two years later, and 59 percent continued to incur FFS expenditures of $10,000 or more.

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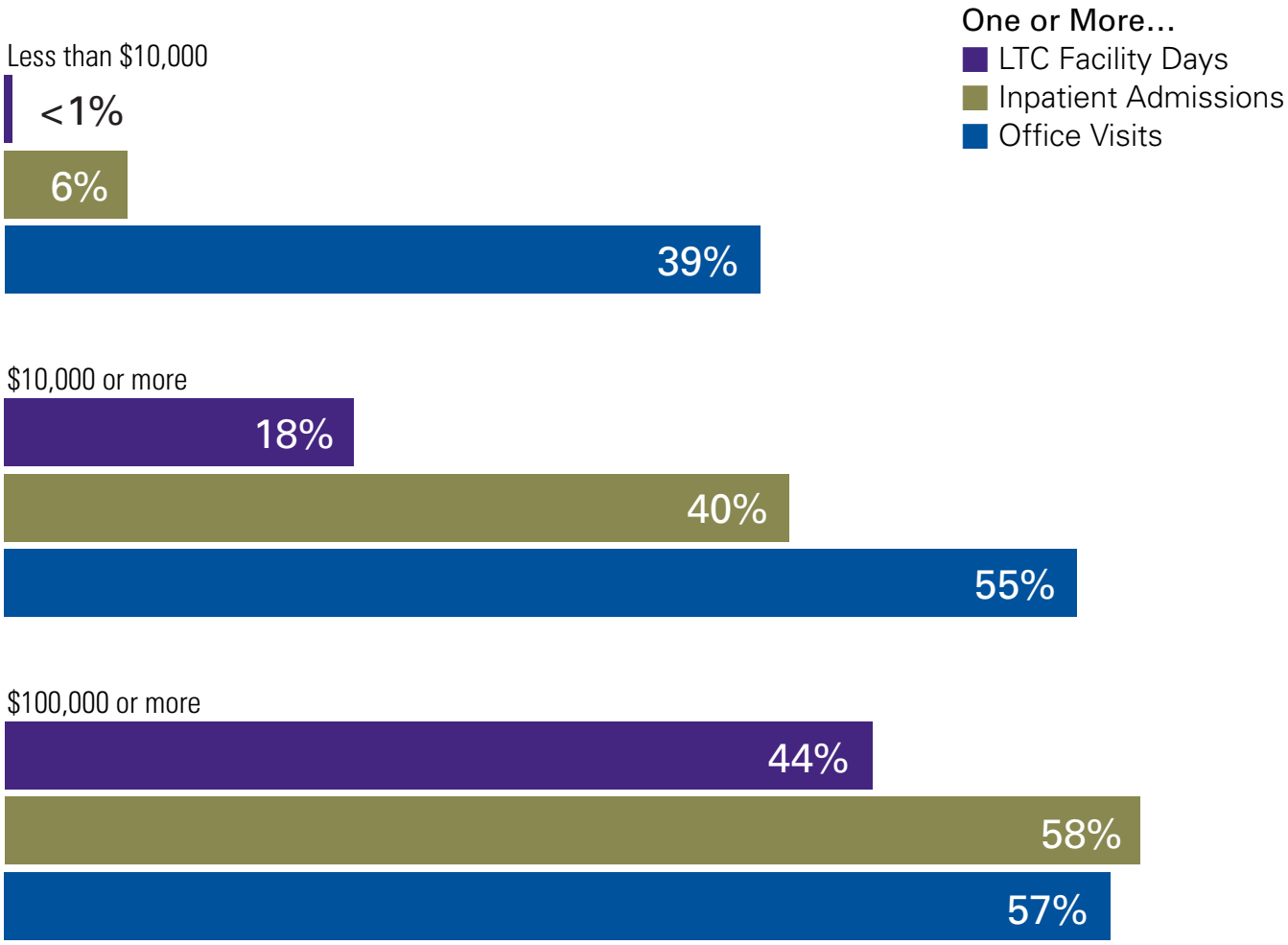
Service Use,
by Cost of Care, FY 2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

High-cost beneficiaries were 45 times more likely than other Medi-Cal beneficiaries to have had a long term care facility claim, 6 times more likely to have had a hospital claim, and 1.4 times more likely to have had an office visit claim. These claims do not include those paid by Medicare or other payers for which there was no cost incurred by Medi-Cal.

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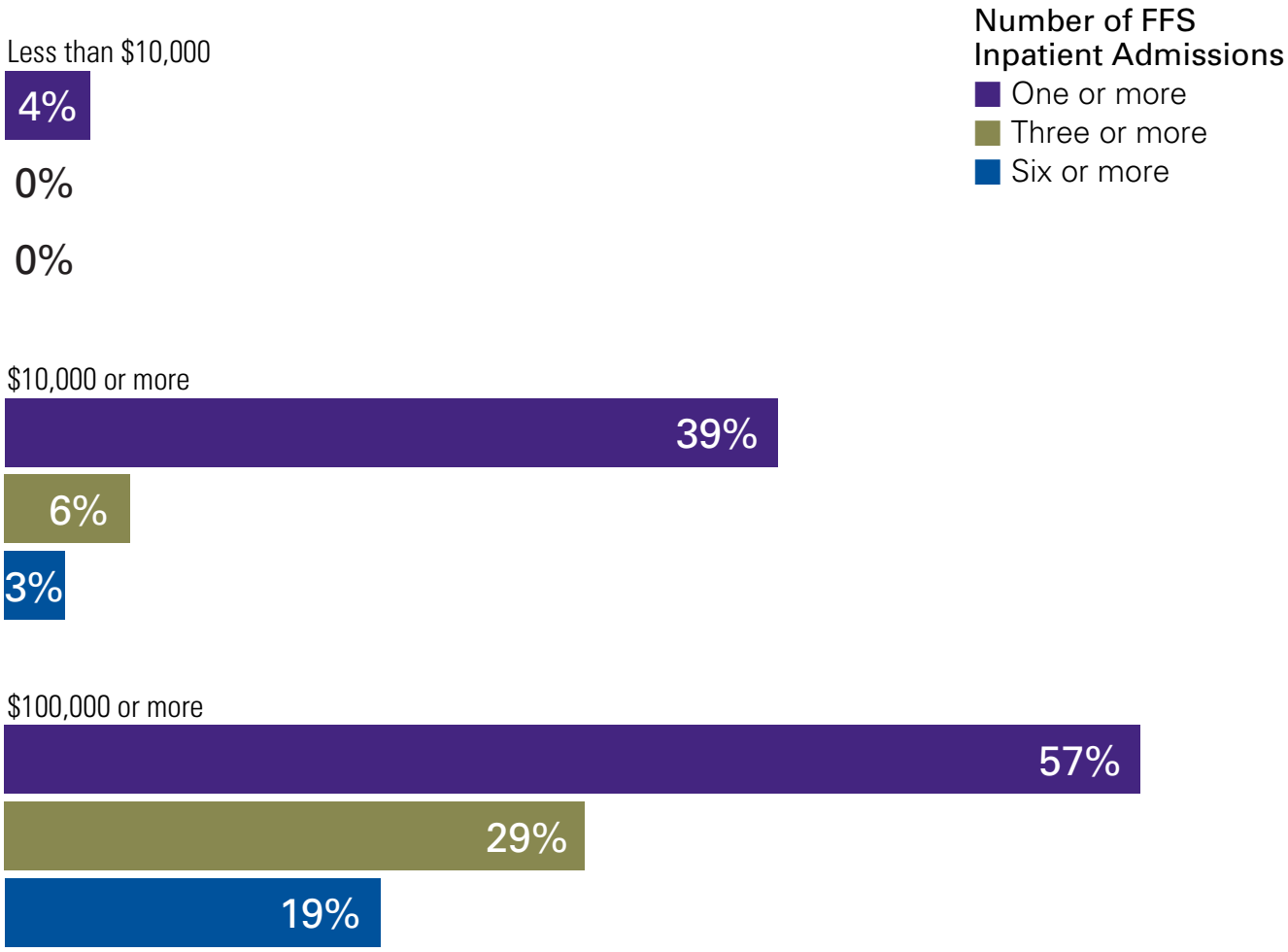
Hospital Admissions,
by Cost of Care, FY 2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 and claims from FY 2006 and FY 2007 (extracted May 2009).

Nearly 40 percent of high-cost beneficiaries had an inpatient admission paid for by Medi-Cal. Three percent—more than 18,000 beneficiaries—had at least six hospital admissions.

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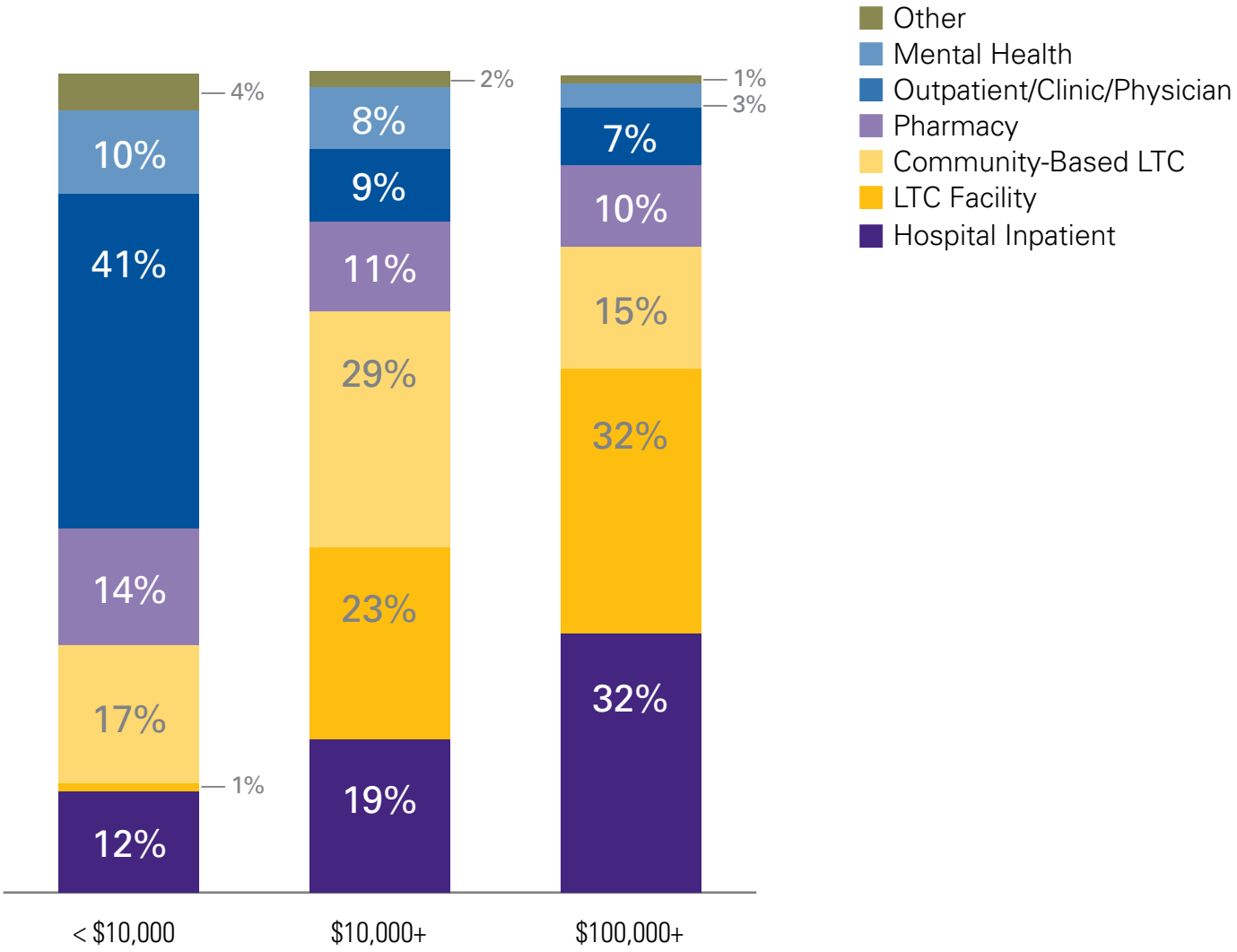
Medi-Cal Fee-for-Service Spending,
by Type of Service and Cost of Care, FY 2008



Notes: "Community-Based LTC" includes in-home support services, home and community-based services, and home health. "LTC Facility" includes nursing facilities and intermediate care facilities serving people with developmental disabilities.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

Of the $19 billion spent by Medi-Cal on high-cost beneficiaries, 29 percent was for community-based long term care, 23 percent was for care in a long term care facility, and 19 percent was for inpatient hospital care.

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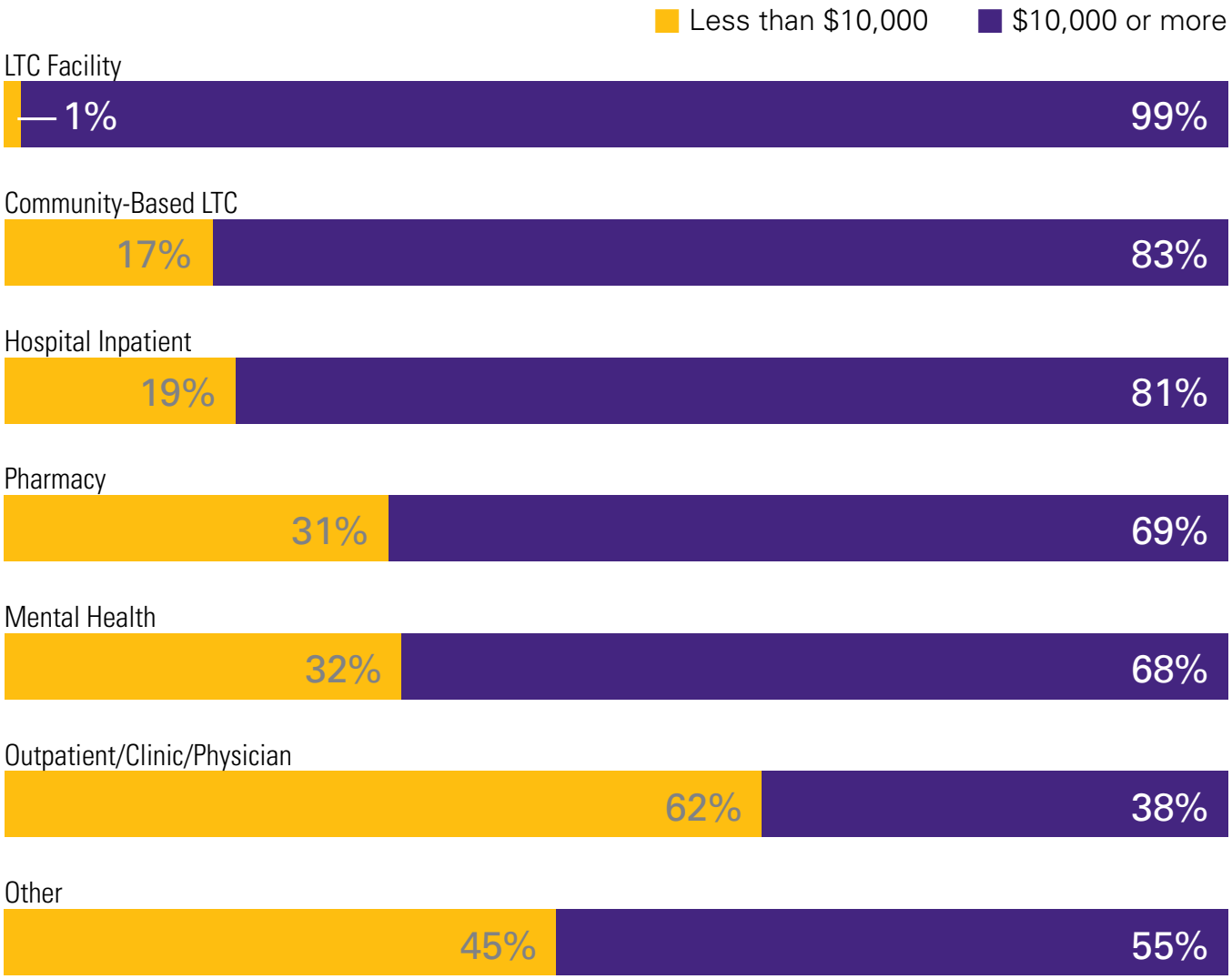
Distribution of Medi-Cal Fee-for-Service Expenditures,
by Type of Service and Cost of Care, FY 2008



Notes: "Community-Based LTC" includes in-home support services, home and community-based services, and home health. "LTC Facility" includes nursing facilities and intermediate care facilities serving people with developmental disabilities. Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

High-cost beneficiaries accounted for 99 percent of long term care facility expenditures, 81 percent of inpatient hospital expenditures, and 83 percent of community-based long term care expenditures.

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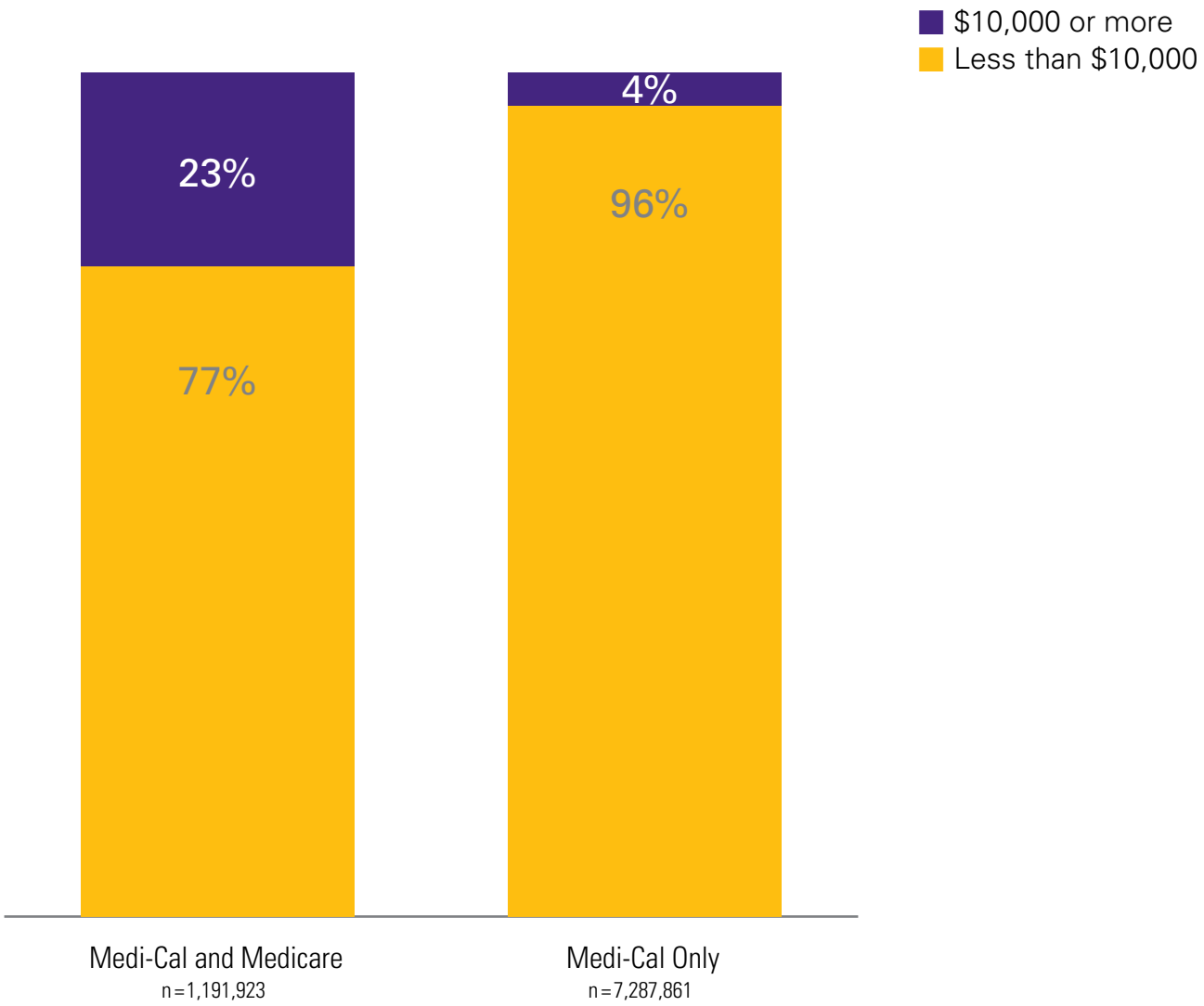
Distribution of Beneficiaries,
by Coverage Type and Cost of Care, FY 2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

Nearly one-fourth (23 percent) of dual eligibles—beneficiaries enrolled in both Medi-Cal and Medicare—had Medi-Cal FFS expenditures of $10,000 or more. By contrast, only 4 percent of Medi-Cal-only beneficiaries were in this high-cost group.

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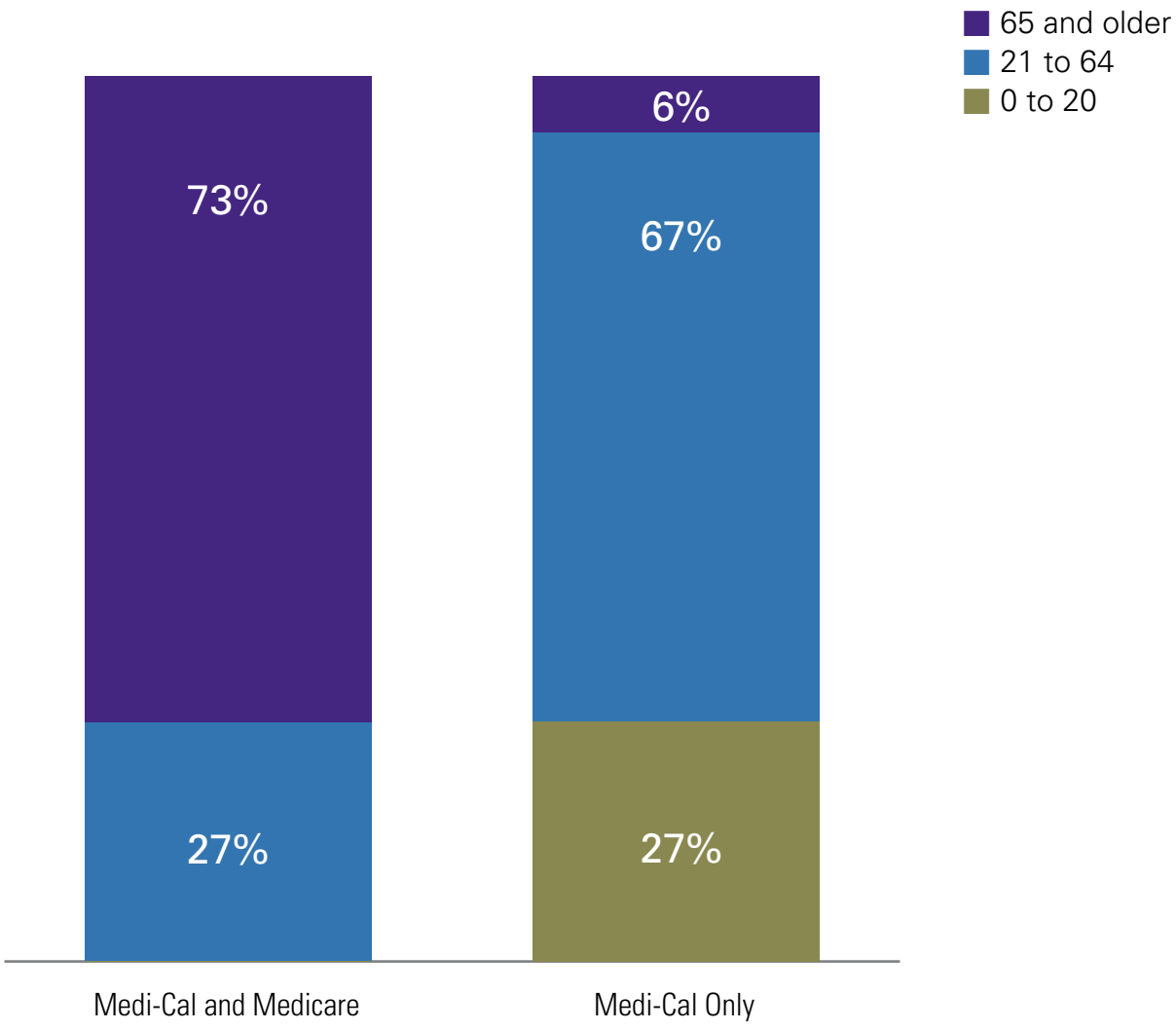
Age Group of High-Cost Beneficiaries,
by Coverage Type, FY 2008



Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

Medi-Cal High-Cost Beneficiaries
Medicare Status

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The majority of high-cost dual eligibles are aged 65 or older, whereas most of high-cost Medi-Cal-only beneficiaries are under age 65.

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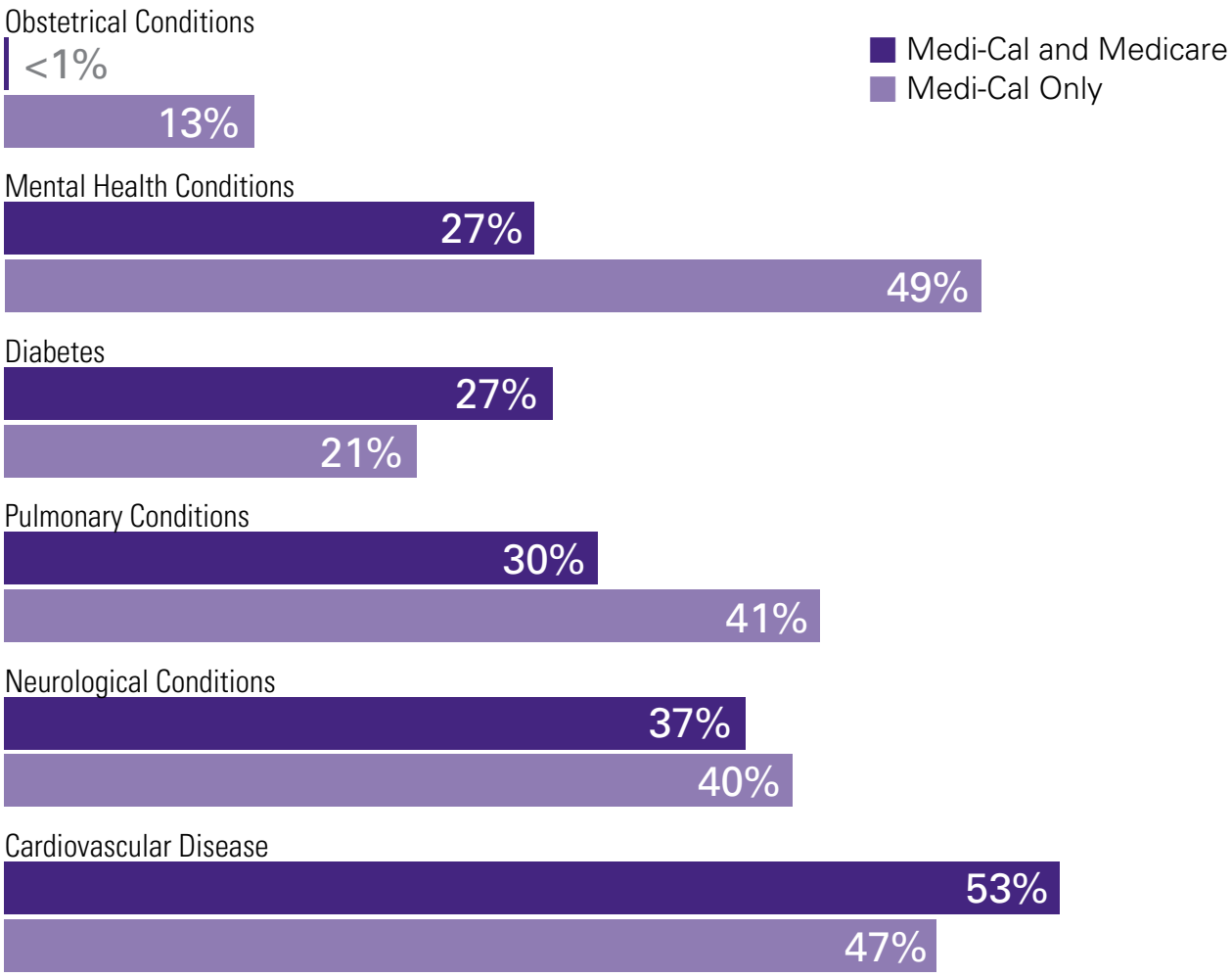
Prevalence of Selected Conditions among High-Cost Beneficiaries, by Coverage Type, FY 2008



Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

The prevalence of many common conditions is similar among high-cost dual eligibles and high-cost Medi-Cal-only beneficiaries. The greatest difference is in the prevalence of mental health conditions, which is more common among high-cost, Medi-Cal-only beneficiaries.

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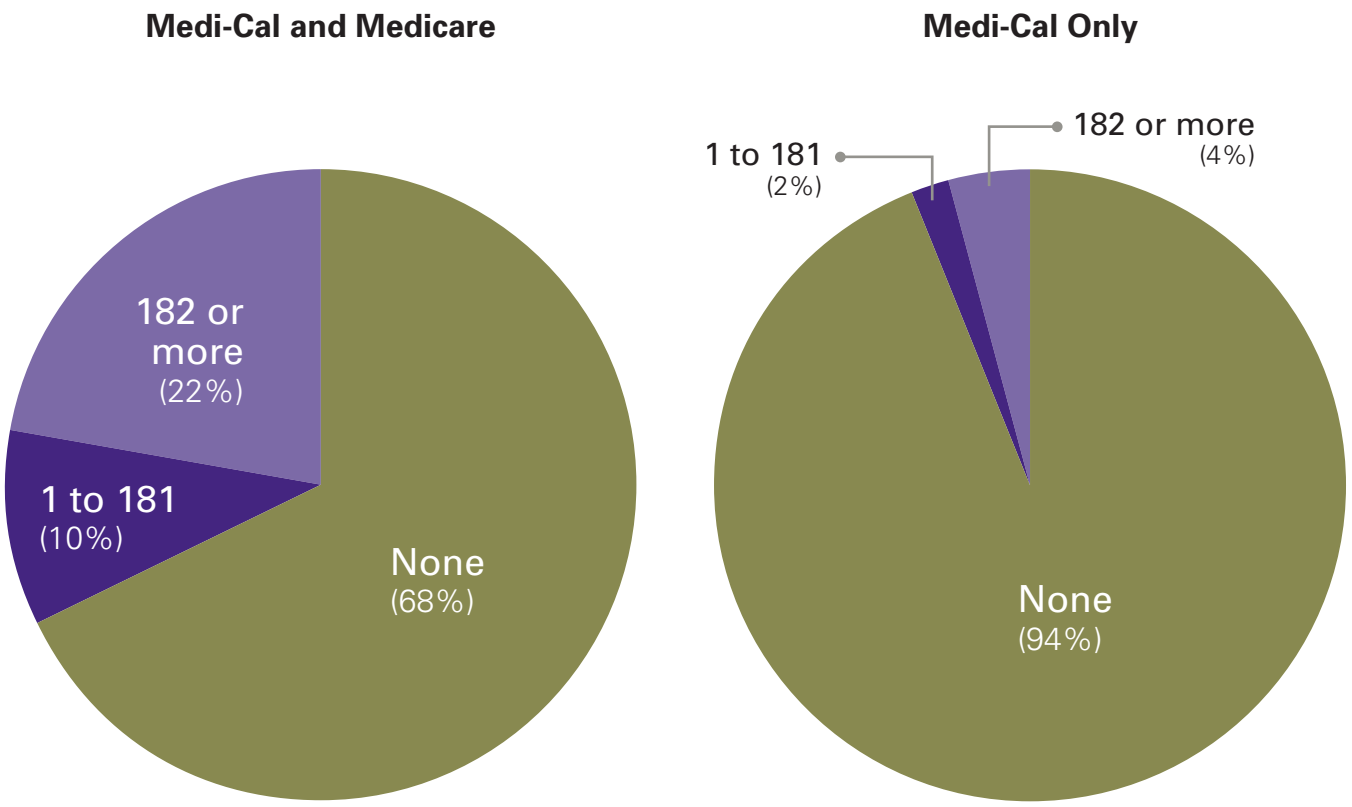
Long Term Care Facility Use among High-Cost Beneficiaries, by Coverage Type, FY 2008

NUMBER OF DAYS IN A LONG TERM CARE FACILITY



Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

High-cost dual eligibles were five times more likely than high-cost, Medi-Cal-only beneficiaries to reside in a long term care facility for six months or more.

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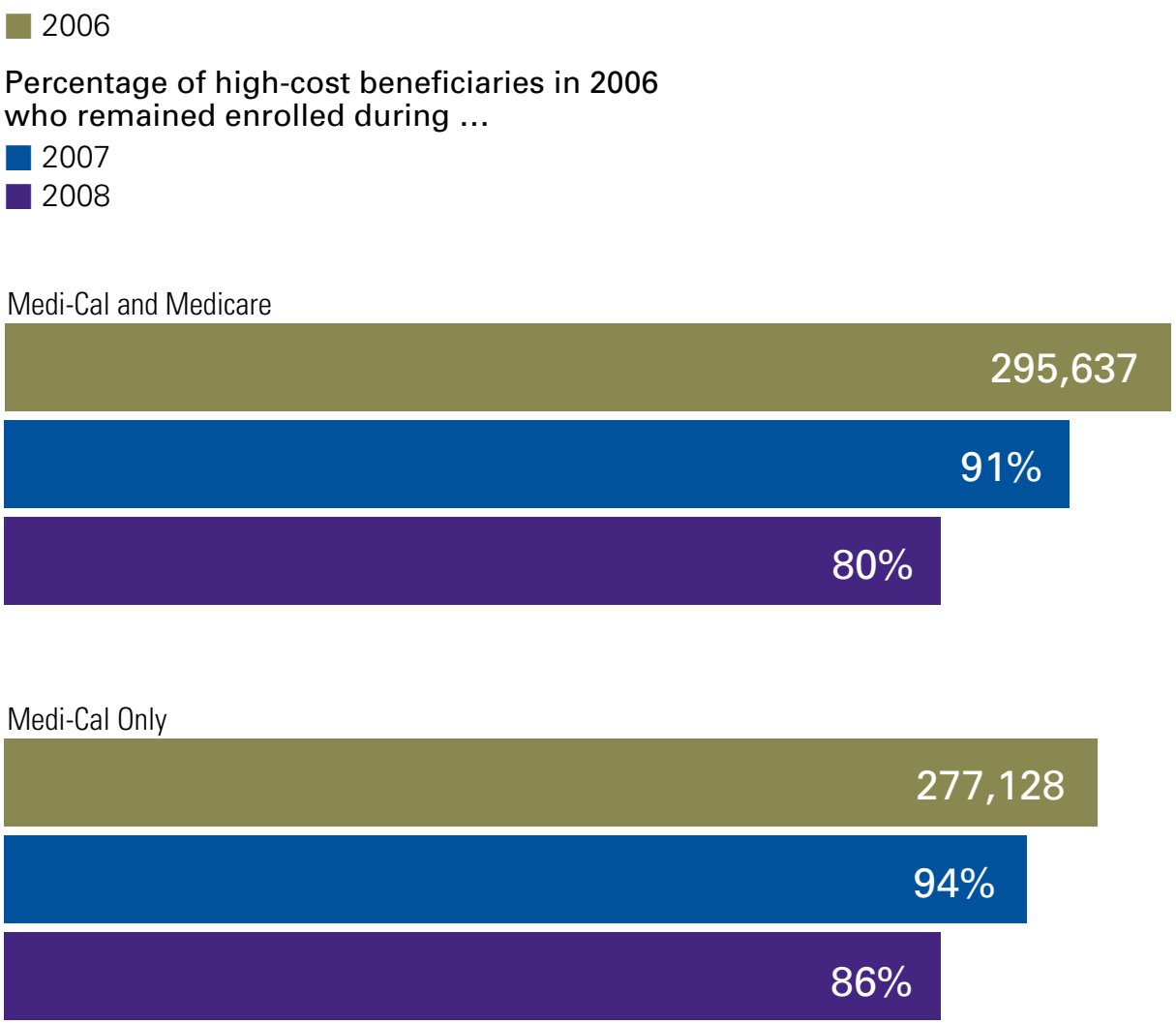
Continuity of Medi-Cal Enrollment among High-Cost Beneficiaries, by Coverage Type, FY 2006–2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 and claims from FY 2006 and FY 2007 (extracted May 2009).

There were high levels of continuity of coverage among both Medi-Cal-only and dual-eligible beneficiaries.

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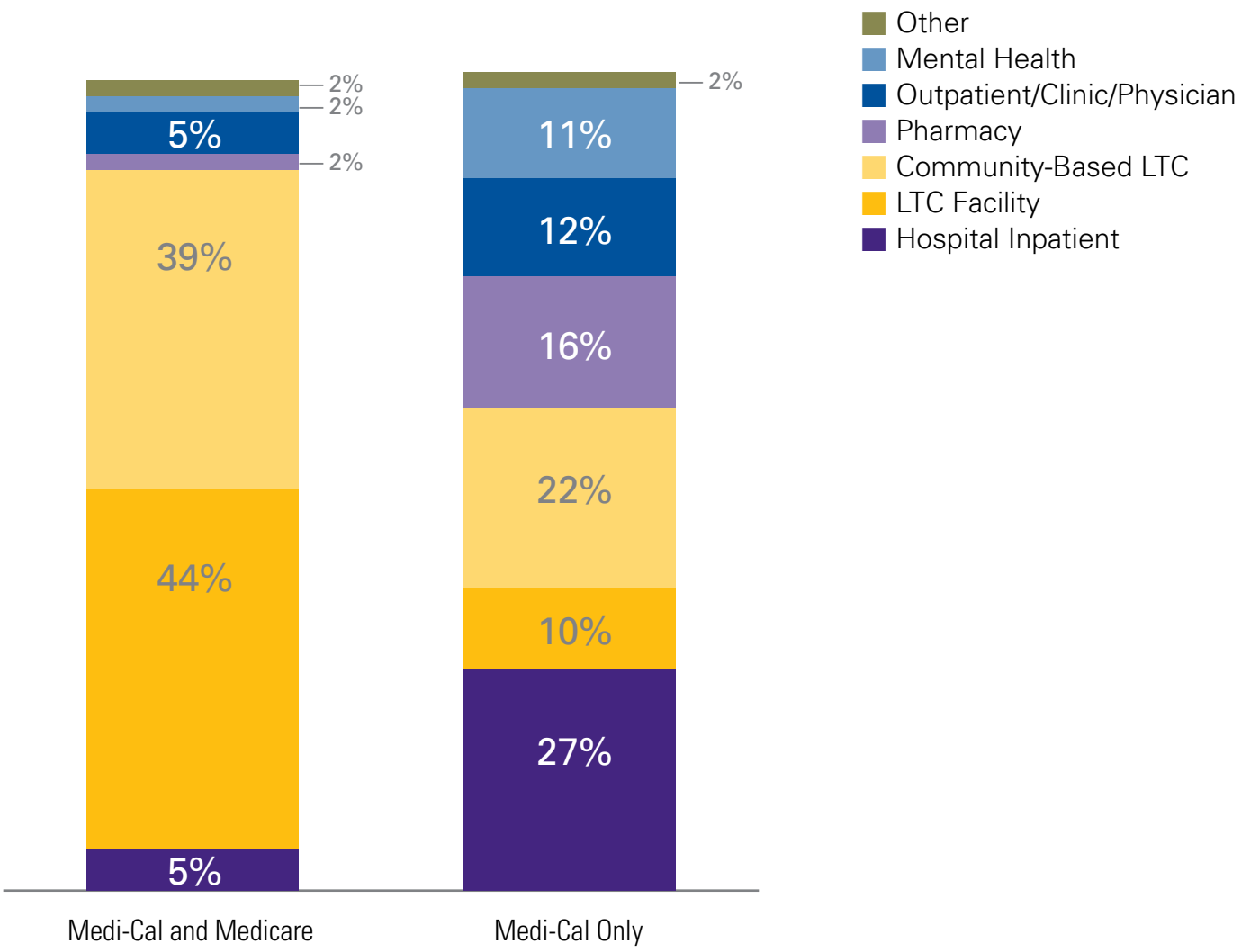
Fee-for-Service Spending among High-Cost Beneficiaries,
by Type of Service and Coverage Type, FY 2008



Note: Medicare covers short-term nursing facility services only. Medicare-covered stays are generally in lieu of inpatient care or for services immediately following hospitalization.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted April 2010).

While 43 percent of Medi-Cal expenditures for high-cost Medi-Cal-only beneficiaries were for inpatient and pharmacy services, these categories represented less than 10 percent of expenditures for high-cost dual eligibles, since Medicare is the primary payer for these services.

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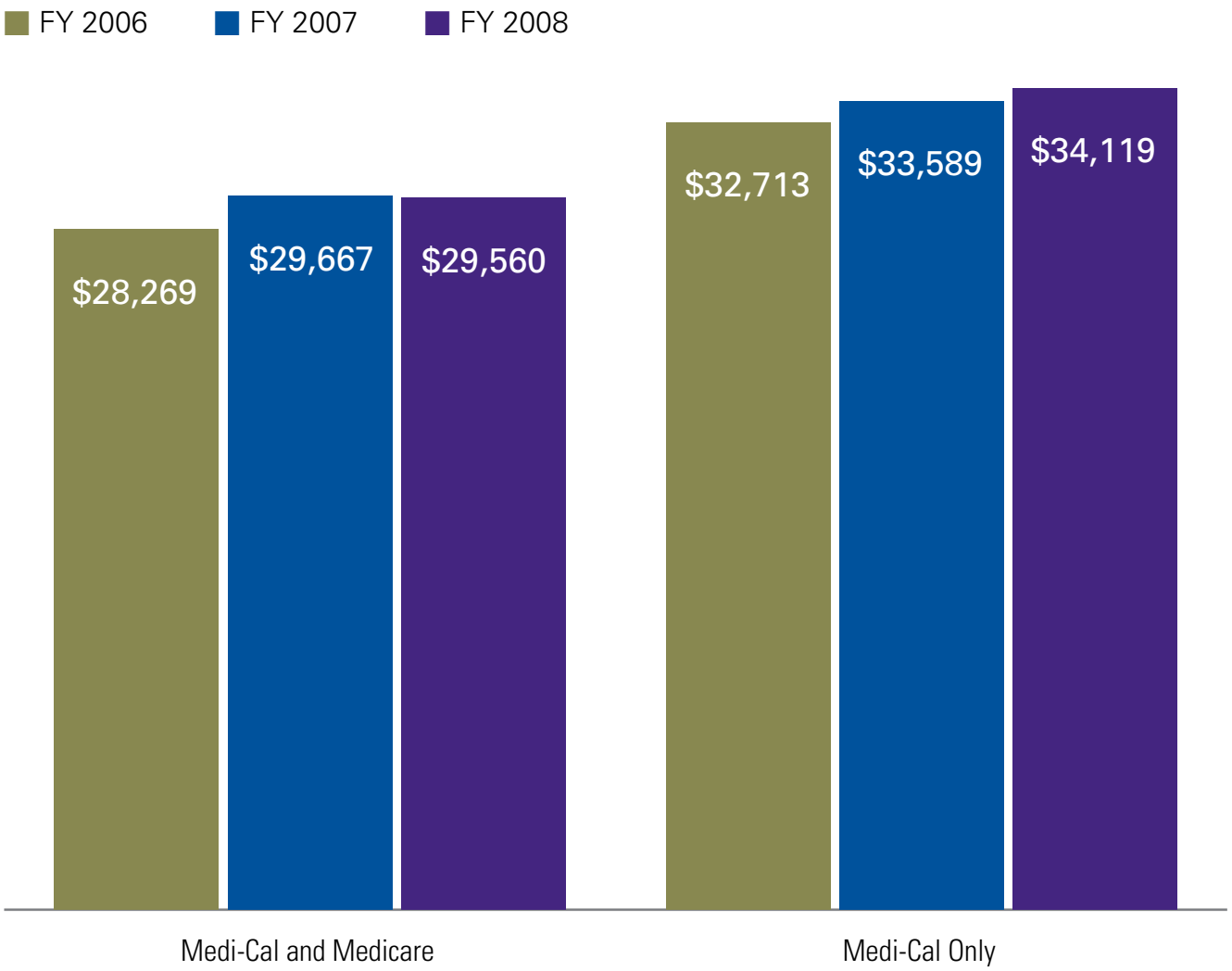
Fee-for-Service Spending Trends among High-Cost Beneficiaries, by Coverage Type, FY 2006–2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 and claims from FY 2006 and FY 2007 (extracted April 2010).

Medi-Cal High-Cost Beneficiaries
Medicare Status

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Average Medi-Cal expenditures per high-cost beneficiary were approximately $4,600 greater for beneficiaries with Medi-Cal only. However, per beneficiary spending grew at a similar rate (4 percent) from FY 2006 to FY 2008 for both dual-eligible beneficiaries and those with Medi-Cal only.

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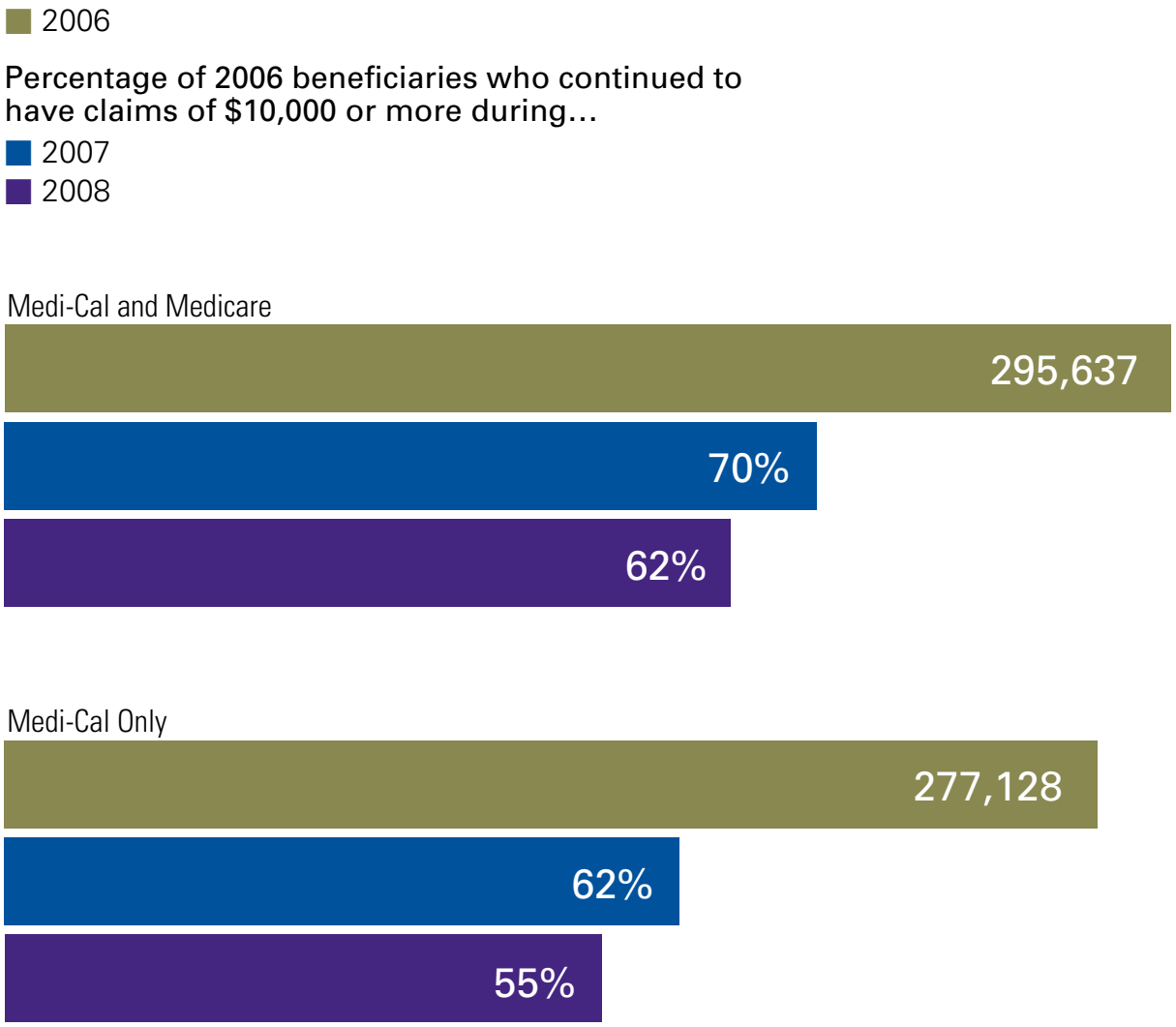
Persistence of High Costs among High-Cost Beneficiaries,
by Coverage Type, FY 2006–2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 and claims from FY 2006 and FY 2007 (extracted April 2010).

Sixty-two percent of high-cost dual eligibles in FY 2006 also had costs exceeding $10,000 in the two subsequent years, largely due to the continuity in a long term care facility. Just over half (55 percent) of high-cost Medi-Cal-only beneficiaries in that year had high costs in 2008.

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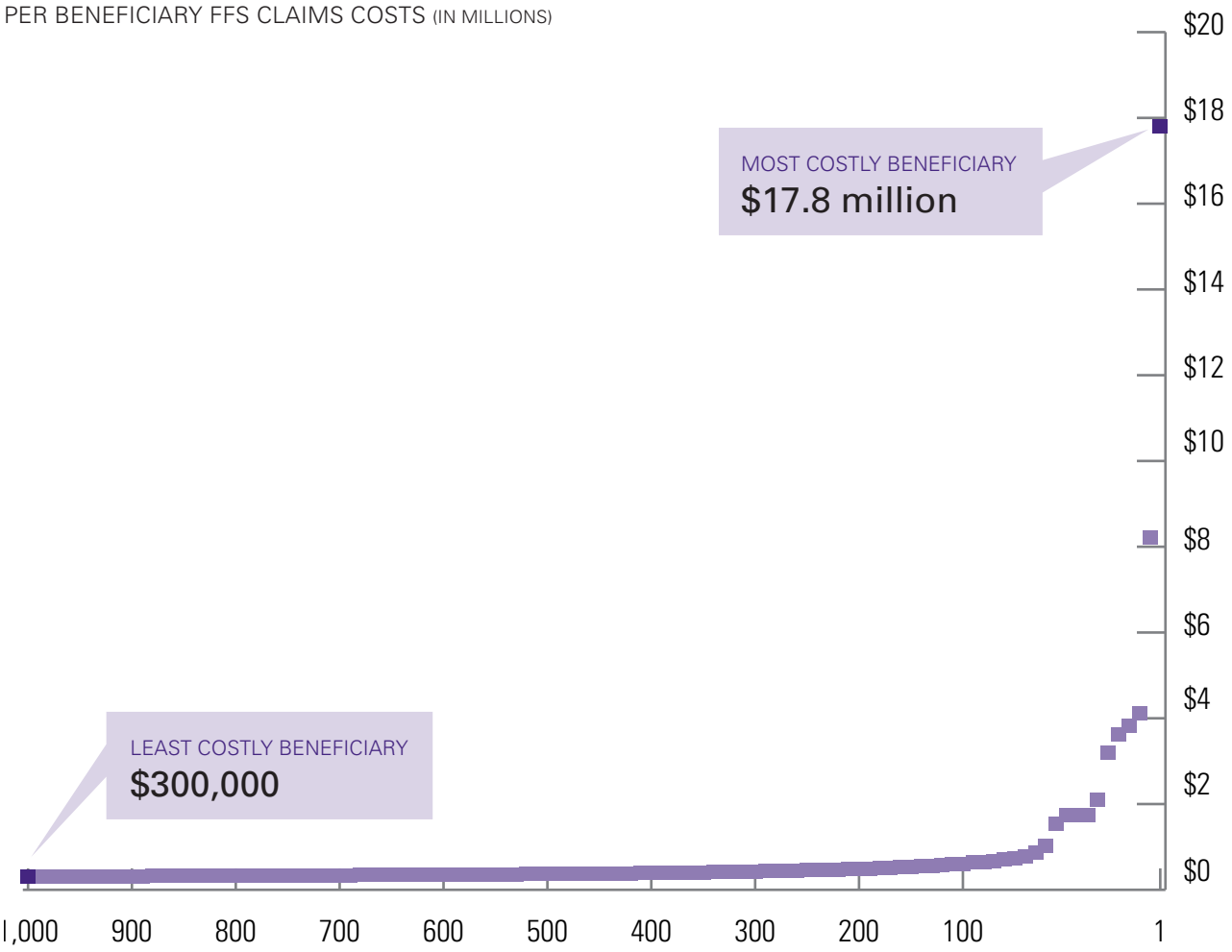
Distribution of Spending,
1,000 Most Costly Beneficiaries, FY 2008



Note: Reflects fee-for-service expenditures only. Pharmaceutical expenditure data does not include rebates collected by the state from manufacturers.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

Medi-Cal High-Cost Beneficiaries
1,000 Most Costly

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For the 1,000 most expensive beneficiaries, Medi-Cal spent an average of $460,000 per person. Spending for the top five beneficiaries totalled $37.6 million, the majority (86 percent) of which was spent on pharmaceuticals.

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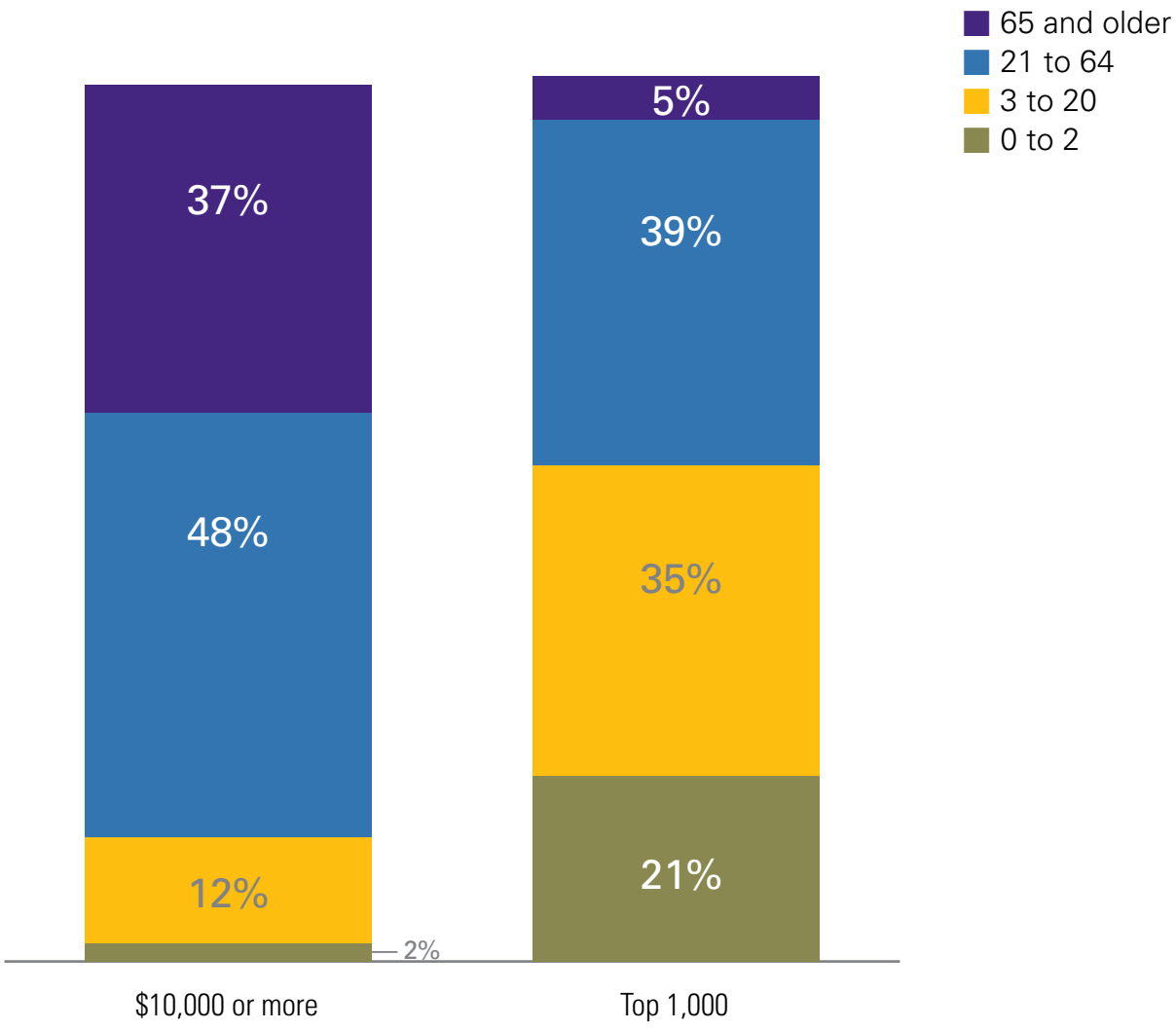
Age Group,
High-Cost and 1,000 Most Costly Beneficiaries, FY 2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

More than half (55 percent) of the 1,000 most costly beneficiaries were under age 21, compared to only 15 percent of all high-cost beneficiaries.

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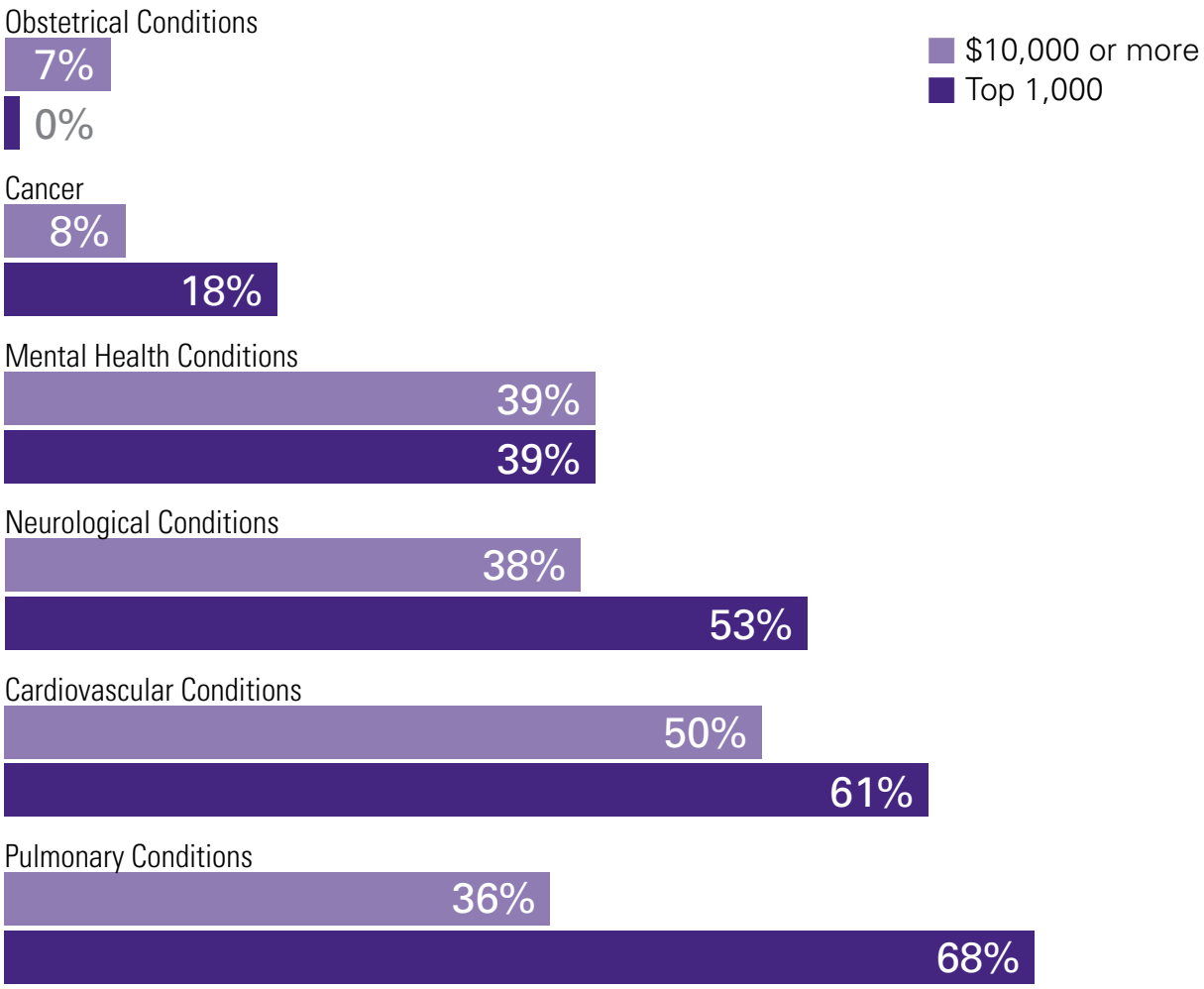
Prevalence of Selected Conditions,

High-Cost and 1,000 Most Costly Beneficiaries, FY 2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

The greatest morbidity difference between the top 1,000 and all high-cost beneficiaries was in the prevalence of pulmonary conditions. Mental health conditions were equally prevalent in the two groups.

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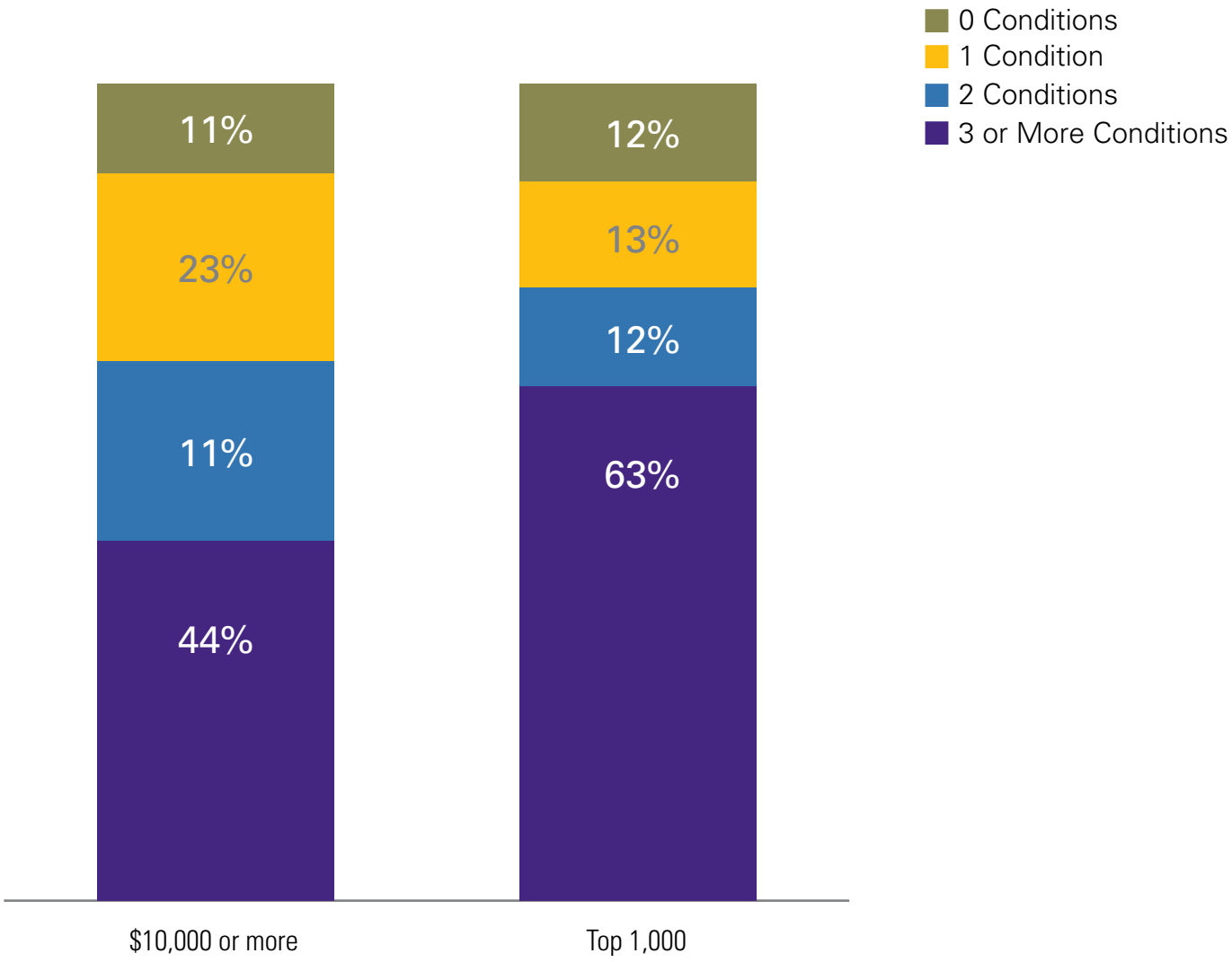
Comorbidity,
High-Cost and 1,000 Most Costly Beneficiaries, FY 2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

The 1,000 most costly beneficiaries were more likely to have three or more conditions than high-cost beneficiaries overall.

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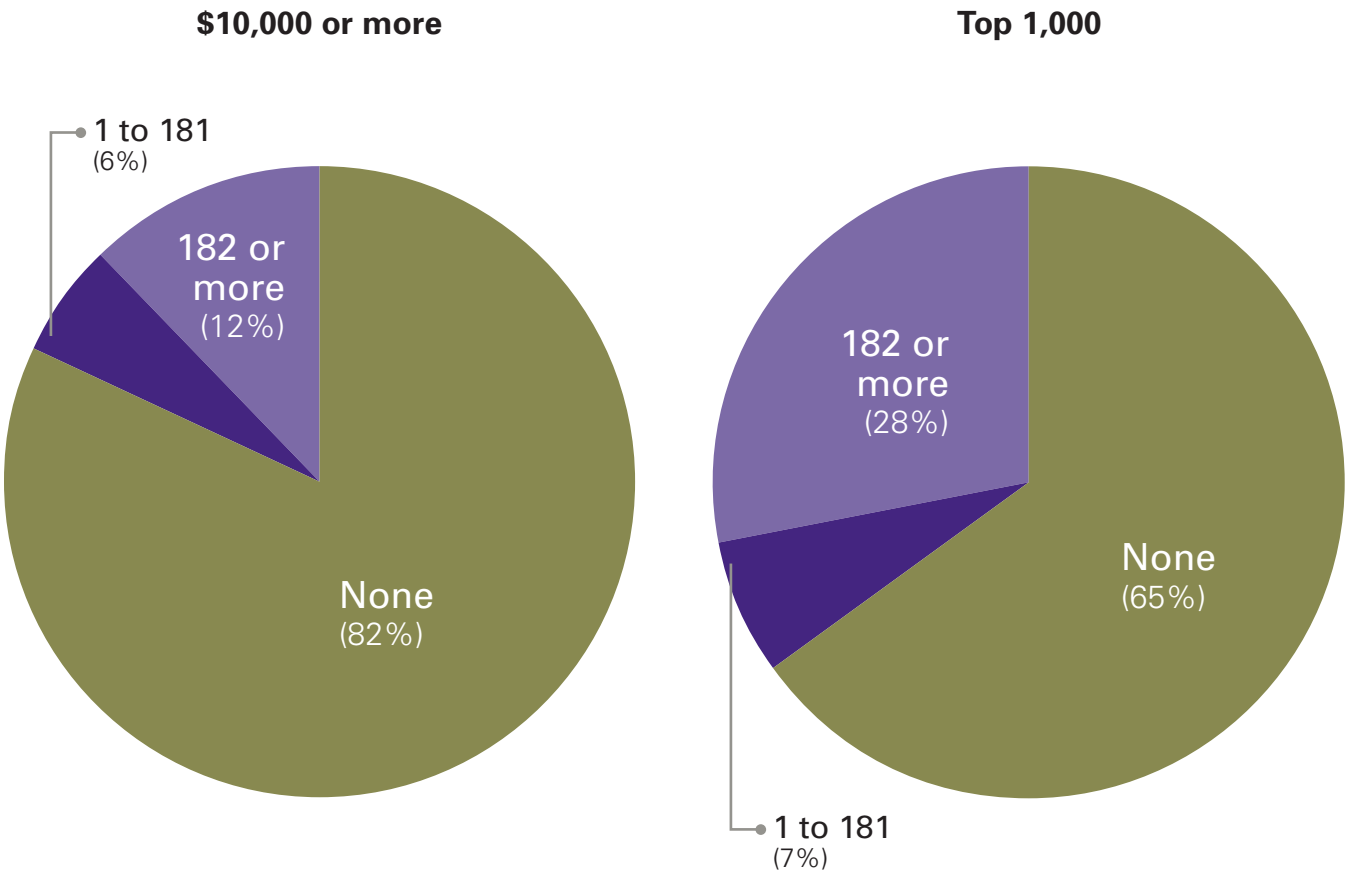
Long Term Care Facility Use,
High-Cost and 1,000 Most Costly Beneficiaries, FY 2008

NUMBER OF DAYS IN A LONG TERM CARE FACILITY



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

The 1,000 most costly beneficiaries were more than twice as likely as high-cost beneficiaries overall to reside in a long term care facility for six months or more.

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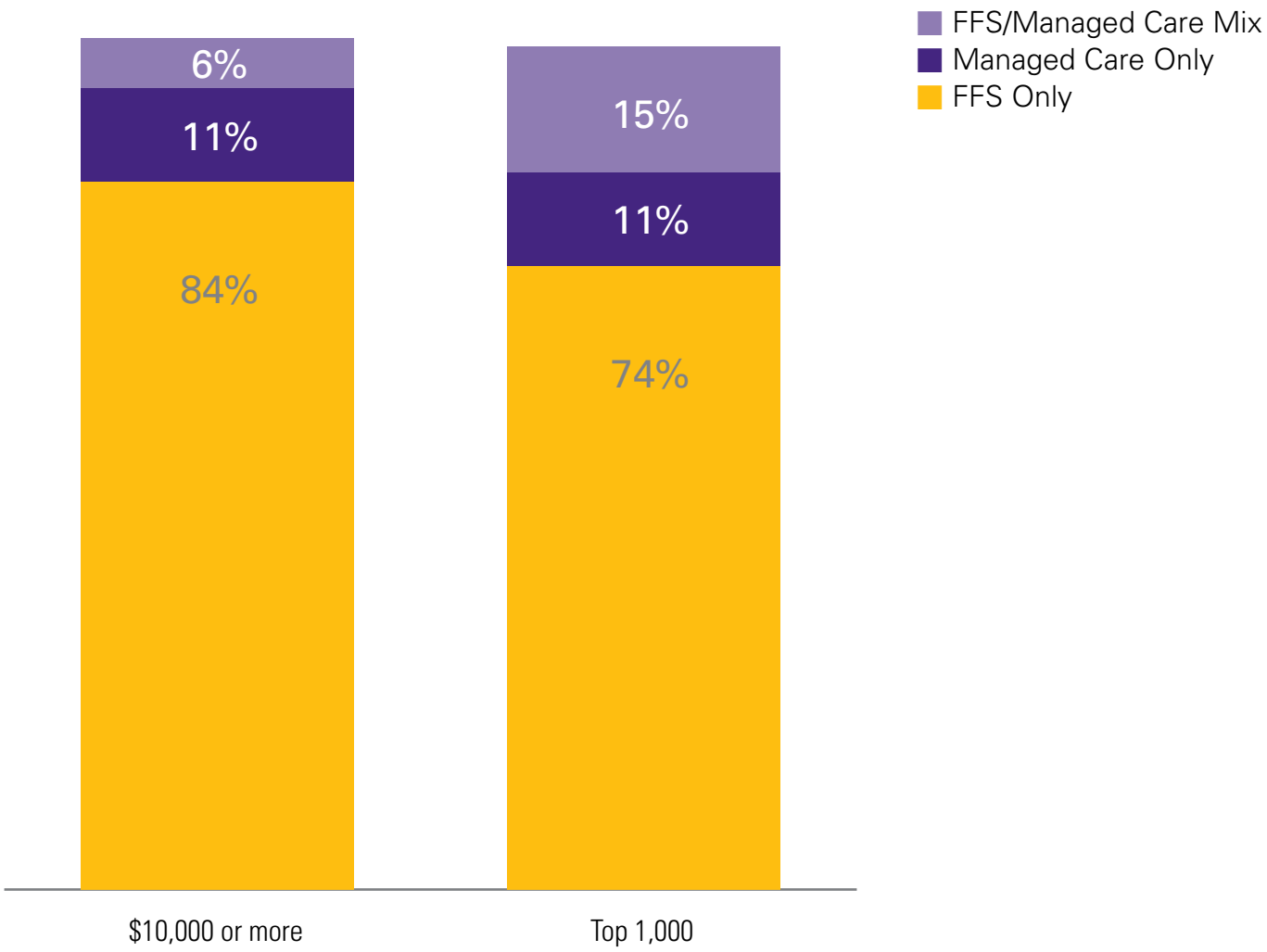
Managed Care Enrollment,

High-Cost and 1,000 Most Costly Beneficiaries, FY 2008



Notes: FFS/Managed Care Mix represents beneficiaries with at least one month of fee-for-service coverage and one month of Medi-Cal managed care in FY 2008. Expenditures for Managed Care Only represent fee-for-service claims for services and pharmaceuticals carved out of payments to managed care plans.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

More than one in four of the 1,000 most costly beneficiaries were enrolled in a managed care plan for at least one month during the year.

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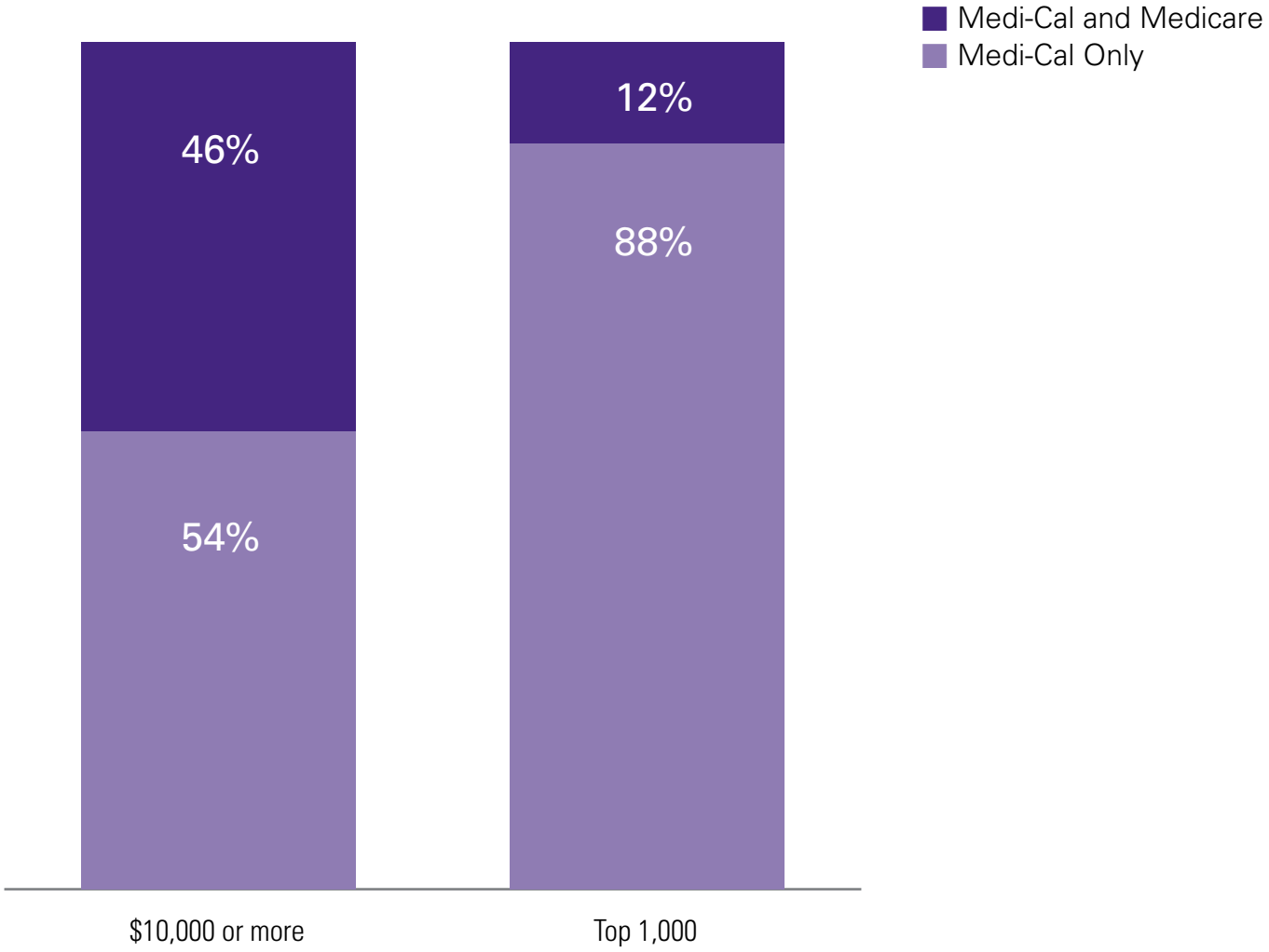
Medicare Coverage,

High-Cost and 1,000 Most Costly Beneficiaries, FY 2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

The 1,000 most costly Medi-Cal beneficiaries were nearly four times less likely than all high-cost beneficiaries to have Medicare coverage.

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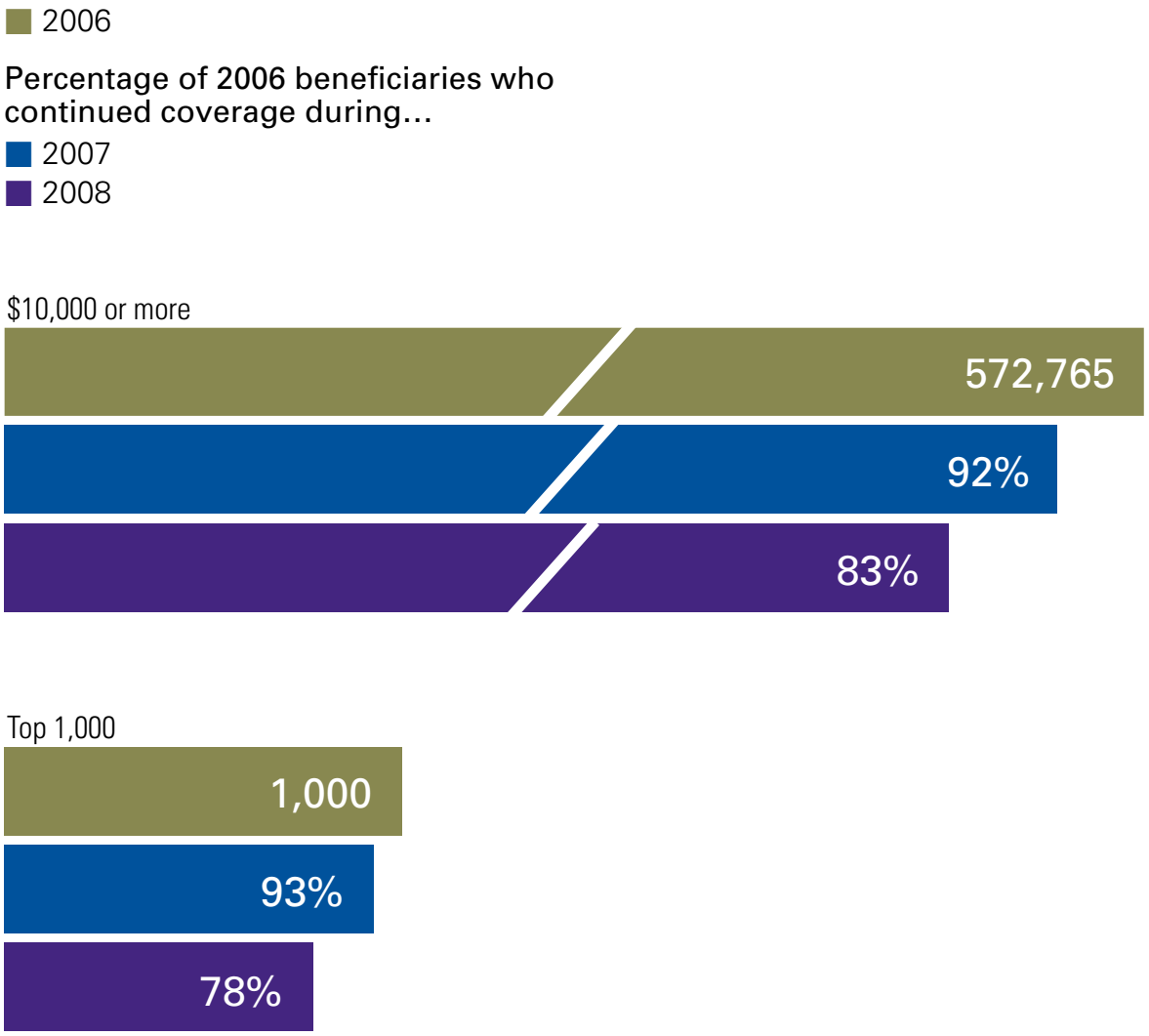
Continuity of Coverage,

High-Cost and 1,000 Most Costly Beneficiaries, FY 2006–2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 and claims from FY 2006 and FY 2007 (extracted May 2009).

Compared to high-cost beneficiaries overall, the 1,000 most costly beneficiaries in 2006 were less likely to have Medi-Cal coverage two years later.

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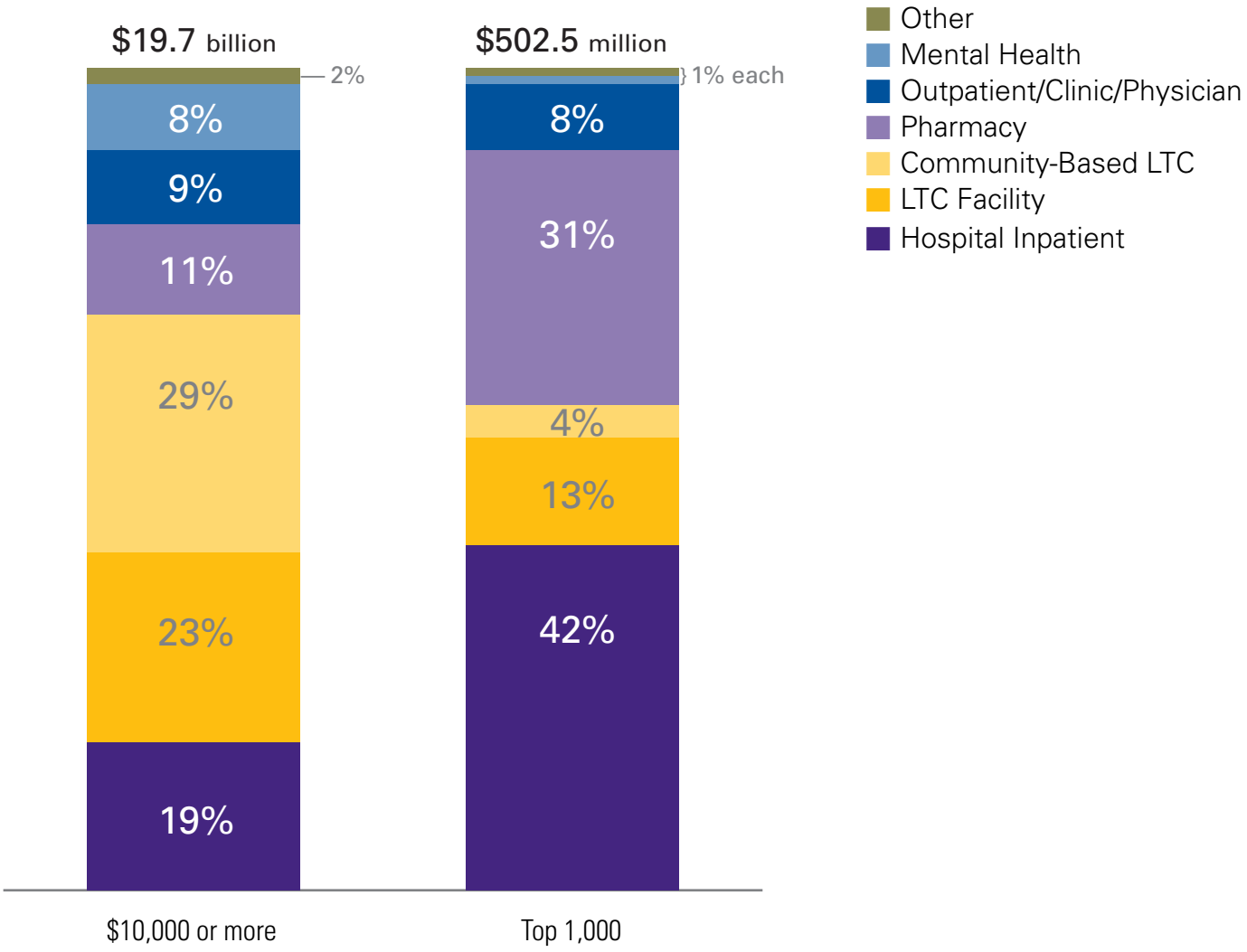
Fee-for-Service Spending, by Type of Service,
High-Cost and 1,000 Most Costly Beneficiaries, FY 2008



Note: Reflects fee-for-service expenditures only. Segments may not add to 100 percent due to rounding.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted April 2010).

Inpatient hospital care accounted for 42 percent of Medi-Cal spending for the 1,000 most costly beneficiaries, an average of $211,037 per person. Prescription drugs accounted for 31 percent of spending, an average of $157,613 per person.

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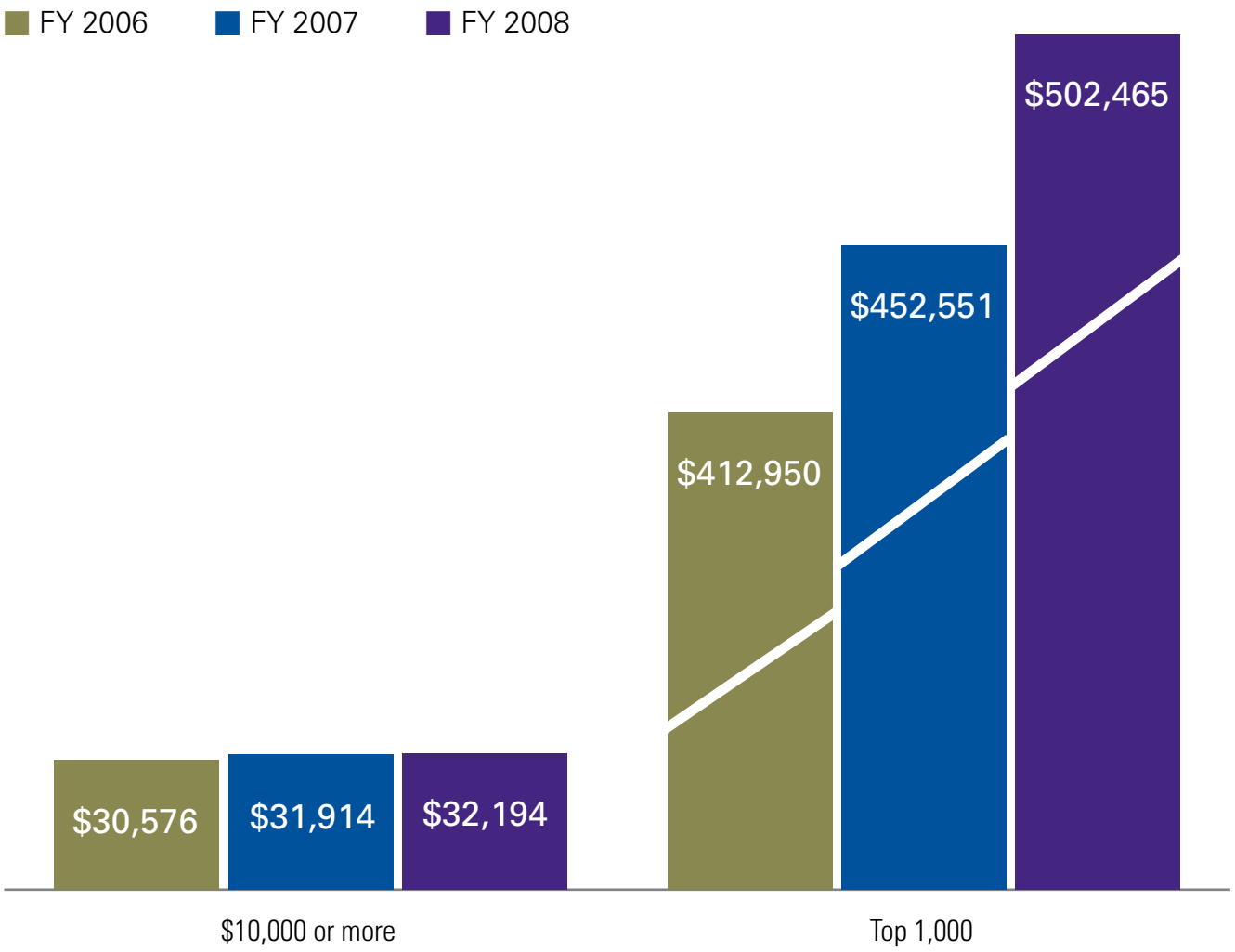
Fee-for-Service Spending Trends,

High-Cost and 1,000 Most Costly Beneficiaries, FY 2008



Notes: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 and claims from FY 2006 and FY 2007 (extracted April 2010).

Medi-Cal fee-for-service spending for the 1,000 most costly beneficiaries grew by 22 percent in two years, while average spending for all high-cost beneficiaries grew by only 5 percent. The greatest increases were for mental health (59 percent) and pharmaceuticals (44 percent).

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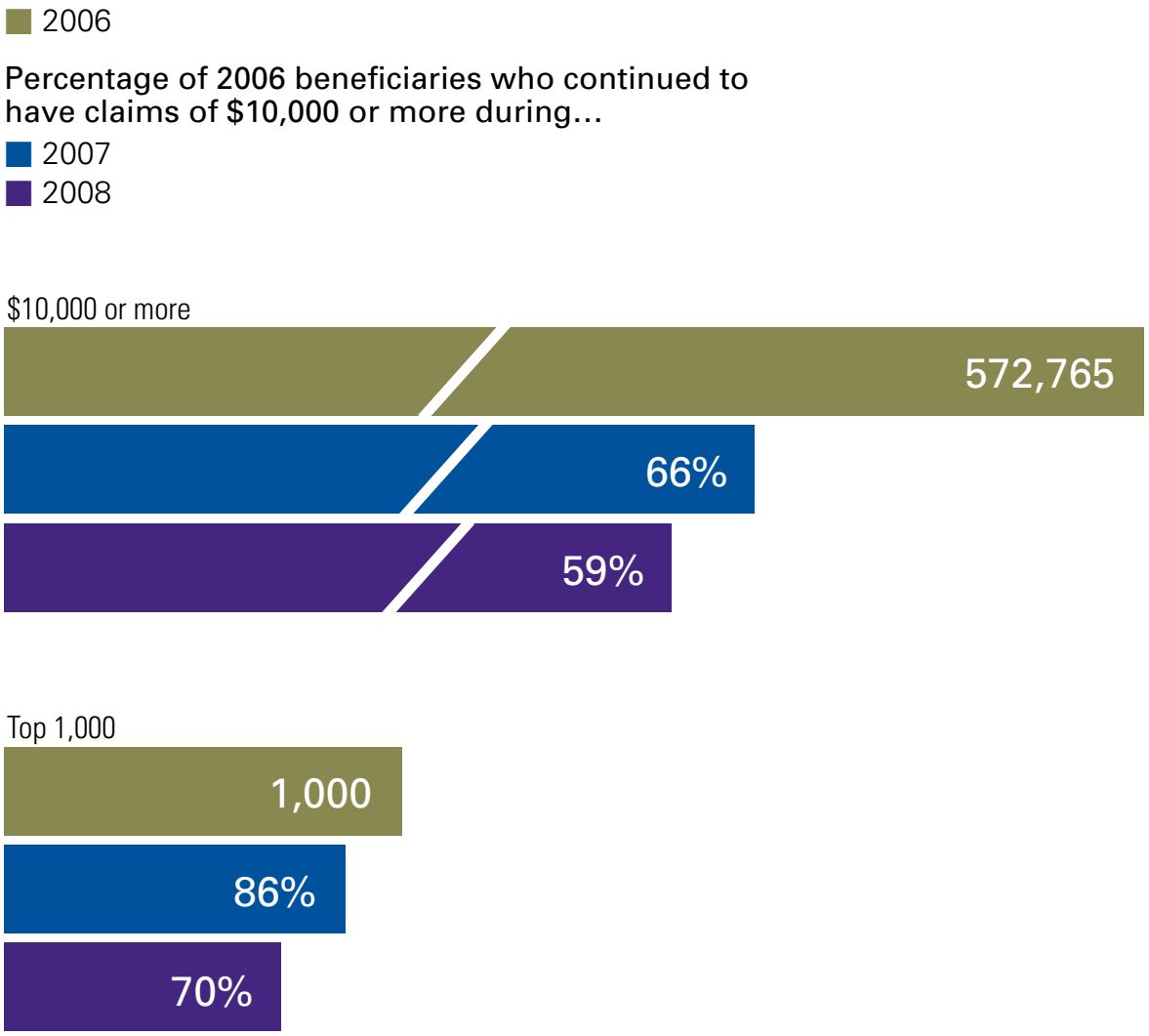
Persistence of High Costs,

High-Cost and 1,000 Most Costly Beneficiaries, FY 2006–2008



Note: Reflects fee-for-service expenditures only.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 and claims from FY 2006 and FY 2007 (extracted May 2009).

As with other high-cost beneficiaries, the 1,000 most costly were likely to incur large expenditures for multiple years: 70 percent of those in the top 1,000 in FY 2006 were also among the top 1,000 in both of the following years.

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Medi-Cal Programs to Manage High-Cost FFS Beneficiaries, FY 2008

The California Department of Health Care Services (DHCS) currently has several programs to manage high-cost, fee-for-service beneficiaries.

	CALIFORNIA CHILDREN'S SERVICES (CCS)	MEDICAL CASE MANAGEMENT	CALMEND	DISEASE MANAGEMENT PILOT #1	COORDINATED CARE MANAGEMENT PILOT #1	COORDINATED CARE MANAGEMENT PILOT #2
Operated Since	1927	1992	2005	2007	2009	2010
Target Population	Children with serious illness and special health care needs	1. Individuals hospitalized or recently discharged from inpatient settings at high-risk of being readmitted to the hospital with complex medical needs 2. Children up to age 21 with chronic or catastrophic illnesses	Individuals with severe mental illness or serious emotional disorder and, generally, co-occuring significant medical disorders	Seniors and individuals with disabilities and chronic conditions including asthma, coronary artery disease, diabetes, and chronic obstructive pulmonary disease.	Seniors with disabilities and chronic conditions who are seriously ill or near the end of life	Indiviudals with chronic conditions and serious mental illnesses
Areas of Operation	Statewide	Statewide	Statewide with pilot-collaborative projects in selected areas	Alameda County; certain zip codes in Los Angeles County	Butte, Contra Costa, El Dorado, Placer, Humboldt, Shasta, Sutter, Tehama, Yuba, and Sacramento	Kern, Kings, Madera, Stanislaus, Tulare, and San Diego
Approach	DHCS, in conjunction with counties, determines program eligibility, authorizes services and provides case management for care related to a beneficiary's CCS qualifying condition. The state also approves providers and oversees quality of care.	DHCS nurse case managers from the utilization review division facilitate hospital discharges and provide case management.	CalMEND DHCS staff and consultants develop and implement programs to improve care for Medi-Cal beneficiaries with SMI or SED in specialty mental clinical sites or through improved integration of primary care and mental health services to these individuals	McKesson medical staff work with providers to develop individualized care plans for beneficiaries. Nurses support plan adherence with phone calls to beneficiaries and other activities including provision of 24-hour advice line and multi-lingual health materials.	APS medical staff work with providers to develop individualized care plans for beneficiaries. Nurses support plan adherence with phone calls to beneficiaries and other activities including provision of 24 hour advice line.	APS medical staff work with providers to develop individualized care plans for beneficiaries. Nurses support plan adherence with phone calls to beneficiaries and other activities including provision of 24 hour advice line.
Vendor	Administered by DHCS	Administered by DHCS	Administered by DHCS in collaboration with DMH and specialty consultants	McKesson Health Solutions	APS Healthcare, Inc.	APS Healthcare, Inc.
Number of Participants	Approximately 180,000 enrollees	Adults: 1,500 per month | Children up to age 21: 3,000 per month	Approximately 2,500 individuals and 2–300 providers by end of 2010	Approximately 17,000 enrollees	Approximately 21,000 enrollees	Approximately 10,500 enrollees

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Findings and Recommendations

California is in the process of renewing its Medicaid 1115 federal waiver and intends to organize new delivery systems for many high-cost beneficiaries. There are several key findings from this report that can inform the state's current programs and the development of new initiatives.

FINDING	RECOMMENDATION
A small share of beneficiaries accounts for a large share of expenditures. In FY 2008, 7 percent of Medi-Cal beneficiaries accounted for 76 percent of fee-for-service expenditures.	Efforts to manage the care and costs of Medi-Cal fee-for-service beneficiaries should focus on this high-cost group of just over 600,000 beneficiaries.
High-cost beneficiaries are predictable. Well over half (59 percent) of high-cost beneficiaries continued to have high costs for two years or more.	The state and providers should anticipate and better manage care and costs for these beneficiaries. The state should partner with health care providers and health plans to improve data-sharing and early identification of complex cases.
Nearly half of high-cost beneficiaries are non-elderly adults, and more than one-third are 65 or older. However, among the 1,000 most costly beneficiaries, 55 percent are under age 21.	Efforts to improve care and slow the growth of Medi-Cal spending must span the age spectrum.
High-cost beneficiaries have a wide array of medical conditions. In FY 2008, most (65 percent) had two or more conditions.	The state should develop and support comprehensive, patient-centered systems of care for high-cost beneficiaries and adapt its payment structures to promote greater accountability for health outcomes and costs.
One-third of high-cost beneficiaries have both a physical and mental health problem, and nearly one in five have used a Medi-Cal-paid long term care facility. The frequency of homelessness or substance abuse among Medi-Cal recipients with a mental health disorder can further complicate care coordination. For many high-cost beneficiaries, use of a long term care facility accounts for the bulk of their expenditures.	To effectively manage the care and costs of high-cost Medi-Cal beneficiaries, better integration of physical health care, mental health care, and long term care is essential.
Inpatient hospital care was the source of 19 percent of expenditures for high-cost beneficiaries in FY 2008, and 42 percent of expenditures among the 1,000 most costly beneficiaries. Forty percent of high-cost beneficiaries had an inpatient hospital admission, and 6 percent had three or more admissions. Long term care facilities account for 23 percent of expenditures among high-cost beneficiaries.	Hospitals and nursing facilities should play a central role in reducing the growth of expenditures for high-cost beneficiaries. Medi-Cal payment policies should align financial incentives across providers to reduce inpatient admissions for ambulatory-sensitive conditions, prevent longer than necessary hospital stays, decrease readmission rates, and promote less costly alternatives to institutional care.
Beneficiaries with both Medi-Cal and Medicare coverage (dual eligibles), represented 46 percent of high-cost beneficiaries. Most (73 percent) high-cost dual eligibles were elderly.	Efforts should be made to better align Medi-Cal and Medicare policy goals and financial incentives. Historically, it has been difficult for states to develop systems of care that better integrate services covered by Medi-Cal and Medicare. Recent changes, enacted as part of federal health care reform, may ease some of the barriers to integration.
Managed care enrollees can still generate high fee-for-service costs. Nearly 64,000 beneficiaries enrolled in managed care for the full year incurred fee-for-service expenditures of $10,000 or more.	As long as some Medi-Cal-covered services are excluded from the list of benefits for which managed care plans are responsible, many managed care enrollees will incur high fee-for-service costs. With appropriate oversight, reducing the number of so-called "carved-out" services can enhance coordination and promote greater accountability among plans for health outcomes and costs.

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Methodology

The California HealthCare Foundation contracted with The Lewin Group to conduct an analysis of fee-for-service (FFS) Medi-Cal expenditures and provide an assessment of the highest cost beneficiaries.

Data Sources. The Lewin Group extracted a subset of the Medi-Cal NextGen Management Information System/Decision Support System (MIS/DSS) data warehouse in May 2009. Some expenditure data was extracted in April 2010. The NextGen MIS/DSS is refreshed each month. The Lewin Group aggregated each covered individual's annual coverage months, claims costs (by medical service category), demographic variables, managed care enrollment status, Medicare coverage status, and evidence of 19 health conditions. Individuals with only non-certified months of eligibility were excluded. The tables used in this report were created using this aggregated data.

Timeframe. The California Department of Health Care Services (DHCS) uses a July through June fiscal year. The primary period of study for analysis was the 12-month period beginning in July 2007 and extending through June 2008. This period—referred to in this report as FY 2008—was the most recent 12-month period for which fee-for-service costs were considered to be predominantly complete with respect to claims lags. Services incurred during FY 2008 were tabulated in this report, paid as of March 31, 2009. Additional claims costs may have been incurred for the study's timeframe which had not been paid as of the cut-off date used. These costs were projected to be insignificant in their impact on the report findings. An analysis of a subgroup of claims from FY 2006 and FY 2007 was also conducted to determine the proportions of continuous Medi-Cal coverage and average claims per person.

Definitions. In this report, high-cost beneficiaries are defined as beneficiaries with costs of $10,000 or more in FY 2008 unless otherwise noted. The Lewin Group screened Medi-Cal FFS claims and managed care encounters for treatment of 19 commonly occurring health conditions. These conditions were: HIV/AIDS; breast cancer; cervical cancer; prostate cancer; other cancers; diabetes; psychiatric disorders; alcohol dependence; Alzheimer's; other neurological disorders; congestive heart failure; hypertension; other cardiovascular disorders; asthma; chronic obstructive pulmonary disorder; other pulmonary disorders; nephrological disorders; and obstetrics. For some analyses, the 19 conditions were aggregated into broader condition categories (i.e. congestive heart failure, hypertension, and other cardiovascular disorders were collapsed into one category for cardiovascular conditions).

Considerations. For this study, only costs paid for directly by the state via the FFS payment mechanism, which accounted for 81 percent of total Medi-Cal costs, were included. Half of Medi-Cal beneficiaries were enrolled in health plans and generated the remaining 19 percent of Medi-Cal costs which were paid for by the health plan. While these costs were not included in this analysis, any FFS claims costs that Medi-Cal beneficiaries incurred while enrolled in health plans were included.

Expenditure data and discussions of costs per beneficiary do not take into account pharmaceutical rebates collected by the state from manufacturers. This may create a significant reduction in net costs for the Medi-Cal program but it is not likely this would disproportionately affect expenditure data for high-cost beneficiaries.

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About the Authors

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

FOR MORE INFORMATION

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