Diagnosing Medi-Cal: A Deeper Look into California’s Medicaid Program

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I. Executive Summary

Nationwide, rapidly rising health-related costs are straining budgets at every level of government. The United States Government Accountability Office (GAO) recently stated, “The primary driver of fiscal challenges for the state and local government sector in the long term continues to be the projected growth in health-related costs. Specifically, state and local expenditures on Medicaid and the cost of health care compensation for state and local government employees and retirees are projected to grow more than GDP.”1

In the coming years, the health insurance system will undergo significant changes due to the implementation of the federal Affordable Care Act (ACA). The ACA is sweeping legislation with the stated goal of significantly reducing the number of uninsured Americans, reducing health care costs, and improving the quality of health care. Medicaid, the nation’s public health insurance program for low-income and medically high need individuals is the primary vehicle for implementing the ACA. Already covering 57 million individuals nationwide, Medicaid and its costs will grow as states elect to expand their Medicaid programs beyond current levels.

By enrollment, Medi-Cal is the nation’s largest Medicaid program. In 2012, it covered 7.6 million people, or more than a fifth of the state’s population. As the second largest portion of the state budget and as one of the budget’s fastest growing expenses, Medi-Cal has historically been a primary target for cost containment. Although the state has been relatively effective at containing its per-enrollee Medicaid costs, the program’s overall costs have still risen significantly. Additionally, Medi-Cal’s relatively low (and still declining) reimbursement rates have discouraged more and more physicians from providing services to Medi-Cal patients, reducing access to care for many enrollees.

On January 1, 2014, the state will expand Medi-Cal under the ACA, significantly increasing program enrollment. However, Medi-Cal will expand significantly before then as well. The state is currently transitioning all children enrolled in its Healthy Families Program (HFP) into Medi-Cal, a process that began on January 1, 2013.

This larger Medi-Cal population will aggravate already prevalent challenges for the program, namely unsustainable cost growth and poor access to care for many of the program’s beneficiaries. Even without enrollment increases, these would still be concerns given the unprecedented growth in health prices, declining physician participation Medi-Cal, and existing doctor shortages throughout the state.

In this analysis, we first detail Medi-Cal’s basic structure. We then analyze the program’s current expenditures, efficiency, and access to care. We conclude with a discussion of various strategies the state should consider to improve the program in the coming years. Our findings include the following:

- **Significant enrollment increases.** It is estimated that average monthly Medi-Cal enrollment will be 9.1 million in 2014, or nearly one-fourth of the state’s population. This is a 78% increase from the 5.1 million enrolled in 2000. UCLA-UC Berkeley simulation model projections indicate that Medi-Cal enrollment may grow to nearly 10 million by 2019.

- **Rapid cost growth overall.** State spending on the Department of Health Care Services (mainly comprised of Medi-Cal) grew from $14.4 billion in 2007-08 to $24.1 billion in 2013-14. This 67% growth is the largest for any state budget area. Overall, it is estimated that the most costly 7% of beneficiaries account for 75% of Medi-Cal expenditures.

- **Per-enrollee cost growth slower.** From 2000-10, per-enrollee costs grew at an average annual rate of 3.8%, lower than that of per-capita personal health spending (5.9%) and employer health premiums (9.9%). The state achieved this, in part, by limiting reimbursement rates and optional benefits.

- **A program of extremes.** Pre-expansion, Medi-Cal is extremely lean, to the point of limiting access to care for existing enrollees. Though the nation’s largest program by enrollment and the second largest by expenditures, Medi-Cal spends the least per enrollee. It also has the fourth lowest physician reimbursement rates and second lowest physician participation.

- **Poor access to care.** Approximately 43% of surveyed physicians are unwilling to accept new Medi-Cal enrollees. Several counties have few or no Medi-Cal primary care physicians at all. Adding 2 million patients will increase the demand for doctors, but recent reimbursement rate cuts will disincentivize physician participation and limit their supply.

California, like the federal government and many other states, is tasked with simultaneously expanding Medicaid, limiting its cost growth, and improving the quality of health care. To accomplish these goals, it is integral that the state consider every option for improving the program’s efficiency and prioritize implementing reforms.
II. Background: What is Medicaid?

Medicaid is the nation’s primary health insurance program for low-income and medically high-need Americans, covering more than 57 million people nationwide.3 Established in 1965 as a part of the federal Social Security Act and as somewhat of an after-thought to Medicare, Medicaid is an entitlement program originally intended to provide medical assistance to individuals receiving welfare. Though many analysts predicted that it would eventually dissolve, the program has expanded rapidly in recent years, eclipsing Medicare in enrollment and approaching it in expenditures.4

Medicaid is the primary vehicle for implementing the 2010 federal Affordable Care Act (ACA). The ACA’s stated goal is to significantly reduce the number of uninsured Americans, reduce health care costs, and improve the quality of health care.5 When signed into law, the ACA mandated a Medicaid expansion to those with incomes below 133% of the federal poverty level, or $31,322 for a family of four.6 In 2012, the U.S. Supreme Court ruled that states must be given a choice about whether to participate in the expansion.7 As of July 2013, twenty-three states, including California, and the District of Columbia, have decided to expand their Medicaid programs. Twenty-one states will not and six states remain undecided.8

Both the federal and state governments control Medicaid despite its status as a national program. While states must abide by federal guidelines, such as setting minimum levels of eligibility and benefit offerings, they have flexibility in setting reimbursement rates for physicians, assigning administrative duties, and expanding benefit and eligibility levels beyond the federal minimums. In this way, Medicaid is actually a diverse collection of distinct state-administered programs, all overseen by the federal government. Though their structures vary nationwide, Medicaid programs often face similar challenges.

Medi-Cal – California’s Medicaid Program

California’s Medicaid program, Medi-Cal, plays a large and growing role in California’s health care system. While administered by California’s Department of Health Care Services (DHCS), Medi-Cal is overseen by the federal Centers for Medicare and Medicaid Services (CMS). The County Health and Social Services Department is responsible for determining enrollees’ eligibility and recertifying their statuses.9

Who Does Medi-Cal Cover?

By enrollment, Medi-Cal is the nation’s largest Medicaid program, with an average monthly enrollment of 7.6 million in 2012.10 It is also California’s single largest insurer, covering more individuals than Medicare or any private insurer.11 Today, Medicaid covers a broad low-income population, including pregnant women, children, employed and unemployed parents, disabled individuals, and the poor elderly. Medi-Cal also covers some of those who are enrolled in Medicare (called dual eligibles).

Enrollment eligibility is based on a number of factors, including eligibility for other entitlement programs, state residency, U.S. citizenship status, family assets, and family income.12 Most states extend eligibility beyond federal minimums, particularly for pregnant women and children.13

Starting in 2014, the ACA will simplify Medicaid eligibility rules by adopting a simpler method for determining family income and eliminating family assets from eligibility determination.14 By electing to participate in the Medicaid expansion under the ACA, California will extend Medicaid coverage to children and adults below 133% of the federal poverty limit (effectively 138% due to the use of Modified Adjusted Gross Income budgeting).15 This will extend coverage to parents and even childless adults, who were previously ineligible (Figure 1). According to projections from the UCLA Center for Health Policy Research and the UC Berkeley Center for Labor Research and Education, between 750,000 and 910,000 people will be newly eligible and will choose to enroll in Medi-Cal by 2019.16

Prior to 2013, children who were ineligible for Medi-Cal, but whose families had an annual income below 250% of the poverty limit, were generally eligible for the Healthy Families Program (HFP), which is a federal-state program that extends similar coverage to these children. Starting in January 2013, the state began transitioning all of these children (nearly 900,000) into Medi-Cal as part of a budget deal expected to save the state money because Medi-Cal pays less for health services than HFP does.17 Even without the HFP transition, some children would have transferred to Medi-Cal under its expanded eligibility, given that their family income levels would have fallen within the new income thresholds (about 186,800 children age 6 to 19 have family incomes between 100% and 133% of the FPL).18

UCLA-UC Berkeley projections indicate that between 240,000 and 510,000 of the adults and children expected to enroll in the program by 2019 were already
eligible for Medi-Cal or HFP prior to the Medicaid expansion but were not enrolled. These individuals will join the program based on the “woodwork effect,” a phenomenon in which individuals “come out of the woodwork” to enroll after the program’s expansion, and once the streamlined enrollment process and the ACA garner additional exposure and attention.

**Figure 1: Increase in Medi-Cal Eligibility Under Medicaid Expansion and HFP Transition**

<table>
<thead>
<tr>
<th>Eligibility Group</th>
<th>Federal Poverty Limit (as Percentage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infants (up to age 1)</td>
<td>0% - 100%</td>
</tr>
<tr>
<td>Children (ages 1-5)</td>
<td>100% - 150%</td>
</tr>
<tr>
<td>Children (ages 6-18)</td>
<td>150% - 200%</td>
</tr>
<tr>
<td>Parents</td>
<td>200% - 250%</td>
</tr>
<tr>
<td>Childless Adults</td>
<td>0% - 50%</td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>50% - 100%</td>
</tr>
<tr>
<td>Seniors and Disabled</td>
<td>100% - 150%</td>
</tr>
</tbody>
</table>

These ongoing and pending increases in Medi-Cal enrollment are the most recent in a long history of enrollment growth, which has long outpaced growth in the state’s population. As shown in Figure 2, Medi-Cal enrollment follows a recession-like pattern: This is because Medicaid enrollment is dependent upon the number of low-income people and those without private health insurance, both which increase during poorer economic conditions.

**Figure 2: Medi-Cal Enrollment Growth (2000-2014)**

Medi-Cal enrollment increased rapidly during the 2001 recession. During the economic upswing from 2003-07, Medi-Cal enrollment decreased as a percentage of the population. Since the 2008 economic downturn, enrollment has risen sharply, but plateaued at 7.6 million in 2012 as the economy gradually improved and unemployment fell slightly. In 2014, the state estimates that average monthly enrollment will be 9.1 million people, growing to nearly a fourth of the population. Ultimately, UCLA-UC Berkeley projections, though not directly comparable to state reported values, indicate that enrollment may rise to as much as 10 million by 2019.

**What Does Medi-Cal Cover?**

Medi-Cal covers enrollees with a wide range of health needs and therefore covers a wide spectrum of health services. The federal government mandates that the state provide a basic set of services, including but not limited to physician, nursing facility, hospital inpatient and outpatient, laboratory, family planning services, and certain treatment services for children. In addition to these mandatory services, California chooses to provide optional benefits such as prescription drug, dental, and clinical services. Approximately 33% of national Medicaid spending is on these optional benefits.

Medi-Cal provides significant support for community clinics and public hospitals, which play large roles in providing health services to low income and uninsured individuals as well as those living in rural or underserved areas. Approximately 60% of net patient revenue for public hospitals and 71% of net patient revenue for community clinics comes from Medi-Cal. Medi-Cal also funds nearly half of all births in California.

**Figure 3: Medi-Cal’s Share of California Personal Health Care Spending (by Service Category)**

Overall, Medicaid is one of California’s primary health payers. In 2009, approximately $230 billion was spent on personal health services in California, and Medicaid accounted for approximately $38.9 billion, or 17% (Figure 3). Medicaid generally accounts for the majority of the state’s spending on long-term care. For example, Medicaid funds over a third of California’s nursing home care and over two-thirds of home health services. Conversely, Medicaid funds relatively small portions of dental (6.2%), physician (6.7%), and prescription drugs (8.6%) services.
Over the past 40 years, there has been a nationwide shift away from out-of-pocket and private insurance health spending toward public health spending, with Medicaid experiencing the largest increase in its share (Figure 4). Since 1970, Medicaid has more than doubled its share of health spending, growing from 8% to 17% in 2010. By 2020, it is estimated that Medicaid’s share will rise to 21%. This increase is primarily attributable to the rapid growth in Medicaid enrollment, which has historically outpaced enrollment in other insurance programs and the population as a whole.

**Figure 4: Share of Personal Health Expenditures by Payer (National)**

<table>
<thead>
<tr>
<th>Year</th>
<th>Other</th>
<th>Medicaid</th>
<th>Medicare</th>
<th>Out of Pocket</th>
<th>Private Health Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1970</td>
<td>19%</td>
<td>8%</td>
<td>12%</td>
<td>40%</td>
<td>22%</td>
</tr>
<tr>
<td>1980</td>
<td>17%</td>
<td>11%</td>
<td>17%</td>
<td>27%</td>
<td>28%</td>
</tr>
<tr>
<td>1990</td>
<td>16%</td>
<td>11%</td>
<td>19%</td>
<td>22%</td>
<td>33%</td>
</tr>
<tr>
<td>2000</td>
<td>13%</td>
<td>13%</td>
<td>23%</td>
<td>17%</td>
<td>35%</td>
</tr>
<tr>
<td>2010</td>
<td>13%</td>
<td>17%</td>
<td>23%</td>
<td>14%</td>
<td>34%</td>
</tr>
<tr>
<td>2020</td>
<td>11%</td>
<td>21%</td>
<td>23%</td>
<td>11%</td>
<td>33%</td>
</tr>
</tbody>
</table>

**How Does Medi-Cal Provide Benefits?**

Medicaid is a publically financed medical insurance provider, not a government-run health care delivery system. The state pays physicians, hospitals, other providers, and health plans for services provided to the program’s enrollees. Medi-Cal covers health care in one of two ways: fee-for-service or managed care.

Under fee-for-service, qualified health providers bill the state after providing covered medical services. The state then reimburses the provider at the pre-established Medi-Cal reimbursement rate. In recent decades, there has been a shift from fee-for-service enrollment into managed care enrollment. As of January 2012, only 38% of the Medi-Cal population was enrolled in the fee-for-service system.

On the other hand, managed care operates on a prepaid basis. In this system, the state contracts with health maintenance organizations (HMOs) to provide care to beneficiaries. These health plans build provider networks to help better coordinate care for enrollees. Managed care enrollees may generally receive coverage from any provider who accepts payments from the health plan. In exchange for providing care to enrollees, health plans receive monthly “capitation payments.” These capitation payments are predetermined calculated amounts negotiated with the state and paid monthly per enrollee, regardless of the amount of services that each enrollee actually receives during the year. In this way, the health plans take on financial risk because the actual cost of providing care for a given enrollee may be more or less than the predetermined capitated amount for each enrollee. As of January 2012, approximately 62% of the beneficiary population was enrolled in managed care plans.

This year, the state intends to expand managed care to an additional 28 counties where it is not currently offered. Additionally, the state will continue to expand managed care to all elderly and disabled enrollees in an effort to better coordinate their care. Until recently, this mandate included Medi-Cal “only” enrollees, not the 1.2 million who are dually eligible for both Medi-Cal and Medicare. But in 2014, the state wishes to work with the federal government to establish a coordinated care initiative, MediConnect, in eight pilot counties to enroll most Medicare-Medi-Cal dually eligible beneficiaries into managed care plans as well. In 2014, the state expects 70% of the Medi-Cal population to be enrolled in managed care plans, an increase from 62% in 2012.

Several Medi-Cal services are not currently provided under managed care, leaving managed care enrollees to obtain these services in the fee-for-service system. These services are called “Managed Care Carve-Outs.” For example, although many elderly and disabled beneficiaries are now enrolled in managed care plans, most long-term care services they utilize, such as nursing homes and in-home services are still provided only through fee-for-service. In addition, dental services, prescription drugs, and many behavioral health services, such as mental health services and substance abuse prevention, are also carved out of managed care and provided by counties through fee-for-service. However, the state indicated in the enacted 2013-14 budget that Medi-Cal will begin integrating long-term services into managed care plans.

**III. Medi-Cal Expenditures**

Since the program’s establishment, Medicaid’s cost has increased rapidly due to enrollment growth and the inflation of health prices. Since 1970, California's Medicaid expenditures have doubled nearly six times,
growing at an average annual rate of 9.7%, from $1 billion to $49 billion in 2012 (see Figure 5).\(^{47}\)

The federal government pays a Federal Matching Assistance Percentage (FMAP) for every Medicaid dollar the state spends. This FMAP is based on each state’s “need,” as measured by the state’s per capita income relative to the U.S. average.\(^{48}\) California, with one of the nation’s highest per capita incomes, receives the minimum federal match of 50%, meaning that the state evenly splits the cost of Medicaid with the federal government.\(^{49}\)

![Figure 5: California Medicaid Expenditures 1970-2012 (excludes Administrative Costs)](image)

However, as part of the American Recovery and Reinvestment Act (also known as “the federal stimulus”), states received temporary increases in federal funding from 2009 to 2011.\(^{50}\) For example, the federal government paid two-thirds of California’s 2011 Medicaid costs. This additional funding phased-out in 2012, requiring states to fund larger portions of their Medicaid costs. In 2012, the federal government paid half of California’s $49 billion in Medicaid expenditures.

Of the four major spending categories, **acute care** represented the largest portion of California Medicaid spending in 2012, accounting for 44% of outlays (Table 1). Acute care includes hospital services, such as inpatient and outpatient hospital care, and non-hospital services such as physician and clinical services. **Capitation payments and premiums** accounted for 28% of overall expenditures. Capitation payments and premiums include spending on managed care plans and premiums paid to Medicare on behalf of dual-eligibles. **Long-term care** accounted for 27% of spending. Long-term care includes both institutional long term care, such as nursing and mental health facilities, and non-institutional long term care, such as home health and personal care. **Prescription drugs**, including the net effects of drug rebates, accounted for 2%.

### Table 1: California Medicaid Outlays, in billions (2012)\(^{52}\)

<table>
<thead>
<tr>
<th>Type</th>
<th>1997</th>
<th>2012</th>
<th>Average Annual Growth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>$8.97</td>
<td>$21.87</td>
<td>6.1%</td>
</tr>
<tr>
<td>Non-Hospital</td>
<td>$5.83</td>
<td>$12.43</td>
<td>5.2%</td>
</tr>
<tr>
<td>Capitation Payments &amp; Premiums</td>
<td>$3.14</td>
<td>$9.43</td>
<td>7.6%</td>
</tr>
<tr>
<td>Managed Care</td>
<td>$2.18</td>
<td>$11.70</td>
<td>11.9%</td>
</tr>
<tr>
<td>Medicare</td>
<td>$0.67</td>
<td>$2.25</td>
<td>8.4%</td>
</tr>
<tr>
<td>Long Term Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Institutional</td>
<td>$3.44</td>
<td>$5.80</td>
<td>3.6%</td>
</tr>
<tr>
<td>Non-Institutional</td>
<td>$1.18</td>
<td>$7.57</td>
<td>13.2%</td>
</tr>
<tr>
<td>Drugs</td>
<td>$1.18</td>
<td>$0.99</td>
<td>-1.2%</td>
</tr>
<tr>
<td>Collections</td>
<td>-$0.41</td>
<td>-$1.20</td>
<td>n/a</td>
</tr>
<tr>
<td>Total</td>
<td>$17.21</td>
<td>$48.97</td>
<td>7.2%</td>
</tr>
</tbody>
</table>

#### Acute Care

Acute care spending has increased at an average annual rate of 6.1% since 1997. Perhaps surprisingly, non-hospital acute care spending outpaced hospital spending over the same time period (average annual growth of 7.6% vs. 5.2%, respectively). However, hospital spending is still significantly larger than non-hospital acute care ($12.4 billion vs. $9.4, respectively).\(^{53}\)

#### Capitation Payments and Premiums

Since 1997, spending on capitation payments and premiums has increased rapidly, growing at an average annual rate of 11.2% over the 15 year period. This is in large part due to the accelerated transition of beneficiaries into managed care plans. Capitation payments are primarily used toward acute care services, given that prescription drugs and most long-term care services are provided only as fee-for-service.

#### Long-Term Care

Long-term care expenditures grew significantly over the last 15 years, 7.3% annually on average. The state has attempted to limit the growth of long-term care costs by transitioning beneficiaries from costly institutional settings to non-institutional settings. For example, California has seven active Section 1915 (c) waivers, which grant the state the ability to provide long-term care services in home-and-community-based settings instead.\(^{54}\) Partly as a result of these efforts, spending on non-institutional long-term care was the fastest growing category over the past 15 years (13.2%). Non-institutional long-term care spending is now higher than institutional long-term care spending ($7.6 billion vs. $5.8 billion, respectively).\(^{55}\).
Prescription Drugs
Spending on prescription drugs has declined since 1997, shrinking by an average annual rate of 1.2%. This decline began in 2006 with the new Medicare Part D, which automatically enrolled all dual-eligibles and began funding a significant portion of the state’s share of drug costs.\(^5^6\)

Medicaid spending is generally based on the number of enrollees and the cost associated with each enrollee. An analysis of these two variables reveals significant disparities among enrollment groups, namely, a small number of beneficiaries account for the largest share of costs. Approximately 40% of Medi-Cal expenditures can be attributed to the blind and disabled, though these enrollees comprise only 11% of the beneficiary population (Figure 6).\(^5^7\)

Figure 6: Composition of Medi-Cal Enrollment v. Expenditures by Basis of Eligibility (2011)\(^6^8\)

Overall, the blind/disabled and aged populations represent 21% of enrollment, but account for 70% of expenditures. Children and adults, however, account for nearly 79% of overall enrollment, but only 30% of Medi-Cal’s costs. Overall, it is estimated that 7% of the most expensive beneficiaries account for 75% of Medi-Cal expenditures.\(^5^9\)

This skewed distribution occurs because blind, disabled, and elderly enrollees are the most likely to rely on long-term care and more expensive services to address their greater health needs. However, Medicaid expenditures still substantially understate the full costs of providing health coverage for many of these individuals, particularly the aged population, because Medicaid is not the only payer covering their costs. Rather, many are “dual-eligibles,” those also enrolled in Medicare, which becomes the primary payer for their health costs. As shown in Figure 7, the aged spend the least of all enrollment groups on acute care services.\(^6^0\) Medicare covers most of these costs, but not long-term care services, which are mainly covered by Medicaid.\(^6^1\)

Figure 7: Distribution of Medicaid Expenditures by Service Category and Service Type: (2011)\(^6^2\)

Rising Medi-Cal Costs and the State Budget
The costs for essentially all forms of health insurance have increased rapidly in recent years. This is largely due to an aging and growing population, health price inflation, and the technological advances of new and more complex health services. Together, these compounding elements have increased health costs at rates exceeding inflation, per capita income, and the overall economy. States overseeing Medicaid are tasked with the great challenge of limiting the program’s cost growth in light of these factors.

Medicaid has often been referred to as the “PacMan of state budgets,” indicating that over time, the program consumes larger and larger shares of state revenues.\(^6^3\) According to the National Association of State Budget Officers, in 2011, Medicaid accounted for 23.7% of all national state government spending, making it the single largest program in the fiscal year.\(^6^4\) When state-only funds are considered, it constitutes 17.4% of spending and is the second largest, behind K-12 education.\(^6^5\)

California’s state Medi-Cal spending has fluctuated greatly in recent years due to increased federal assistance, program cuts and expansions, and payment deferrals. Within these fluctuations, however, is significant cost growth overall. In California’s 2013-14 enacted budget, the state allocated $24.1 billion in state funds to the Department of Health Care Services (DHCS) (mainly comprised of Medi-Cal spending).\(^6^6\) This is a 67% increase from the $14.4 billion in state
spending for DHCS in 2007-08.\textsuperscript{67} Approximately half of the growth in Medi-Cal spending during this time period is attributable to enrollment increases and the other half is attributable to increases in per enrollee costs, though not all Medi-Cal costs are directly attributable to the enrollee population.\textsuperscript{68}

**Figure 8: Cumulative Growth in State Spending for Select Budget Areas 2007-08 to 2013-14\textsuperscript{69}**

![Graph showing cumulative growth in state spending for select budget areas 2007-08 to 2013-14.]

This spending growth outpaces spending in all other budgetary areas. For example, during this period, actual state spending on UC and CSU fell 27%, Department of Education spending fell 7%, Corrections grew 10%, and overall state spending grew only 5% (Figure 8). In 2014, DHCS spending will comprise 17% of all state spending, compared to only 10% five years prior.\textsuperscript{70}

Even with increased assistance from the federal government, state Medicaid costs have still increased significantly and are likely to continue growing in the long-term. The federal government will fund all of the costs associated with the expanding Medicaid population for the first three years (through 2016), and will phase down to 90% by 2020, leaving the state to pay the remaining 10% then on.\textsuperscript{71} Additionally, the federal government will increase its funding share of children from the Healthy Families Program from 65% to 88% in 2015.\textsuperscript{72} However, the state will fund its normal share for new enrollees who are currently eligible, but elect to enroll only after the Medicaid expansion is implemented.

Pre-expansion, the newly eligible Medicaid population generally received health services from county funds through indigent care services. Because the health care responsibility for these individuals will transfer to the state, the state will redirect these county savings to offset its own Medi-Cal cost growth. The state will redirect county funds, starting with $300 million in 2014, to help pay for the expansion population, while establishing a system for redirecting funds there on.\textsuperscript{73}

Savings are estimated to be $900 million in 2014-15, and $1.3 billion in 2015-16 and 2016-17.\textsuperscript{74}

Children transferring from the Healthy Families Program were previously paid for under the Managed Risk Medical Insurance Board, but these responsibilities have shifted to the Department of Health Care Services to achieve savings because Medi-Cal generally pays less per child.\textsuperscript{75}

**Limiting the Cost Per-Enrollee**

Medicaid costs are a function of the number of enrolled individuals, the level of benefits utilized, and the rates paid to providers. To manage rising costs, rather than implement eligibility restrictions to reduce enrollment, California has focused on limiting its cost per enrollee. Taking enrollment growth into account, California has been relatively effective at limiting its Medicaid cost growth.

From 2000 to 2010, Medi-Cal per enrollee costs increased by an average annual rate of 3.8% (Figure 9). This average annual growth rate, while still significant, is much lower than that of overall per capita health spending (5.9%) and employer health premiums (9.9%). California has the lowest Medicaid cost per enrollee in the nation.\textsuperscript{76} In 2010, the national Medicaid per enrollee cost was $5,592 while California’s was only $3,451, 38% lower.\textsuperscript{77}

**Figure 9: Average Annual Growth in Cost per Medicaid Enrollee vs. Overall Health Cost Per Capita, Health Premiums (2000-2010)\textsuperscript{78}**

![Graph showing average annual growth in cost per Medicaid enrollee vs. overall health cost per capita, health premiums (2000-2010).]

One of the state’s most notable cost containment strategies has been limiting or cutting the rates it pays physicians. For example, Medi-Cal’s reimbursement rates to physicians have grown much slower than those nationally (Table 2). Between 2003 and 2008, Medi-Cal reimbursement rates increased only 2%, compared to 15% nationwide. From 2008 to 2012, California’s
reimbursement rates actually decreased 1%, while they grew an average of 5% nationwide. Medi-Cal’s reimbursement rates have also grown significantly less than health inflation during these periods, meaning the state’s reimbursements for medical services have been declining in real dollars and are not keeping pace with the trends of health costs, Medicare, and private insurance. In 2012, California’s physician reimbursement rates were only 51% of Medicare rates, with primary care rates being the lowest at 43%.

Table 2: California’s Reimbursement Rates

<table>
<thead>
<tr>
<th>Reimbursement Rates</th>
<th>CA</th>
<th>U.S.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative Growth 2003-08</td>
<td>2%</td>
<td>15%</td>
</tr>
<tr>
<td>Cumulative Growth 2008-12</td>
<td>-1%</td>
<td>5%</td>
</tr>
<tr>
<td>2003 Medicaid-Medicare Fee Ratio</td>
<td>0.59</td>
<td>0.69</td>
</tr>
<tr>
<td>2008 Medicaid-Medicare Fee Ratio</td>
<td>0.56</td>
<td>0.72</td>
</tr>
<tr>
<td>2012 Medicaid-Medicare Fee Ratio</td>
<td>0.51</td>
<td>0.66</td>
</tr>
</tbody>
</table>

California attempted to reduce reimbursement rates in 2011, including a 10% reimbursement cut for physicians, dentists, pharmacists, and other Medi-Cal providers. This cut was met with significant opposition, but following a long appeals process, the 9th U.S. Circuit Court of Appeals upheld them in May 2013. Two years later, providers will not only experience a 10% cut, but they will also have to pay back two years’ worth of retroactive cuts. State officials have specified that these “claw back” cuts can be paid over four years, meaning Medi-Cal providers will experience a 15% rate reduction over the next four years and an ongoing 10% reduction thereafter. The state estimates that the 10% cut represents approximately $600 million annual addition to the state budget.

The state has also cut many “optional benefits” to contain costs. For example, in 2009, the state excluded the following from coverage under the Medi-Cal: Acupuncture services, adult dental services, audiology services, chiropractic services, incontinence creams and washes, optometric and optician services, podiatric services, psychology services, and speech therapy services. In 2012, the state eliminated Adult Day Health Care (ADHC) benefits and replaced it with a new program called Community-Based Adult Services which essentially provides equivalent services at the same rate, but only for half of current ADHC beneficiaries. In California’s 2013-14 enacted budget, the state indicated that it would restore adult dental services.

Many of these cost containment strategies, particularly those affecting physician reimbursement rates, have hindered access to care for many of the program’s enrollees. Moody’s Investors Service recently stated, “The appeals court ruling demonstrates that states can change Medicaid reimbursements unilaterally.” The recently upheld reimbursement rate cuts are likely to have a negative impact on physician participation. Several health providers have already rallied against the cuts, claiming that they will have no choice but to see fewer or no Medi-Cal patients. Moody’s Investors Service also stated that the recent reimbursement rate cuts are credit positive for the state, but are credit negative for hospitals, a number of which rely on Medicaid funding to remain in operation.

IV. Medi-Cal Access to Care

Obtaining health insurance coverage is only a means to an end--actually accessing and receiving services from health professionals. Measuring access to care has been an important variable in analyzing the effectiveness of health insurance. Many studies show that high provider accessibility, particularly primary care, tends to lead to better health for the surrounding population by preventing disease and disability, detecting and treating illnesses or other health conditions, preventing hospitalizations, and lowering mortality rates.

Overall, Medicaid has improved access to care for many of its beneficiaries while alleviating most of the financial burden associated with receiving health services. Recently, the Oregon Health Study stirred the health reform debate because it was the first randomized study that measured the impact of Medicaid on health care access and health outcomes. The study found that Medicaid increased the use of physician services, prescription drugs, and hospitalizations. Additionally it found that Medicaid increased the probability of having a regular place to receive care by 50%, increased the use of preventive services and screening by more than 50%, and virtually eliminated out-of-pocket catastrophic medical expenditures. However, the study found no statistically significant improvements in health outcomes.

Though there is no such study for Medi-Cal specifically, enrollee survey responses show that Medi-Cal has improved access to care compared to those without health insurance. However, it is also becoming clear that Medi-Cal enrollees have significantly less access to care than those with other forms of insurance.

According to a 2011 survey from the California HealthCare Foundation, adults covered by Medi-Cal are nearly twice as likely as other insured adults in California to report difficulty in scheduling a doctor’s appointment...
Approximately 26% of surveyed Medi-Cal adults reported difficulty in scheduling an appointment with a primary care physician and 42% reported difficulty in scheduling an appointment with a specialist. Among non-Medi-Cal insured adults, these percentages drop to 15% and 24%, respectively.

A health access survey presented to the California Medical Association found that 36% percent of Medi-Cal enrollees report being turned away by a doctor who did not accept their insurance while only 9% of other insured Californians report the same. It also found that only 54% of enrollees had a physical or preventive care appointment in the last year and only 51% of Medi-Cal enrollees received health care immediately when they thought they needed it. For other insured Californians, these figures were 71% and 74%, respectively. Furthermore, Medi-Cal enrollees are four times more likely than other insured Californians to visit a hospital emergency room because they cannot schedule a non-emergency appointment with a doctor.

In 2009, the UCLA Center for Health Policy Research Institute found that 24% of Medi-Cal adults had no regular source of care, which was more than those with individually purchased (15%) and employer-based health insurance (8.9%), but less than those who were uninsured (51.9%).

Benchmarked against other states, California’s Medicaid program performs worse than average on several Medicaid access measures. According to the U.S. Department of Health and Human Services, Medi-Cal performs worse than average regarding the number of adults and children who sometimes or never received routine care when they wanted or needed it.

Barriers to accessing health professionals correlate with an inefficient use of health care services. For example, as suggested by Table 3, limited health provider access may cause many patients to seek treatment for otherwise routine problems in hospital rooms, leading to expensive and preventable hospitalizations. It has been found this is particularly true for those with relatively worse health.

Medi-Cal enrollees are generally less healthy than the overall population. They are more likely to be obese and are more likely to smoke than any other insurance population, including the uninsured. Furthermore, more than 25% of Medi-Cal enrollees self-assess their health as being either “fair” or “poor,” which is more than twice the percentage for all other insured individuals (11%).

### Physician Participation

In Medicaid, one of the existing roadblocks to delivering health care services is the lack of physician participation in the program, a long-standing problem nationwide. Nationally, it is estimated that one-third of all physicians refuse to see Medicaid enrollees. Physicians are often less willing to accept both Medicaid and uninsured patients, choosing to instead provide their services at a reduced cost to either one group or the other.

<table>
<thead>
<tr>
<th>Response</th>
<th>Medi-Cal Enrollees</th>
<th>Other Insured Californians</th>
<th>Uninsured Californians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty getting appointments (Primary, Specialist)</td>
<td>26%, 42%</td>
<td>15%, 24%</td>
<td>N/A</td>
</tr>
<tr>
<td>Difficulty finding physician who accepts insurance (Primary, Specialist)</td>
<td>23%, 34%</td>
<td>11%, 13%</td>
<td>N/A</td>
</tr>
<tr>
<td>Turned down by doctor who did not accept insurance</td>
<td>36%</td>
<td>9%</td>
<td>N/A</td>
</tr>
<tr>
<td>Always received health care right away when you thought you needed it</td>
<td>51%</td>
<td>74%</td>
<td>27%</td>
</tr>
<tr>
<td>Had a physical or preventative care visit in last year</td>
<td>54%</td>
<td>71%</td>
<td>35%</td>
</tr>
<tr>
<td>Always made a non-emergency appointment within 3 weeks of request</td>
<td>46%</td>
<td>67%</td>
<td>21%</td>
</tr>
<tr>
<td>Went to hospital ER because you could not get an appointment with a doctor or clinic</td>
<td>17%</td>
<td>4%</td>
<td>9%</td>
</tr>
<tr>
<td>No regular source of care</td>
<td>24%</td>
<td>15% (individual)</td>
<td>52% (employer-based)</td>
</tr>
</tbody>
</table>
These national concerns also apply to California’s Medicaid program. A 2008 California HealthCare Foundation and UC San Francisco (UCSF) study, found that approximately two-thirds of all California physicians report having Medi-Cal patients within their practice (Figure 10). Conversely, 92% of California physicians have private insurance patients and 78% have Medicare patients. A comparable 67% have uninsured patients. Among reporting physicians, although two-thirds currently treat Medi-Cal patients, 43% indicated that they are unwilling to accept new enrollees.

Figure 10: Physician Participation in Medi-Cal (as of 2008)

According to the state, there are 20,500 primary care physicians registered with the Medi-Cal program, meaning that there are approximately 3.2 primary care physicians per 1,000 Medi-Cal enrollees, excluding dual-eligibles. However, there is a wide disparity in the distribution of Medi-Cal primary care physicians among California’s counties (Figure 11). There are no Medi-Cal primary care physicians in Alpine, Sierra, and Trinity counties and fewer than 1 per 1,000 enrollees in 10 other counties. Counties with relatively few Medi-Cal primary care physicians rely on Federally Qualified Health and Rural Health Clinics (957 available as of the first quarter in 2012) that are able to provide primary care services. In 2009, the UCLA Center for Health Policy Research found Medi-Cal adults’ regular source of care is slightly more likely to come from a clinic (38.2%) than a private doctor (37.5%).

Conversely, there are over 4.5 primary care physicians per 1,000 enrollees in 8 counties, including over 10 per 1,000 in San Mateo and San Francisco counties. However, these physician totals reflect only “nominal” or potential physicians. They are registered but not necessarily practicing actively, which raises concerns about each individual physician’s commitment and availability to see Medi-Cal patients. Additionally, these ratios do not account for the fact that Medi-Cal physicians do not only see Med-Cal patients. Enrollees are heavily concentrated among a limited number of physicians who provide the bulk of their care to Medi-Cal patients, with 25% of accepting providers providing care to 80% of Medi-Cal patients.

Why Don’t Health Providers Accept Medi-Cal?

A broad range of factors impact a physician’s willingness to participate in the Medicaid program. Low Medicaid reimbursement rates relative to those for Medicare and private payers are usually considered the main reason for low physician participation in Medicaid. The relationship is straightforward: the less Medicaid pays relative to the actual cost of services, the less financially feasible it is for physicians to participate. As we found earlier, Medi-Cal payments to physicians are half of what Medicare pays to them.

California sets Medi-Cal reimbursement rates on an ad-hoc basis and cuts them when trying to balance its budget, which has been a longstanding concern. For example, in 2001, the California Legislative Analysts’ Office (LAO) stated, “Rate adjustments have generally been adopted on an ad hoc basis and not upon an assessment of the access of Medi-Cal beneficiaries to quality health care. Thus, there is not a rational basis for Medi-Cal rates. In comparison, Medicare uses a
comprehensive, annual updated, rate-setting system.”\textsuperscript{113} Years later, in 2008, the LAO noted, “In general, FFS [fee-for-service] physician rates have not changed since the Legislature granted rate increases in the 2000–01 budget year, though medical costs continue to rise.”\textsuperscript{114}

Though a concern nationally, the issue is perhaps more acute in California, given that Medi-Cal physician reimbursement rates have lagged well behind the national average. As of 2012, California’s reimbursement rates ranked 47\textsuperscript{th} nationally.\textsuperscript{115} As of 2011, California also ranked 49\textsuperscript{th} in physician participation, correlating with its low reimbursement rate ranking. Although there is a relationship between reimbursement rates and physician participation, there is great variation in the relationship among states (Figure 12). Thus, simply raising reimbursement rates may be insufficient to bolster physician participation.

Research has shown that there have been other reasons for low physician participation such as payment delays, administrative burdens, and difficult or noncompliant beneficiaries. A Center for Studying Health System Change study found that quick reimbursement times have a positive effect on physician participation and slow reimbursement times have a negative effect.\textsuperscript{116} Even in states with higher Medicaid reimbursement rates, physician participation diminishes when accompanied by relatively slow reimbursement times, lowering physician participation to levels nearer to those states with relatively low rates.\textsuperscript{117} The study classified California as having both low and slow reimbursement, which provides further explanation for its low physician participation.\textsuperscript{118}

**Figure 12: Reimbursement Rates (measured as percent of Medicare Fees) v. Physician Participation**\textsuperscript{119}

Under the Health Care and Education Reconciliation Act, passed alongside the ACA, the federal government will fund a temporary two-year (2013-2014) increase in reimbursement rates for 146 primary care services, raising the rates up to Medicare levels for family physicians, internists, pediatricians and some qualifying specialists.\textsuperscript{120} Physicians participating in both the fee-for-service and managed care systems will receive these elevated rates. In California, it is estimated that this will result in a substantial 136%, or nearly two-and-a-half times, increase in current reimbursement rate levels, compared to a 73% increase nationwide.\textsuperscript{121}

Due to the temporary nature of the increases, this effort may delay some physicians from leaving Medi-Cal more than it will attract those physicians who do not already see Medi-Cal patients, thereby failing to expand the number of health care providers available to the significantly larger Medi-Cal population.\textsuperscript{122} Even so, the temporary reimbursement rate increases under the ACA have been delayed, meaning that physicians will have to wait to receive the higher rates. The Department of Health Care Services “tentatively” anticipates the hike to take effect in September.\textsuperscript{123}

**Managed Care and Health Access**

One important goal of managed care is to improve access to and the quality of care by relying on the managed care plan’s provider network to better coordinate each enrollee’s care as opposed to letting each enrollee navigate the fee-for-service system on his own. Through these coordinated care efforts, managed care plans should reduce the reliance on emergency rooms, would provide beneficiaries with regular primary care sources, and emphasize primary care and health outcomes.\textsuperscript{124}

Some studies show that managed care has indeed improved care coordination and reduced unnecessary hospitalizations. A California HealthCare Foundation study found that from 1994 to 2002, the average annual preventable hospitalization rates among a small subset of Medi-Cal beneficiaries was as much as one-third lower in managed care than in fee-for-service.\textsuperscript{125}

However, it remains to be seen how managed care plans improve access to care for seniors and the disabled specifically. A 2011 study found there was no significant difference in any perceived measure of access to care for seniors and disabled persons transferring from fee-for-service, but most beneficiaries reported their access and quality of care was either the same or better than it had been under fee-for-service.\textsuperscript{126}

There are some reasons to be critical of managed care’s ability to significantly improve access to care. First, it has...
been found that managed care does not increase physician participation in the Medicaid program.\textsuperscript{127} Medi-Cal uses its low fee-for-service reimbursement rates as a baseline for managed care's capitation rates, thereby keeping managed care rates relatively low and making it difficult for the plans to develop strong provider networks.\textsuperscript{128} Additionally, as shown earlier, many Medi-Cal covered health services are carved out of managed care and provided only in fee-for-service, though the state is to integrate these into managed care plans.

V. Medicaid Reform

California’s Medicaid program faces rapidly increasing enrollment and compounding budgetary pressures, particularly in times of significant fiscal strain for the state budget, which have resulted in cuts to the program. Program cuts are a double edged sword: cutting the program saves the state money, but generally decreases the quality of care. Moreover, program cuts fail to address the underlying cost growth among medical services. In some cases, cuts to the program may actually raise costs.\textsuperscript{129} And even in light of program cuts, Medi-Cal remains as the second largest and fastest growing budget area. Here we will briefly survey several cost containment and care improvement strategies that have been proposed or are being adopted in the health care system.

Medicaid reforms fall within a select number of categories (sometimes interrelated), including but not limited to: changing the way providers are paid, changing the way providers are organized, increasing the number of providers, increasing the role of the enrollee, and/or increasing transparency.

![Image](image.png)

**Table 4: Medicaid Reform Strategies**

<table>
<thead>
<tr>
<th>Type of Reform</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Payment Structure</td>
<td>Create incentives for providers to accept Medi-Cal patients and focus on value rather than volume. Reduce waste, improve efficiency, and improve quality of care.</td>
<td>Pay for Performance, Bundled Payments, Risk-Adjusted Global budgets</td>
</tr>
<tr>
<td>Provider Organization</td>
<td>Integrate and coordinate care among providers, whether through provider networks, teams, or health facilities.</td>
<td>Managed Care Provider Networks, Patient Centered Medical Homes, Accountable Care Organizations</td>
</tr>
<tr>
<td>Increase Number of Providers</td>
<td>Increase number of available providers to improve access to care.</td>
<td>“Scope of Practice” laws, loan repayment/forgiveness, telemedicine</td>
</tr>
<tr>
<td>Increase Enrollees’ Role</td>
<td>Activate enrollees as consumers of health care to encourage efficient use of health services.</td>
<td>Consumer Directed Health Plans, Cost Sharing</td>
</tr>
<tr>
<td>Increase Transparency</td>
<td>Increase transparency to hold systems accountable, detect inefficiencies and fraud, reveal potential for improvements.</td>
<td>Increase transparency of Medicaid data, capitation and reimbursement methodology, access and quality measures</td>
</tr>
</tbody>
</table>

**Provider Payment Structure**

Medi-Cal should provide an incentive for providers to accept Medi-Cal patients. It should adjust physician payments to better reflect the actual cost of providing services so that seeing Medi-Cal patients will be more financially feasible for health providers. The Federal government (through the Centers for Medicare and Medicaid Services) requires that state Medicaid programs, "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."\textsuperscript{130} Statewide, there is mounting evidence that Medi-Cal is falling short of this standard.\textsuperscript{131} Although reimbursement rates directly result in an increase in expenditures, they may lower costs due to preventable hospitalizations and care provided in other expensive settings.\textsuperscript{132}

Medi-Cal should also shift toward provider payment structures that generate an incentive for providers to focus on value rather than volume. For example, fee-for-service payments to health providers encourage volume and use of higher more expensive care. But other payment models, including Pay-for-Performance (P4P) and bundled payments encourage providers to improve quality of care and coordinate with other health professionals using financial incentives.\textsuperscript{133}

In 2009, the California Legislative Analysts' Office recommended that the legislature enact a law directing DHCS to create a statewide P4P program for Medi-Cal.\textsuperscript{134} The LAO speculated that P4P could improve the quality of care, lower hospital admissions, and lower costs.
Provider Organization

California already intends to continue expanding its managed care programs and leverage the programs’ provider networks to better coordinate and integrate care for its Medi-Cal population. This will be of particular use to the aged and disabled populations, which consume relatively larger shares of Medicaid costs and health resources. However, the state should seek to reduce service fragmentation between managed care and fee-for-service programs, as it hinders coordinated care efforts and creates a perverse incentive for managed care plans to shift services to the more expensive fee-for-service system.\(^{135}\) The state must also ensure that capitation rates are adequate enough for managed care plans to remain solvent and develop strong provider networks.

As the state continues with this transition, it should also look to further leverage other coordinated and integrated care models, such as Patient-Centered Medical Homes (PCMHs).\(^{136}\) In PCMHs, various health professionals provide comprehensive, coordinated, and accessible services that are catered to the particular needs of their patient populations.\(^{137}\) In Vermont, PCMH’s decreased emergency department use by 31\%, reduced inpatient services by 21\%, and lowered associated per-person per-month costs by 22\%.\(^{138}\) Twenty-five states, excluding California, use these models in their Medicaid programs.\(^{139}\) A proposal by Assemblyman Richard Pan would define medical homes and move California closer to implementing a similar structure.\(^{140}\)

Increasing Number of Health Providers

To alleviate some access to care concerns, some have indicated that California needs more health providers, particularly in light of the larger insured population under the ACA.\(^{141}\) While bolstering the health provider supply is a long-term endeavor, a frequently proposed solution is leveraging existing health professionals by expanding their permitted scope of independent practice to include some traditional physician duties. For example, Senator Ed Hernandez has proposed to permit nurse practitioners, pharmacists, and optometrists to undertake some physician duties, which would expand the state’s health workforce.\(^{142}\) Currently, nurse practitioners are permitted to treat patients and prescribe medications without physician oversight in 18 states, plus the District of Columbia.\(^{143}\)

There are 17,032 nurse practitioners in California, meaning there is high potential for these health professionals to alleviate existing provider access concerns.\(^{144}\) It has been found that nurse practitioners perform equally as well as physicians on important clinical outcome measures, such as mortality, reduction of symptoms, health status, and functional status.\(^{145}\)

Increase Role of Enrollee

The true cost of health services is largely obscured from Medicaid enrollees and healthcare consumers more generally. Federal restrictions generally shield Medicaid enrollees from cost sharing.\(^{146}\) The state should encourage enrollees to more efficiently use health care services, thereby lowering costs. Introducing a personal stake into patient purchasing decisions, or a “skin in the game” approach, has proven effective elsewhere.\(^{147}\)

Indiana has introduced a consumer-directed health care model for low-income residents under its Healthy Indiana Plan and provides members with a health savings like account. Each participant funds the account up to 5\% of gross family income.\(^{148}\) The plan allows members to “rollover” unused funds to the next year if they received appropriate preventive care and the plan imposes emergency room copayments to encourage members to seek routine care at clinics or physician offices. Overall, the plan has reportedly been successful at reducing ER use, encouraging less expensive generic drug use, and has earned high enrollee satisfaction.\(^{149}\)

Increase Transparency

The U.S. Government Accountability Office (GAO) has deemed Medicaid as “high-risk,” meaning it that it has greater vulnerability to fraud, waste, abuse, and mismanagement.\(^{150}\) Increasing transparency will help hold the system accountable and allow the public, researchers, lawmakers, and stakeholders to make more informed decisions. It will also help detect fraud and reveal potential for program improvements.

California should continue to increase transparency of its health programs, including the public release of Medicaid data, capitation and reimbursement rate setting methodologies, and access and quality of care measures. Many available data sources are non-inclusive, inconsistent, and not readily accessible. Additionally, though most enrollees are in managed care, available data sources still cater to the fee-for-service system.

Currently Assembly Bill 209 (by Assemblyman Richard Pan) aims to create greater transparency and accountability in the Department of Health Care Services by requiring quarterly oversight meetings and the public release of data dashboards displaying quality and access measures.\(^{151}\)
VI. Conclusion

Medicaid faces unique challenges in each state, but many reflect a similar nationwide narrative. As the Chief Actuary from the Centers for Medicare and Medicaid Services stated, “Determining how to optimally balance our collective demand for the best possible health care with our non-unlimited ability to fund such care through private and public efforts represents one of the most challenging policy dilemmas facing the nation.”

As one of the largest and fastest growing portions of California’s budget, Medi-Cal has been a primary target for state cost containment. By running a lean program, Medi-Cal has been relatively effective at limiting its per-enrollee cost growth to levels lower than per capita health spending in the overall health system. Still, program costs have still increased significantly, outpacing all other areas of the budget from 2007-08 to 2013-14.

The program faces rapidly rising enrollment and severe provider access problems. Medi-Cal enrollment will rise from 7.6 million in 2012 to 9.1 million in 2014, and may ultimately grow to 10 million by 2019. As more people enroll, the existing provider access disparities between Medicaid and other health insurance programs will worsen and become even more important to resolve.

Looking forward, California should focus on reform efforts that address the underlying growth in the cost of health services as opposed to implementing impulsive cuts to the program. California should leverage the findings and foundations of innovative health care payment and delivery models that bolster the quality of care while lowering costs. Additionally, the state should make the program more transparent to promote system accountability, efficiency, and effectiveness.

As a subset of the overarching health care system, many Medicaid reforms actually should be aimed at the larger health system. Rising health costs and doctor shortages plague the entire health system, not Medicaid exclusively. Although Medicaid has significant (and growing) purchasing power, it cannot address these issues alone.

Containing Medicaid costs and ensuring high quality care is important, especially given the growing role Medi-Cal plays in California’s health care system. When discussing Medicaid and Medicaid reforms, we will soon be discussing how to effectively and efficiently provide health care to one-fourth of the entire state and how to fund over one-fifth of the state’s total health costs. That is no small endeavor.
VII. Appendix A: Medi-Cal Enrollment

There have been great confusion and inconsistencies over the correct number of individuals that are actually enrolled in Medi-Cal. Enrollment figures differ in two primary ways: by timeframe measured, and by definition of “eligible.” These distinctions cause enrollment totals to differ significantly. For example, in 2011, the state reported that average monthly enrollment was approximately 7.5 million. However, many of those enrolled in the program do not remain in the program the entire year. Often, Medi-Cal enrollees are only in the program for as little as one month. Those short-term enrollees are not sufficiently represented. The state-reported number of all individuals enrolled in the program for at least one month changes the enrollment figure to 9.2 million, 23% increase from the average monthly enrollment number.

Furthermore, the state-reported values are actually classified as “certified eligibles,” where the state restricts the definition of eligibility used in its counts by excluding those in the Family PACT program, pregnant women who have “presumptive eligibility,” and those with an unmet Share of Cost (SOC).153 The federally maintained data source, the Medicaid Statistical Information System (MSIS), does not contain these restrictions. Consequently, enrollment reported in the MSIS is much higher than state-reported values. According to the MSIS, average monthly enrollment for California’s Medicaid program was just under 9 million while the number of those ever enrolled was 11.6 million. Thus, depending on the data source and time frame measured, up to 31% of California’s population participated in the program in 2011. See these differing, but accurate, values of Medi-Cal enrollment are seen in Figure 13 and 14.

Figure 13: Different Medi-Cal Enrollment Figures for 2011 (as % of Population)154

Figure 14: Point in Time Medi-Cal population by Age Group (July 2011)155
VIII. Appendix B: Methodology and Data Sources

This utilized many data sources. Often, we used multiple data source to complement one another because each one has its own unique strengths. Note that sometimes values will differ between data sources for various reasons such as the given time frame, collection methodology, and category definitions. The main data sources are described below.

- **Medicaid Statistical Information System (MSIS)** - The MSIS database contains state-submitted eligibility and claims data from the Medicaid population, including demographic characteristics and payments made for various eligibility categories and health service types. Values from federal fiscal years 1999 to 2011 are available online in the MSIS Datamart. We excluded those in the Children’s Health Insurance Program from enrollment counts. Note that this data is based on a federal fiscal year. Centers for Medicare and Medicaid Services. Medicaid Statistical Information System (MSIS) State Summary Datamarts. <http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MedicaidDataSourcesGenInfo/MSIS-Mart-Home.html>

- **Center for Medicaid Services Form 64 (CMS-64)** - Each quarter states are required to submit the CMS-64 report, which contains a statement of expenditures for which states are entitled to Federal reimbursement. Amounts are derived from invoices, cost reports, and eligibility records. We aggregated expenditures into the following broad categories: Hospital Acute Care, Non-Hospital Acute Care, Institutional Long-Term Services and Supports, Non-Institutional Long-Term Services and Supports, Managed Care Medicare, Prescription Drugs, and Collections. Expenditures from 1997 to 2011 are available online via the Financial Management Reports. We obtained expenditure data from 2012 and years prior to 1997 directly from the Centers for Medicare and Medicaid Services. Note that this data is based on a federal fiscal year. Center for Medicaid and CHIP Services. CMS-64 Quarterly Expense Report. <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Data-and-Systems/MBES/CMS-64-Quarterly-Expense-Report.html>

- **Merging of MSIS and CMS-64** - We merged CMS-64 data and MSIS data for FY 2011 by taking average monthly enrollment totals and expenditure distributions by service and eligibility type in MSIS and combining it with actual expenditure totals in CMS-64. We adopted a methodology similar to that taken by the Medicaid and CHIP Payment and Access Commission. Please consult the following for more detailed technical guide. Medicaid and CHIP Payment and Access Commission. MACStats: Medicaid and CHIP Program Statistics. June 2013. Pages 61 to 65. <http://www.macpac.gov/macstats>


- **California Department of Health Care Services** - Provides state-reported Medi-Cal data and statistics through the Research and Analytics Studies Branch (RASB). In addition, DHCS also presents Medi-Cal local estimates reports that estimate expenditures and enrollment for the current and upcoming fiscal year. State of California, Department of Health Care Services. Medi-Cal Local Assistance Estimates. <http://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/default.aspx>

- **Kaiser Family Foundation** - The Kaiser Family Foundation maintains a State Health Facts data resource that provides data on health care costs, health coverage, Medicaid, Medicare, and other health related topics. The Henry K. Kaiser Family Foundation. State Health Facts. <http://kff.org/statedata/>
Endnotes:

4 Average Medicare enrollment in 2012 is expected to be 49.5 million. Medicaid expenditures in 2012 are estimated to be $459 billion, while Medicare expenditures estimated to be $591 billion.
9 The Supreme Court decision in National Federation of Independent Business v. Sebelius (2012), allowed states to exclude themselves from the Medicaid expansion without loss of federal funding for its existing program.
11 This information is subject to change.
12 Constitutional amendment subject to change.
14 California State, Department of Health Care Services. May 2013 Medi-Cal Estimate Caseload Tab, <http://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/default.aspx> For a comparison of other state reported enrollment totals, see the following. Note that values are only up to 2011.
17 Medi-Cal eligibility is a complex web of varying factors. Please consult the following flow chart for a more descriptive overview of traditional Medi-Cal eligibility.
19 For more information regarding current Medi-Cal eligibility at the federal level, consult the following:
20 Center for Medicaid and CHIP Services. Eligibility. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html> For a comparison of other state reported enrollment totals, see the following. Note that values are only up to 2011.
23 Medi-Cal eligibility is a complex web of varying factors. Please consult the following flow chart for a more descriptive overview of traditional Medi-Cal eligibility.
25 For more information regarding current Medi-Cal eligibility at the federal level, consult the following:
27 California wishes to keep the asset test for determining eligibility for long-term care services. It must obtain federal approval, however.
29 The text of the ACA says 133 percent, but the law requires the use of Modified Adjusted Gross Income when calculating eligibility. This method will effectively add 5% to the 133%, minimum.
32 Ibid
34 For example, in addition to simplifications of eligibility rules, the ACA will also require optimized use of electronic data sources, and allow citizens to apply for Medi-Cal through the new health exchanges.
35 Note that working adults’ income eligibility extends to 106%. Also note that the Medicaid expansion does not extend eligibility for seniors and disabled persons.
38 Kaiser Family Foundation, State Health Facts, Medicaid & CHIP Indicators. <http://kff.org/medicaid/stateactivity/state/California>
40 Years before 2006 were obtained directly from the Department of Health Care Services.
With only the addition of Healthy Families children, the state projected that average monthly enrollment would increase to 8.6 million in 2014. UCLA-UC Berkeley projected an ACA enrollment addition of between 1 to 1.4 million by 2019. Assuming no baseline trends, this gives an upper bound of 10 million. Future enrollment may vary considerably.


54 These include Assisted Living, In Home Operations, the Multipurpose Senior Services Program, Pediatric Palliative Care, and others.


56 The expanding use of non-institutional long-term care services by those who would have not otherwise used long-term care will result in increased costs. We were unable to determine whether this was prevalent in Medi-Cal.

57 According to CMS Office of the Actuary, as a result of Medicare Part D, all dual-eligibles were automatically enrolled in Part D and Medicare served as the primary source of their prescription drug coverage. Nationally, Medicare drug spending (net of rebates) decreased 44 percent from 2005 to 2006. Medicaid still provides some drug coverage for dual-eligibles that Medicare Part D does not cover.


59 This excludes DSH payments and Non-DSH supplementary payments, since these cannot directly be attributable to any enrollment group. These results came from merging CMS-64 data with MSIS data. Please refer to Appendix B for more information.

60 This excludes DSH and non-DSH supplementary payments, since these cannot directly be attributable to any enrollment group. In addition, we use average monthly enrollment and exclude those in CHIP. These results came from merging CMS-64 data with MSIS data for FY 2011 (federal). See Appendix B for more information.

61 This refers to fee-for-service expenditures in FY 2008.


58 Ibid.

62 According to LAO, “For SNF Costs, Medi-Cal Picks Up Where Medicare Leaves Off. If a dual eligible requires ‘post-acute’ or ‘skilled nursing care’ for therapy or rehabilitation following hospitalization, then Medicare Part A pays for the first 20 days of the beneficiary’s stay in a nursing home. Medi-Cal pays the beneficiary’s copayments for the next 80 days. After 100 days in the SNF, the beneficiary’s Part A benefit expires, and Medi-Cal begins to cover the cost for the remainder of the stay. Medicare does not cover nursing home stays that involve ‘custodial’ or ‘respite care.’ These are services for beneficiaries who are not undergoing active therapy or rehabilitation programs, but instead need to reside in nursing homes for medical reasons. Medi-Cal pays for dual eligibles in this category, and these services make up the majority of SNF costs for SPDs.” California Legislative Analyst’s Office. Integrating Care for Seniors and Persons with Disabilities. Page 11-12. February 2012. <http://www.lao.ca.gov/analysis/2012/health/integrating-care-021712.pdf>

63 This excludes DSH and non-DSH supplementary payments, since these cannot directly be attributable to any enrollment group. We exclude those enrolled in CHIP. These results came from merging CMS-64 data with MSIS data for federal FY 2011 (federal). See Appendix B for more information.

64 This has been stated on numerous occasions, though the origin of such a reference was not determined during this analysis. The following is an example of this reference.


66 Ibid.

67 All expenditures include state only spending, thereby excluding federal funds.

2007-08 values were obtained from:


68 Ibid

69 Enrollment grew 37% from 6.7 million in 2008 to 9.1 million in 2014. Medi-Cal per-enrollee costs grew from 5510 to 7600, a 38% increase. Assuming shared intersectional impact, enrollment growth accounted for 49% of the growth with state-only per-enrollee costs accounting for 51%. Of course, per-enrollee costs are not adjusted to reflect disproportionate growth among enrollment groups, given that the addition of enrollment groups with lower per-enrollee costs will artificially deflate the overall cost per-enrollee figure. Furthermore, some spending, such as administration costs and supplementary payments are not directed attributable to any particularally enrolled. These values differ from CMS totals.

State of California, Department of Health Care Services, Medi-Cal May Local Assistance Estimate for Fiscal Years 2007-08 and 2013-14.

70 Ibid.


73 Following 2014, counties will then be able to choose from two options: 1.) A 60-40 split of any savings, with the state receiving the higher amount, or 2.) A more precise calculation of how much counties save from residents enrolling in Medi-Cal based on how much counties spent on indigent care over the last four years.


74 Ibid.


Average growth in the cost per Medicaid enrollee does not account for the changing dynamics of the enrollment population. For example, the addition of children will artificially lower the cost per enrollee because children cost less than the average enrollee. Normalized spending growth that controls for the disproportionate growth among different enrollment groups results in a 4.1% average annual growth rate.

Medicaid Per Enrollee Spending Growth was calculated from:
Per Capita health spending growth from FY2000-2009 was calculated from:
Per Capita Spending growth from FY 2009-2010 was estimated by the author, by extrapolating per capita growth rates by service type from the following:


The enacted budget includes $33.8 million to provide preventative adult dental benefits beginning May 1, 2014. Annual costs are estimated to be $211.5 million.


A literature review of many of these studies can be found here:

The results of the Oregon Health Study, also known as the Oregon Health Insurance Experiment, were published in the New England Journal of Medicine. Results can also be found on the study’s website: Oregon Health Study. Oregon Health Study Findings. <http://oregonhealthstudy.org/for-participants/findings/>


119 Includes Medi-Cal enrollees between ages 19-64 who were enrolled all year.


120 The AMA has indicated that there are currently 33,822 primary care physicians in the state, implying a physician participation rate of 63%, which is comparable to previously cited survey findings. However, the numbers in the AMA are not necessarily comparable to the number of Medi-Cal physicians due to methodology and time frame measured. Association of American Medical Colleges. 2011 State Physician Workforce Data Book. November 2011. Page 13. <https://www.aamc.org/download/263512/data>


122 Note these are raw values, not adjusted for Medi-Cal population density or shares of physician’s practices.


Medi-Cal only enrollment for January 2012 was used in order to correspond to the 2012 Quarter 1 measurement of primary care physicians.


125 Note that this ranking excludes Tennessee.


127 Ibid

128 Overall, the log-linear model returns an R² of 0.34. Excludes Tennessee due to lack of reimbursement data

Values for Physician Participation came from the following study:

Values from this study are mapped out here as well:

Values for Medicaid to Medicare Reimbursement Ratios can be obtained from the following source:

129 This primary care fee increase is fully funded (temporary for 2013-2014) up to the difference between a state’s Medicaid fees in effect on July 1, 2009 and Medicare fees in 2013. It is not clear at this time whether the recent reimbursement rate cuts will require a state contribution, as these rates may not be lower than those as of July 1, 2009.


130 Ibid

131 The California legislature passed a bill in June 2012 that mandated rates return to pre-2013 levels in 2015 unless the enhanced federal match continues. AB 1467 Monning, Chapter 23, Statutes of 2012. Refer to Section 14105.196


133 Please refer to the following source for an overview of the effectiveness of managed care nationwide.


135 Greene J, Blustein J, Remler D. “The Impact of Medicaid Managed Care on Primary Care Physician Participation in Medicaid.” Medical Care, vol. 43, no. 9, 2005.


137 For example, benefit cuts may cause enrollees to receive care in more expensive settings. It is estimated that in 2020-2021, a full cut of Adult Day Health Care would have saved the state $197.2 million, but would have ultimately lead to a $71.9 million net cost to the state because of losses of tax revenue, and cost shifts into nursing homes and other long term care services. The Lewin Group. CA Adult Day Health Care Economic Impact Report. May 2010. <http://www.lewin.com/-/media/Lewin/Site_Sections/Publications/EconImpactofEliminatingCAMedicalDayHC.pdf>


139 California HealthCare Foundation and researchers at the University of California at San Francisco found that in 2008, Medi-Cal beneficiaries had less access to care than the general population. There were 50 primary care physicians available per 100,000 Medi-Cal beneficiaries, compared to 59 for the population overall. Both figures were outside the recommended range of 60 to 80. The number of non-primary care specialists available
per 100,000 Medi-Cal beneficiaries was 65, far fewer than the 115 specialists per 100,000 for the population as a whole, and much lower than the recommended range of 85 to 105 per 100,000 population. However, these figures rely only on survey data and not on actual data from Medi-Cal claims, although survey data has proven to be accurate in its measurement of physician participation.


133 A study by the Common Wealth Fund found that promoting primary care would help bend the Medicare cost curve. Using a simulation model, they project that permanently increasing Medicare payments by 10% would increase primary care visits and expenditures, but would lower the cost for other services six fold, mostly due to drops in inpatient hospital costs and rehabilitation care. They calculate that the net savings would be 2% of overall Medicare expenditure.


134 Bundled payments can also be grouped into the provider organization category. Under a system of bundled payments, an insurer pays a single price for the services needed in an entire episode of care. This means that rather than paying for each service, the focus turns to a patients “episode”. The improvement in quality of care comes from the encouraged coordination between multiple types of providers.


135 For example, given that long-term care is only offered in fee-for-service, managed care plans have an incentive to move beneficiaries into long term care to divert costs away from acute care.

136 Accountable Care Organizations can also be grouped into the payment structure category.


137 Patient-Centered Primary Care Collaborative, Achieving the Triple Aim: How Medical Home Impacts Quality, Outcomes, and Cost. <http://www.pcpcc.net/content/achieving-triple-aim>


138 The federal Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas (HPSAs) as having shortages of primary medical, dental, or mental health providers. In California, approximately 20% of the population resides in a primary care HPSA, 9.1% reside in a dental HPSA, and 14.9% reside in a mental HPSA.


146 Findings obtained from the following:


150 SOC beneficiaries must contribute to their coverage by paying their medical expenses up to a predetermined amount each month before they qualify for Medi-Cal benefits. California’s Family Planning, Access, Care, and Treatment (Family Pact) program provides individuals with family planning and STD prevention services. The Presumptive Eligibility Program allows qualified providers to grant immediate, temporary Medi-Cal coverage for ambulatory prenatal care and prescription drugs for pregnancy related conditions for low-income patients.


151 State Values obtained from the following:


152 Federal values exclude those eligible for the Children’s Health Insurance Program.


State of California, Department of Finance, California County Population Estimates and Components of Change by Year, July 1, 2010-2012. Sacramento, California, December 2012.
