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## **Medi-Cal Transformation**

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## Introduction

In 2014, up to three million uninsured low income Californians will be eligible to enroll in Medi-Cal, joining the 7.3 million already in the program and another 3 million uninsured will be eligible for private insurance the Exchange.<sup>1</sup> Some want to shift an additional 1 million persons from the Exchange to a Basic Health Plan operated by Medi-Cal.<sup>2</sup>

Projected participation rates in Medi-Cal vary by a factor of two.<sup>3</sup> If we fail to fix Medi-Cal we will likely have low enrollment. New program participants will need an eligibility and enrollment system that is easy to understand and use, a primary care doctor and a well-managed delivery system built on prevention and dedicated to improvement in health status.

Since the federal government will pay 100% of the costs of the new eligibles for the first three years, eventually declining to 90% by 2019, this is an enormous opportunity and a daunting challenge for the Medi-Cal program, for those policy makers, advocates and clinicians who care about the health status and health needs of low-income Californians.

To take advantage of the opportunity, we need to address the following before 2014: financing the system, simplifying eligibility and enrollment, and improving reimbursement, outcomes and provider participation. Without making these improvements, participation, subscriber health outcomes and provider satisfaction are likely to be low.<sup>4</sup> This paper is intended to promote this discussion and hopefully its resolution.

## Financing

The projections are that ACA implementation will be a very positive financial benefit to California, roughly cost neutral to California state government and a very substantial benefit to county health and mental health budgets beginning in 2014.<sup>5</sup> The financial benefits will very much depend on how thoughtfully and effectively we implement ACA.

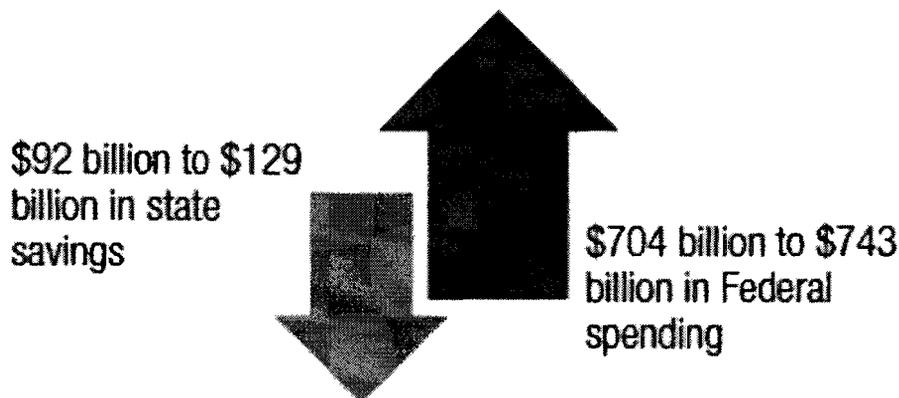


Figure 1. Effect of ACA on Federal and State Budgets

Source: Buettgens M, Dorn S, Carroll C, The Urban Institute. "Consider Savings as Well as Costs: State Governments Would Spend at Least \$90 Billion Less With the ACA than without It from 2014 to 2019," July 2011.

Medi-Cal (\$46 billion) is financed through a match – roughly ½ by the federal government and ½ by the state.<sup>6</sup> Of the state share, roughly \$15 billion is state General Fund and the rest is funded by a combination of county contributions, provider fees, and managed care plan fees.<sup>7</sup>

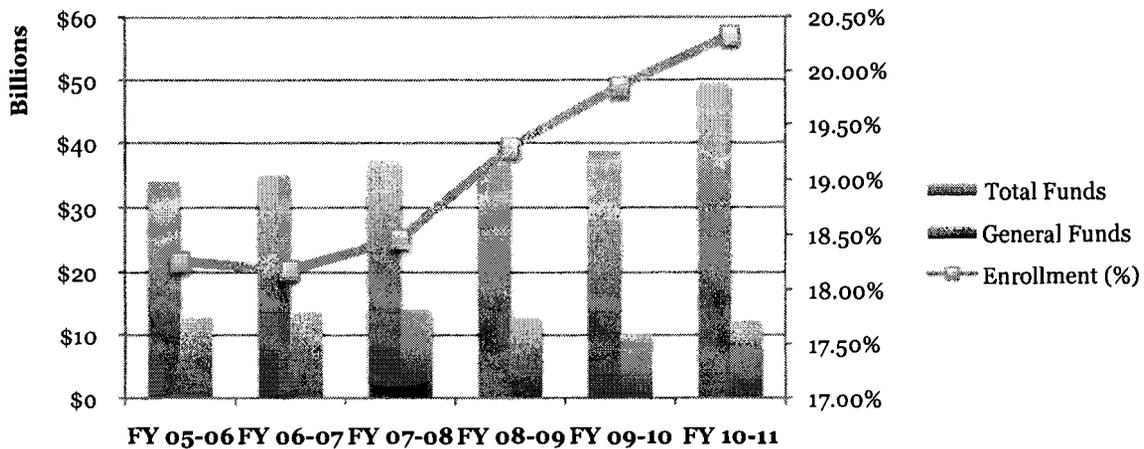


Figure 2. Total and General Fund Medi-Cal Expenditures, FY 2005-06 to 2010-11.

Sources: State of California, Legislative Analyst's Office, 2005-06 California Spending Plan, 2006-07 California Spending Plan, 2007-08 California Spending Plan, 2008-09 California Spending Plan, 2009-10 California Spending Plan, 2010-11 California Spending Plan.

The state General Fund has been under enormous pressure due to the recession and slow recovery.<sup>8</sup> Medi-Cal has been under terrible pressure -- due to the growing program enrollment, rising health care prices and flat to declining General Fund support -- leading to significant rate reductions and benefit eliminations.<sup>9</sup>

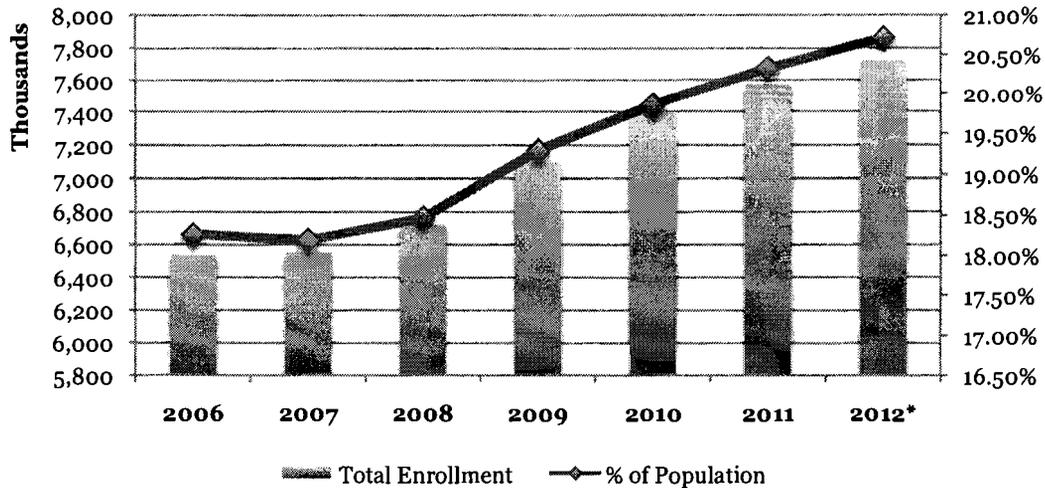


Table 1. Medi-Cal Enrollment, 2006-07 to 2012-13. Estimates for 2012 are taken from the Governor's proposed FY2012-13 budget plan, and do not reflect the inclusion of Healthy Families children into the Medi-Cal program; their inclusion would increase the caseload from 7.7 million to 8.3 million.

Source: State of California, Department of Health Care Services – Research and Analytical Studies Section, Medi-Cal Population Enrollment Trends, 2000-2009; State of California, Department of Finance, Proposed Budget for FY2012-13.

Current county contributions come in a variety of forms: match on the §1115 waiver, match on county hospital inpatient services, match on mental health, match on certain administrative expenditures and match on county hospital DSH and SNCP. Many of these contributions are from county hospitals and UC hospitals that pay for their own share of Medi-Cal DSH, SNCP and inpatient services. Some are in the form of certified public expenditures, and others are intergovernmental transfers.

Medi-Cal is heavily dependent on county contributions, many of which are derived from the state-to-county health and mental health realignment funds, while others are from county discretionary funds.<sup>10</sup> Realignment funds are a portion of the state's sales tax and vehicle license fees that are transferred to the counties to pay for public health, mental health and care to the uninsured. In essence, the state transfers funds to the counties, which in turn may (or in some cases are required to) return them to the state as Medicaid match.<sup>11</sup> Realignment funds fell by about 10% due to the recession as sales tax revenues and vehicle license fees declined.<sup>12</sup>

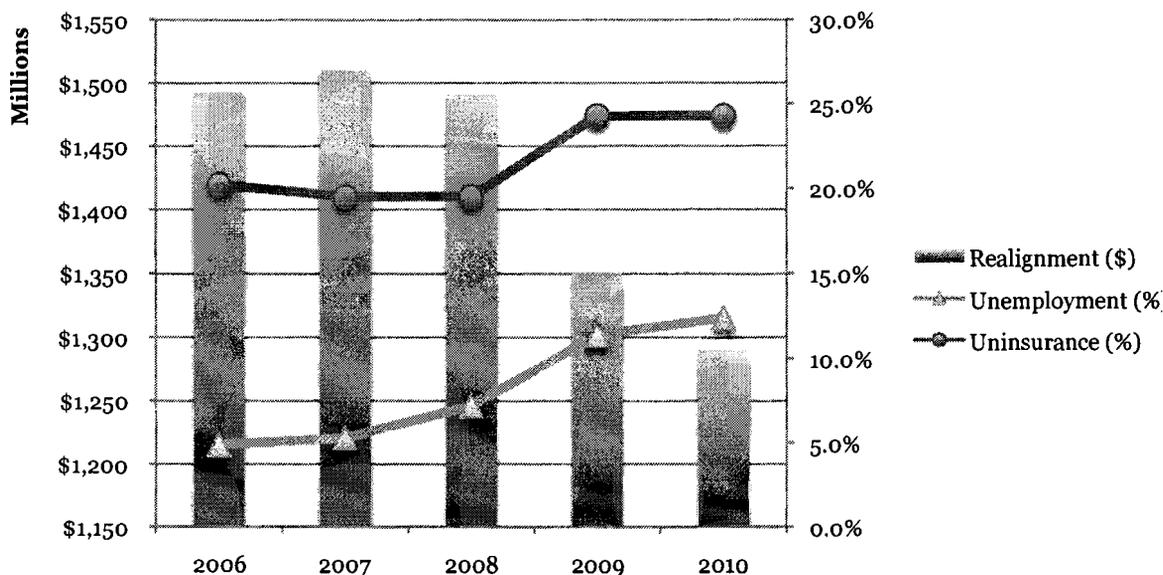


Figure 3. Realignment, Unemployment and Uninsured Rates, California 2006-2010.

State of California Controller's Office – Division of Accounting and Reporting, "FY2005-06 Program Allocation (New Base for FY2006-07);" "FY2006-07 Program Allocation (New Base for FY2007-08);" "FY2007-08 Program Allocation (New Base for FY2008-09);" "FY2008-09 Program Allocation (New Base for FY2009-10)," & "FY2000-10 Program Allocation (New Base for FY2010-11)." State of California Employment Development Department, Labor Market Information Division "Industry Employment and Labor Force – by Annual Average (1990-2010); March 2010 Benchmark (Not Seasonally Adjusted)." UCLA Center for Health Policy Research, "2005 California Health Interview Survey;" "2007 California Health Interview Survey;" and "2009 California Health Interview Survey."

The ACA funds care to the uninsured adults with incomes less than 133% of FPL with 100% federal match for three years and then a three-year phase down to a 90/10 match.<sup>13</sup> This will provide a budget windfall for county health and mental health programs as the federal government pays the full cost of what was previously a county responsibility.<sup>14</sup> The size of the windfall is unclear and variable from county to county depending on two factors: 1) the design and financing of their current and future program for county indigents<sup>15</sup> and 2) the success of local enrollment efforts.<sup>16</sup> The state may well also have a budgetary benefit of uncertain proportions as uninsured individuals who use state programs shift into the Exchange and Medi-Cal expansions; for example the Exchange and Medi-Cal expansion are likely to pay for services to individuals enrolled in ADAP (AIDS Drug Assistance Program), BCCTP (Breast Cancer Treatment), GHPP (Genetically Handicapped Persons Program) and other state programs.<sup>17</sup>

Provider fees, which some call "taxes", come from hospitals, nursing homes and managed care plans in order to supplement their low reimbursement rates and preserve the Medi-Cal program; this allows hospitals to receive supplementary payments up to, but not more than their Medicare rates.<sup>18</sup> For example the hospital fee generates nearly \$14 billion through December 2013 including the fee and the federal match.<sup>19</sup> Some entities have the option to adopt fees to help fund their reimbursement levels, but others have not yet chosen to do so.<sup>20</sup> Provider fees might be eliminated by Congress as part of a federal budget deficit reduction package.<sup>21</sup>

	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10
Fee on Skilled Nursing Facilities	\$115.6	\$231.9	\$247.4	\$274.3	\$282.4	\$315.6
Fee on ICFs/DD	25.2	27.6	27.1	22.8	18.6	19.3
Fee on Managed Care Organizations		234.5	241.2	239.0	251.9	67.9
Premium Tax on Medi-Cal Managed Care Organizations						157.0
<b>Total</b>	<b>\$140.8</b>	<b>\$494.0</b>	<b>\$515.7</b>	<b>\$536.1</b>	<b>\$552.9</b>	<b>\$559.8</b>

Note: The hospital fee (AB 1383) is not shown in this chart as it still requires federal approval. These figures do not precisely reflect the fee revenue actually collected because of late payments, provider non-payment, and other factors.

Source: Department of Health Care Services May 2009 Medi-Cal Assumptions, and Assembly Committee on Appropriations.

Figure 4. Estimated Revenue from California's Medi-Cal Related Provider Assessments (in millions).

Source: Klutz B, Rosenstein S, California HealthCare Foundation, "Financing Medi-Cal's Future: The Growing Role of Health Care-Related Provider Fees and Taxes," November 2009.

Hospitals as well will have a financial benefit as the state and federal government and private insurance companies will begin to pay for up to 6 million of California's 7 million uninsured, but this is partially offset by reductions in Medicare and Medi-Cal payments.<sup>22</sup> Hospitals' bad debt and charity care to the uninsured will decline;<sup>23</sup> their uncompensated care due to Medi-Cal underpayments will increase. Hospitals' federal DSH payments will be eventually decreased; reimbursements for county indigents will decline as individuals in these programs transition into Medi-Cal.<sup>24</sup> State DSH formulas and financing will need to change.<sup>25</sup> Hospitals' willingness to support an extension of the provider fee might increase to support their uncompensated care to Medi-Cal eligibles.

To summarize, General Fund financing of the Medi-Cal program has declined as percent of program spending; Medi-Cal is heavily dependent on financing agreements with counties and institutional providers. These agreements are receiving increasing federal scrutiny, and this financing is tenuous due to Congress' need to reduce the federal budget deficit and to the shifting nature of agreements with counties, the federal government and provider associations. Federal policy makers are debating proposals ranging from Medicaid block grants, to replacing the waiver process, streamlining eligibility, increasing beneficiary cost sharing, repealing state maintenance of effort, phasing out provider taxes, establishing a single blended rate, and capping the growth rate in federal program spending.<sup>26</sup>

In light of the increase in federal funding for the uninsured and the changing federal/state landscape, it is time for California to restructure, and repair the Medicaid program's finances.

#### Recommendations:

- 1) The state contribution to Medi-Cal should be augmented by a uniform county match (e.g. a local match of 3-5%) that replaces all other matches and is phased in as county program eligibles transition into Medi-Cal and the Exchange.
  - a. It should be designed to create the right incentives<sup>27</sup> to reward county efforts to improve program enrollment, health outcomes and cost efficiency. For example, if a county is able to reduce federal and state program expenses by improving quality and outcomes, it should share the savings. If a county better coordinates care or does a better job on prevention and reduces expenditures on the "frequent fliers" it should be able to share in the savings.
- 2) The state needs to consider a broad-based services sales tax<sup>28</sup> to replace all provider fees and commit to increase payment rates for Medi-Cal providers to Medicare levels as discussed in the next section. These revenues should be protected in a Special Health Trust Fund dedicated to these specific agreed upon improvements in Medi-Cal.

- 3) Hospitals have shown extraordinary leadership in support of the hospital fee. California hospitals and policymakers ought to agree to continue the hospital fee until a better financing system can replace it; the distribution of the fee should be linked to payments that create incentives for improved quality and outcomes.
- 4) The state and federal governments should negotiate a blended, composite rate for all aspects of the Medi-Cal program.

### Reimbursement rates, payment reforms

California's reimbursement rates are quite low with exceptions for safety net providers (FQHC clinics and DSH Hospitals that have special protections prescribed by Congress).<sup>29</sup> The reimbursement methodologies for hospitals and doctors have not been updated for decades. Moreover reimbursement rates differ by provider types with physician and other professional reimbursement at the bottom of the pile.<sup>30</sup> The ACA funds an increase in Medi-Cal primary care reimbursements to Medicare levels for two years at the same time as the program is being expanded to enroll the lowest income "working poor" individuals; this should help attract additional physicians into the program, especially if it can be sustained.

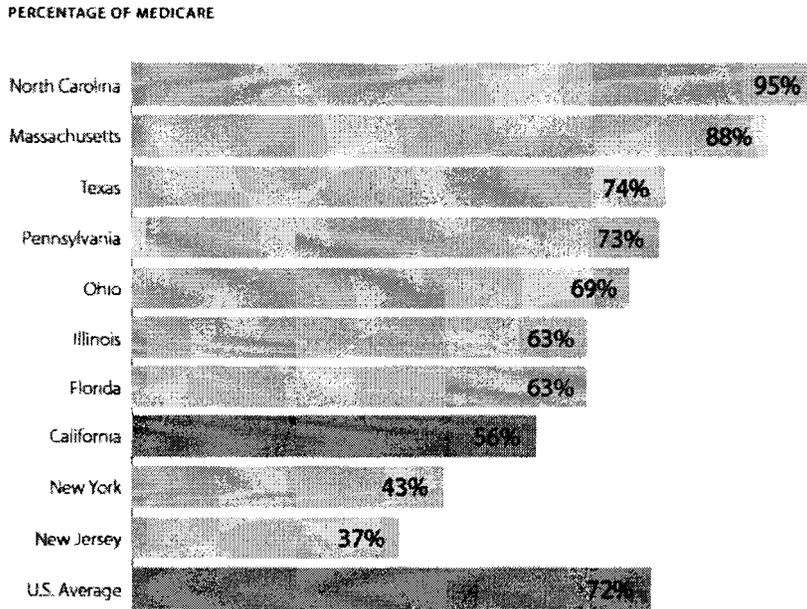


Figure 5. Medi-Cal Physician Payment Rates as a Percentage of Medicare Rates, 2008.

Source: California HealthCare Foundation, California Health Care Almanac: Medi-Cal Facts and Figures, September 2009.

### *Safety nets and the private sector*

Federal law protects many safety net clinics by assuring payment of their reasonable and necessary costs; these are known as FQHC or PPS payment rates.<sup>31</sup> A steadily growing number of community and county clinics are achieving FQHC look-alike status and Medi-Cal accounts for a growing share of clinics' revenues.<sup>32</sup>

Hospitals, pharmaceutical companies and nursing homes have had stronger legal protections under federal Medicaid laws,<sup>33</sup> while doctors and dentists have not had comparable federal and state legal protections of their reimbursement rates.<sup>34</sup> Thus when the state budget is in deficit, the professional fees paid to clinicians are the easiest to cut. Rarely is the state of California in a flush budget (for example, the late 90's) where they can be increased.<sup>35</sup> The comparative reimbursement in a given community could end

up as follows for example: a doctor's visit might be reimbursed at \$50 in the doctor's office, \$150 in the FQHC community clinic site and \$250 in a county FQHC clinic.<sup>36</sup> This is neither equitable nor sound policy for the future.

*Managed care, rural areas, physician participation*

Most Medi-Cal program's eligibles are enrolled in managed care where payment rates are negotiated between plans and the providers except in small rural counties.<sup>37</sup> The problem of low physician reimbursement rates and physician access is most acutely concentrated in the state's smaller and rural communities where 1) managed care is not mandatory and rarely present,<sup>38</sup> 2) there are insufficient provider networks,<sup>39</sup> and 3) Medi-Cal enrollment represents a very high share of the county residents.<sup>40</sup> The rural access issues are mitigated to a degree to the extent of FQHC and RHC (Rural Health Center) penetration in a given community.<sup>41</sup>

The resistance to managed care in less populous rural communities is partly a concern about the ability of small providers to accept "risk", in part the lack of competition and choice in communities, and also a long-standing aversion by rural providers to managed care in both public and private programs. We think the ability of local managed care plans to negotiate and better coordinate care could help attract local physicians into the program. We believe it makes most sense to expand managed care to the small rural counties through a regional COHS model. Two-plan or GMC models depend on competitive markets to be viable and in most of these communities there are insufficient providers to support the managed competition model.<sup>42</sup>

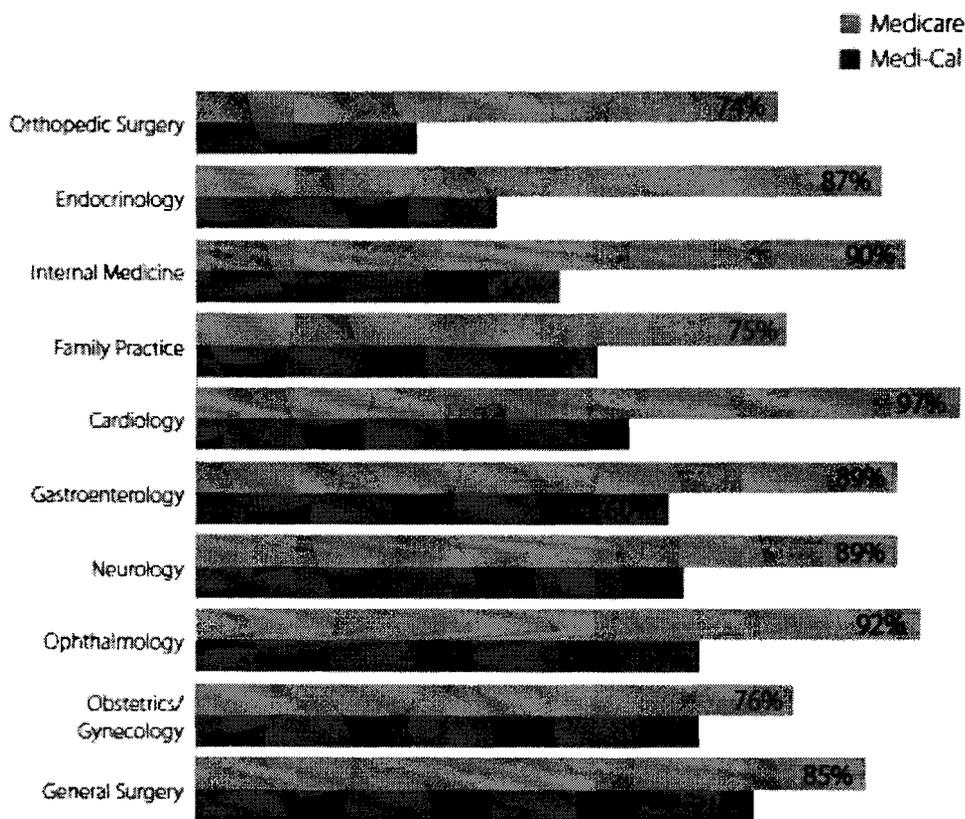


Figure 6. Medi-Cal Participation Among Specialists as Compared to Medicare Participation, 2001.

Source: California HealthCare Foundation, California Health Care Almanac: Medi-Cal Facts and Figures, September 2009.

### *Managed care and the eligibility categories for institutional providers*

Most Medi-Cal spending is in the fee for service sector of the program, and most of that spending is for high cost institutional care (i.e. hospitals, nursing homes, and alternatives to nursing home care, not doctors or other health professionals).<sup>43</sup>

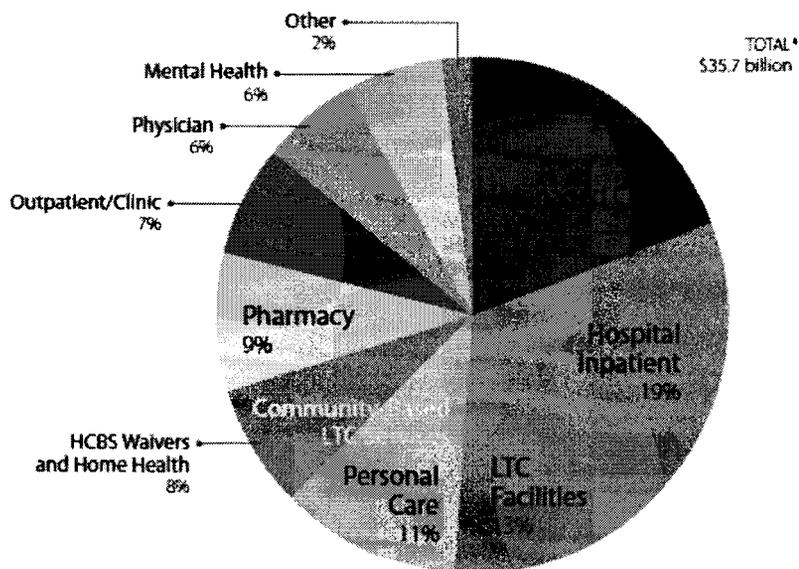


Figure 7. Medi-Cal Expenditure Distribution, 2008.

Source: California HealthCare Foundation, California Health Care Almanac: Medi-Cal Facts and Figures, September 2009.

Managed care is most successful and appropriate to keep patients healthy and out of costly institutional care by providing better access to prevention, primary care, coordination and outpatient services. It can also be useful to manage care post-institutionalization to reduce readmissions and re-occurrence. However it is relatively useless for individuals who become eligible for the program only once they are in the hospital or nursing home and who may be eligible only as long as they remain in an institutional hospital or nursing home setting as typically occurs in the “share of cost” component of Medi-Cal. We need to develop better-organized models, reimbursement incentives and systems of care for individuals using fee for service Medi-Cal.

### *Physician payment rates*

The ACA will increase primary care reimbursement under Medicare by 10%.<sup>44</sup> The ACA will increase Medi-Cal reimbursement rates for primary care to Medicare levels for two years (2013 and 2014) with 100% federal financial participation.<sup>45</sup> The General Fund cost to California of sustaining this increase thereafter grows to \$200 million annually in FY 2015.<sup>46</sup> This could be the right time to redesign and put the right incentives in primary care reimbursement.

Specialists are paid substantially more for their care than are primary care practitioners, and there is a national problem of overpaying for specialists and underpaying primary care.<sup>47</sup> California uses a 1969 Relative Value Scale to compute physician compensation, which badly needs to be updated. Medicare uses the RBRVS (Resource Based Relative Value System), which is also considered to over-weight specialty care. It would cost the state over \$1.5 billion in General Fund to increase physician compensation to Medicare levels in FY 2015.<sup>48</sup>

### *Fee for service, pay for performance, bundled payments and better birth outcomes*

Fee for service reimbursement rewards the number of visits, not the patient outcomes. The low Medi-Cal reimbursements combined with fee for service reimbursement create incentives to operate Medicaid mills,

in which volumes are maximized to increase revenue, and there may be insufficient attention to improving quality and outcomes.

California pay for performance pilot programs showed early promise but did not make notable breakthrough increases in quality, in large part because the payment differential between high and low performers has been quite small and uneven.<sup>49</sup> Transparency of comparative outcomes and physician education on best practices have had success in improving the performance of the poorer performers.<sup>50</sup> There is growing support for linking compensation to best practices and outcomes and shifting from fee for service towards bundled payments – i.e. some form of modified capitation with patient outcome incentives and payments for case management of the chronically ill.

The Medi-Cal and AIM programs pay for nearly half of all deliveries.<sup>51</sup> Payment rates for prenatal care were increased substantially in 1989, leading to a large increase in private OB participation; however OB participation is now not significantly different than other specialties.<sup>52</sup> California and the nation have had a large increase in Cesarean section deliveries, far higher than recommended or warranted with huge variations among hospitals.<sup>53</sup> California’s comprehensive perinatal services program pays for health education, counseling, prenatal vitamins and other services that have proven successful in reducing low birth weight and infant mortality.<sup>54</sup> California has experienced a big reduction in infant mortality to 4.9 per 1000, but still with large variations between ethnic groups.<sup>55</sup> California could consider modifying reimbursement for perinatal care to reward doctors with better birth outcomes and lower rates of Cesarean section deliveries on a risk adjusted basis.

**Recommendations:**

- 1) The highest priority is sustaining the Medi-Cal primary care reimbursement increase at the Medicare level after 2014 so we have sufficient participating primary care doctors for new and current Medi-Cal eligibles. In addition, California needs to restructure primary care reimbursements so they are supportive of and consistent with the development of patient centered medical homes.
- 2) California needs to upgrade, update and restructure physician reimbursement; the target should be equivalent to Medicare levels, but this will require and depend upon new revenues as discussed on p.p. 6-7.
  - a. California should replace and modernize fee for service reimbursements with risk adjusted, bundled payments that incent and reward improved patient outcomes.
- 3) California should modify reimbursement for perinatal care to reward doctors who are able to work with their patients to achieve better birth outcomes and lower rates of Cesarean section deliveries on a risk adjusted basis.

**Spread of managed care, improving its effectiveness**

Managed care through Medi-Cal now covers most children and families, and some of the disabled and elderly and works reasonably well, far better than Medi-Cal fee for service.<sup>56</sup> It will likely cover the newly eligible MIAs beginning in 2014, a large increase in their enrollment. As currently administered in California, managed care has various separate and disconnected components: one for physical health, one for dental health, one for mental health for those with chronic and severely mental illness, and a new separate pilot program for CCS children. It is not beneficial to the patient, the providers or system efficiency to split responsibility and accountability for patient care in this way. It is time to move to “one patient, one plan”.

	2006	2007	2008	2009	2010	% Change
Fee-For-Service	3,273,253	3,292,512	3,320,759	3,451,882	3,389,419	3.5%
Managed Care	3,261,730	3,260,746	3,400,244	3,642,995	4,008,547	22.9%
<b>Total</b>	<b>6,534,983</b>	<b>6,553,258</b>	<b>6,721,003</b>	<b>7,094,877</b>	<b>7,397,966</b>	<b>13.2%</b>

Table 2. Medi-Cal Fee-For-Service and Managed Care Enrollment, 2006-2009.

Source: State of California, Department of Health Care Services – Research and Analytical Studies Section, Trend in Medi-Cal Program Enrollment by Managed Care Status – for FY2003-2010.

California managed care has been implemented for the most part based on county boundaries. While this promotes local control, it is less efficient and effective than a regional managed care model<sup>57</sup> in those regions of the state where individual counties have small Medi-Cal populations.

Managed care does not cover the bulk of Medi-Cal spending for the most severely ill in long term care, for the Medi-Medis or for CCS services, but there are pilots proposed or operational that do so. Care to the seriously ill is where the Medi-Cal program can be most improved and represents the best opportunity to improve care and patient outcomes. There are five new pilots to test whether CCS care can be improved under four different managed care models.<sup>58</sup> The federal and state governments are increasingly interested in coordinating care for the Medi-Medis for which the state and federal governments have shared but divergent responsibilities; that opportunity is now.<sup>59</sup> California's long term care system ranks highly in national evaluations;<sup>60</sup> we have a low and stable percent of our elderly and disabled in nursing homes;<sup>61</sup> we have extensive alternative services to long term care,<sup>62</sup> and we have made major efforts over the years to improve nursing home quality. In recent years, the state budget crisis has led to large proposed and actual cuts to the budgets of the IHSS and ADHC (adult day health centers) programs.

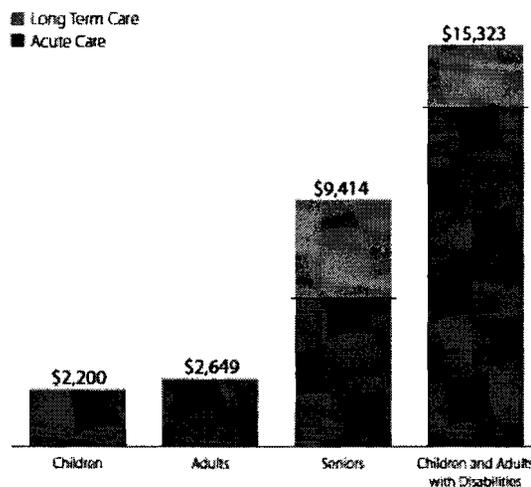


Figure 8. Annual Cost per Medi-Cal Beneficiary, 2008.

Source: California HealthCare Foundation, California Health Care Almanac: Medi-Cal Facts and Figures, September 2009.

California has successful long-standing managed care pilots for long term care services through On Lok, SCAN and other PACE programs, which can be an important building block and model for the rest of the state.<sup>63</sup> California's problem has been the lack of coordination among the multiplicity of alternatives to long-term care programs combined with the recent revenue shortfalls, which are impelling large cuts in several bedrock alternatives to long-term care. The important opportunity for the state and persons in need of long-term care is through better coordination.

**Recommendations:**

- 1) A patient's care should not be trifurcated among many separate managed care plans; this produces confusion, gaps and disagreements over who does and does not have the responsibility to pay for which services.
  - a. Coverage should be consolidated through a single accountable health plan.
  - b. The plan would then choose to use specialty care contractors for conditions requiring special expertise in managing patient care, such as mental health, dental health, long term care or CCS.
- 2) The state should move from managed care based on county boundaries to regional managed care plans in the Central Valley, North Rural, North Central and Bay Area regions. <sup>64</sup>
  - a. We think that competition between a public plan and a private commercial plan is salutary for patients in the larger regions where there are sufficient providers to make competition viable.

- 3) In Home Support Services, nursing homes and other institutional services, and other long term care alternative services should be covered through specialty managed care plans that subcontract with the patient's primary plan so that long-term care can be managed more effectively for the most vulnerable patients.<sup>65</sup>
- 4) The state should take the opportunity to implement managed care for the Medi-Medis.<sup>66</sup> These plans should be carefully phased in and built on the lessons being learned with managed care for the SPD population.
- 5) The state should implement managed care for all CCS children.<sup>67</sup>

## Benefits

The ACA gives states the option to cover comprehensive Medi-Cal benefits or more limited benchmark benefits for the newly eligible Medi-Cal population or potentially something in between. Medi-Cal currently covers benefits ranging from long-term care, hospice care, rehabilitative, mental health, and services to the developmentally disabled and physically handicapped to the more traditional health care such as hospitals, doctors and prescription drugs covered by standard commercial insurance.<sup>68</sup> In recent years, the legislature has terminated Medi-Cal coverage for dental and vision services for adults; they are retained for children due to EPSDT. And more recently adult day health care services (now recast as CBAS) and IHSS services are being restricted.

Many large counties typically cover a smaller benefit package for the uninsured than does the Medi-Cal program.<sup>69</sup> The state's 1115 waiver requires upgrades of county health benefits to a basic minimum<sup>70</sup> and allows counties the flexibility to cover more services if they so choose. (Appendix comparing Medi-Cal, the basic minimum and the waiver minimum)

REQUIRED SERVICES	OPTIONAL SERVICES
<ul style="list-style-type: none"> <li>• In/outpatient hospital</li> <li>• Physician visits</li> <li>• Lab tests and x-rays</li> <li>• Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for children under 21</li> <li>• Family planning and supplies</li> <li>• Federally Qualified Health Centers (FQHC)</li> <li>• Certified midwife</li> <li>• Certified nurse practitioner</li> <li>• Nursing home care for adults over 21</li> <li>• Home health services<sup>1</sup></li> <li>• Nurse midwife services</li> <li>• Pregnancy-related services, including 60-days postpartum care</li> </ul>	<ul style="list-style-type: none"> <li>• Prescription drugs</li> <li>• Medical equipment and supplies</li> <li>• Targeted case management</li> <li>• Adult day health</li> <li>• Personal care services</li> <li>• Physical therapy</li> <li>• Intermediate Care Facilities for Mentally Retarded (ICF/MR)</li> <li>• Inpatient psychiatric for children under 21</li> <li>• Rehabilitation for mental health and substance abuse</li> <li>• Home health care therapies</li> <li>• Hospice</li> <li>• Occupational therapy</li> <li>• Vision services and eyeglasses<sup>1</sup></li> <li>• Dental care and dentures<sup>1</sup></li> <li>• Audiology and speech therapy<sup>2</sup></li> <li>• Chiropractic<sup>1</sup></li> <li>• Psychology services<sup>1</sup></li> <li>• Acupuncture<sup>1</sup></li> </ul>

Figure 9. Medi-Cal Benefits, 2009.

Source: California HealthCare Foundation, California Health Care Almanac: Medi-Cal Facts and Figures, September 2009.

Federal comparability law (with exceptions such as EPSDT) requires that if a service is covered for one category of eligibles, it must be covered for all categories of eligibles – i.e. if it is covered for seniors, it must be covered for children and vice versa.<sup>71</sup> The categorically needy may be covered for more Medi-Cal benefits than the medically needy because they have lower income and fewer assets.<sup>72</sup> The ACA now gives states the new option to cover a benchmark package of essential health benefits for the new Medicaid eligibles.<sup>73</sup>

Most Medi-Cal spending is on categories of individuals with the greatest health needs -- the aged and disabled adults and children, which make up only a small share of Medi-Cal eligibles.<sup>74</sup> California does need the broadest, most comprehensive and flexible set of benefits for these low-income groups.

ACA requires coverage of 10 designated “essential benefits”; this includes dental and vision for children, but not adults; it includes coverage for behavioral health, such as mental health and substance abuse.<sup>75</sup> The precise coverage of those 10 benefits is as yet undefined, but the draft federal concept is to defer this definition process to the states. This may be very much to California’s advantage to tailor the benefits to our state’s priorities. There are four different benchmarks from which the state may select: 1) the three largest plans for federal employees, 2) the three largest plans for state employees, 3) the three largest small employer plans and 4) the largest HMO plan. Federal subsidies for coverage in the Exchange are limited to the 10 ACA benefits, and a state wishing to cover more must pay 100% of the costs.<sup>76</sup>

There is an ability to shift priorities among the 10 listed benefits to, for example, give a greater emphasis on prevention if a state wishes. Thus California now has a range of options to cover the newly Medi-Cal eligible from the 10 listed essential benefits to the 28 listed Medi-Cal benefits. It could cover the new eligibles for the same services as existing Medi-Cal beneficiaries, or it could cover them for the same set of services as are offered in the Exchange.

Medi-Cal	Exchange Plans	Healthy Families
Physician Services and Clinic Services	Ambulatory services	Physician services
Family planning	Preventive/wellness services and chronic disease management	Preventive care services, family planning services
Inpatient/Outpatient Services, emergency Services	Hospitalization, emergency services	Inpatient/outpatient care, Emergency health care services
Maternity and Perinatal Care	Maternity and Newborn Care	Maternity care
Mental Health, Drug and Alcohol	Mental Health and Substance Abuse Disorder Services	Mental health care and alcohol/drug abuse treatment (inpatient/outpatient)
Pharmacy Services	Prescription Drugs	Prescription drugs
Durable Medical Equipment, Physical, occupational, speech therapy	Rehabilitative and habilitative services and devices	Physical, occupational, speech therapy, durable medical equipment
Lab and x-ray	Lab and radiology services	Diagnostic and lab services
Vision Care and dental care for children, EPSDT	Pediatric Services (including dental and vision)	Vision Care and dental care for children
Medical transportation		Medical Transportation
Long Term Care		Home health care services, skilled nursing care

Table 3. Benefits for Medi-Cal, Exchange plans, and Healthy Families

Sources: State of California, Department of Health Care Services, “Medi-Cal Benefits,” ([http://www.dhcs.ca.gov/services/medi-cal/Pages/MediBen\\_Svcs.aspx](http://www.dhcs.ca.gov/services/medi-cal/Pages/MediBen_Svcs.aspx) accessed January 13, 2012). Managed Risk Medical Insurance Board, “Healthy Families Program – Summary of Benefits,” ([http://www.healthyfamilies.ca.gov/HFProgram/summary\\_of\\_benefits.aspx](http://www.healthyfamilies.ca.gov/HFProgram/summary_of_benefits.aspx) accessed January 13, 2012). Affordable Care Act §1302(d)(1).

In addition, the state has an option to discontinue Medi-Cal coverage for adults with incomes above 133% of FPL who will now be eligible for the Exchange. Decisions on the scope of benefits in the Exchange and in Medi-Cal will be extremely consequential for the newly eligible MIAs, possibly for the existing eligible disabled with incomes over 133% of FPL, for those newly eligible for the Exchange.

**Recommendations:**

- 1) California should begin with essential health benefits coverage for the MIAs and other new eligibles.
  - a. Even though the federal government will pay 100% of these new costs for the first three years, we think it is more important to have parallel coverage of all new eligibles in Medi-

- Cal and the Exchange. It will be easier to upgrade coverage if there is a demonstrated need for the new Medicaid eligibles, than to later downgrade coverage.
- 2) When the economy improves, the highest priority should be restoring Medi-Cal's dental coverage for adults. Very low-income adults have little to no disposable income to pay for medical care, and oral health is essential to their overall health.
  - 3) California should seek federal flexibility to use its Medi-Cal program funding to pay for select services to the disabled with incomes between 133 and 200% of FPL who are Exchange eligible – e.g. durable medical equipment like wheelchairs for those with physical handicaps might or might not be part of the Exchange's essential benefits package. If federal approval and matching can be secured, these supplemental benefits should be covered through the Exchange for lower-income Exchange eligibles as a wrap-around
  - 4) California should set up a transparent, deliberative process to carefully weigh the priorities among the 10 essential health benefits to promote wellness, prevention and high value care; affordability and patient outcome effectiveness of the benefits package to governments, individuals and small employers will be key to the sustained success of both the Exchange and Medi-Cal expansions.

### *Mental health/behavioral health*

Medi-Cal covers mental health services to the severely and chronically mentally ill through county Medi-Cal mental health plans.<sup>77</sup> In Los Angeles these are referred to as Tier 1 services. Tier 2 refers to the seriously but not persistently mentally ill. Tier 3 refers to individuals with moderate mental illness; these definitions and restrictions are not the same in all counties.

While some county mental health department plans cover all three tiers of mental health services, many cover only Tier 1 mental health services.<sup>78</sup> Over the next six months, the state must report to the federal government, the extent of local variation and the state plans for mental health coverage in 2014. We think the ACA in combination with the 2008 federal mental health parity statute will require an upgrade of Medi-Cal mental health coverage to cover patients with all three tiers of need for mental health services.<sup>79</sup>

In many counties, there is a beginning effort to coordinate mental and physical health services, with wide variations among the counties.<sup>80</sup> Substance abuse services have also had their own separate county and state agencies; the availability of these services is severely limited in many counties, but there is a strong need to coordinate mental health and substance abuse treatments for individuals with “dual diagnosis”. The ACA will require an upgrade of Medi-Cal behavioral health coverage for substance abuse.<sup>81</sup>

Not all patients with behavioral health issues are models of compliance with their prescribed treatments and with paperwork requirements necessary to maintain program eligibility. Effective behavioral health coverage will require new levels of system accountability to assure continuity of coverage and efficacy of treatment.

### **Recommendations:**

- 1) Medi-Cal coverage of mental health services should be upgraded to cover all three tiers of need and treatments, as the ACA requires.
- 2) Physical and mental health services should be fully coordinated so that clinicians are not in the dark about their respective treatments.
- 3) Under federal law, the key tests for coverage of mental health and substance abuse services should now become the comparative efficacy and effectiveness of the treatments, not the fact of diagnosis of mental illness or the level of its severity. If the program is treating all levels of breast cancer, for example, it should treat equivalent levels of mental illness.
- 4) Coverage of mental health services should be through the local Medi-Cal managed care plans (County Organized Health Plans, GMC and Two Plan models), rather than splitting responsibility for care between two separate plans and care networks.
  - a. The local managed care organizations would then subcontract with the county specialty mental health network and other accountable networks for delivery and management of mental health services.

## Eligibility

Medi-Cal has three types of eligibility, which are embedded in federal and state Medicaid laws: mandatory, optional categorically needy and medically needy.<sup>82</sup> Mandatory would include such groups as individuals receiving SSI, TANF/CalWorks or in foster care.<sup>83</sup> Optional categorically needy would include groups such as individuals who are linked to the mandatory groups and have comparable income and assets, but are not receiving public assistance.<sup>84</sup> Medically needy are individuals and families with the requisite linkage as elderly, disabled or families but with incomes in excess of the Medi-Cal income limits.<sup>85</sup> There are different eligibility rules and income limits for seniors and the disabled living in institutional settings from those who remain in their own homes.<sup>86</sup> Undocumented persons are eligible only for limited emergency and perinatal benefits.<sup>87</sup> The ACA gives states an enormous opportunity to simplify their Medicaid programs.

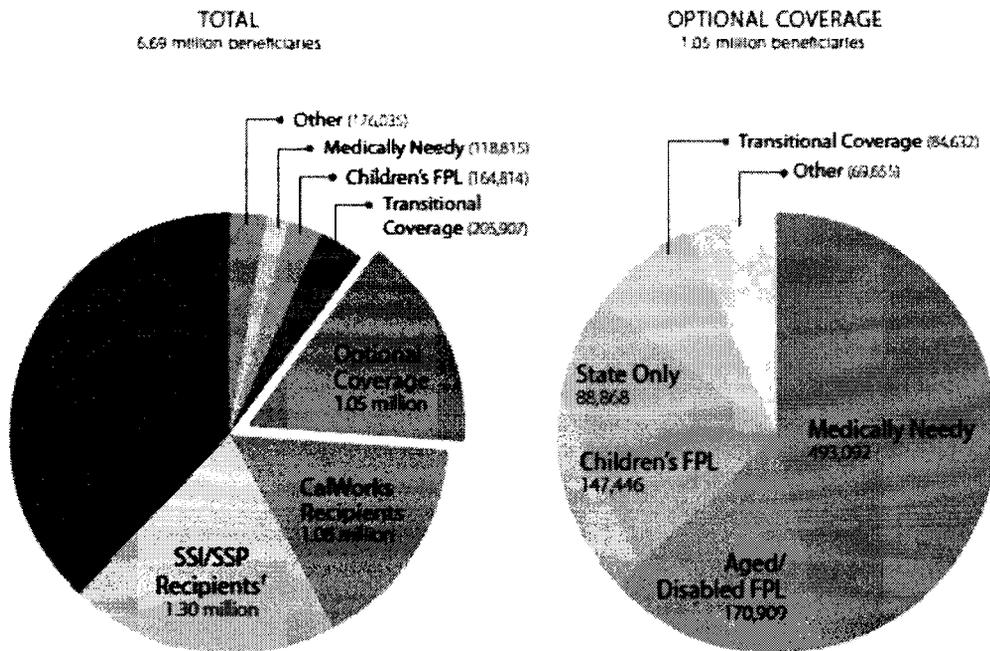


Figure 10. Medi-Cal Enrollment by Eligibility Category, 2010.

Source: California HealthCare Foundation, California Health Care Almanac: Medi-Cal Facts and Figures, September 2009.

The ACA adds a new group of eligibles – the medically indigent adults (MIAs).<sup>88</sup> It increases the income limits to 133% of FPL, consolidates all income deductions into a standard deduction of 5% and eliminates the asset tests for children, parents and adults. Finally it creates the Exchange for individuals with incomes in excess of 133% of FPL and permits states to discontinue eligibility for current Medicaid eligible adults who will now be eligible for the Exchange.<sup>89</sup>

The difficult question that needs to be discussed is whether and in what form Medi-Cal eligibility should evolve as many of the Medi-Cal eligibility categories become superfluous under the ACA expansion.<sup>90</sup> The draft proposed federal regulations to implement the ACA give states some guidance, proposing eligibility for children (0-19), pregnant women, adults 19-64 and the elderly, and giving states much broader flexibility than in the past.<sup>91</sup> The proposed federal regulations give states three statistical and sampling options as to how to distinguish between new eligibles for whom there is a 100% match and old eligibility categories for whom there is typically a 50/50 match in California; states must choose their preferred option by December 31, 2012; it is unclear which would best serve California.<sup>92</sup>

## **Recommendations:**

- 1) Medi-Cal should have one eligibility category for all individuals and families under 133% of FPL, one eligibility category for undocumented persons who are only eligible for the limited scope benefits of emergency care and perinatal care, one category for those in long term care and long term care alternatives and one category for the categorically needy (SSI, TANF and Foster Care) who receive public assistance.
  - a. Individuals currently in the medically needy program should shift into either the Exchange or the Medicaid expansion, depending on their income.
- 2) Individuals currently on Medi-Cal<sup>93</sup> with incomes in excess of 133% of FPL should be transitioned to coverage through the Exchange.
  - a. In the Exchange, they will have a broader choice of plans and providers and more continuity of coverage, but will have to pay more in terms of out of pocket costs such as copays and shares of premiums.
  - b. Medi-Cal and the Exchange should work together with CMS to assure that needed supplemental or wrap around services for persons with disabilities with incomes between 133 and 200% of FPL can be covered and financed as discussed earlier under “benefits”.

### *Asset tests*

Medi-Cal has a series of asset tests governing money in the bank, retirement accounts, homes, cars, life insurance, burial plots, personal property, jewelry, real estate and other assets.<sup>94</sup> Documentation is required;<sup>95</sup> this can be a lengthy and cumbersome process. Asset tests were eliminated over 15 years ago for most children in Medi-Cal and Healthy Families and over 20 years ago for pregnant women.

The ACA eliminates the Medi-Cal asset tests for all MAGI eligibility groups. Asset tests remain for the elderly, the disabled, medically needy and those in institutional care.<sup>96</sup>

Individuals under 65 with disabilities will be able to readily bypass the Medi-Cal asset test by applying for Medi-Cal as an individual who is not disabled. If possible, California should discontinue the asset test for individuals under 65.

The extraordinarily complex asset rules for the elderly are associated with the very high cost of long-term care. Two thirds of those in nursing homes are on Medi-Cal because nursing homes are so extra-ordinarily expensive. Nursing home stays can vary from a few days to a decade or more – for example for an otherwise healthy individual with severe Alzheimer’s or brain damage from an accident or violent assault. Family members of the institutionalized individual may desire to preserve assets and income for spouses still living at home, children and the next generation. A thicket of regulations and exemptions have evolved to prohibit individuals transfers of assets to become eligible for Medi-Cal, but to permit division of assets so that the community spouse can stay in the couple’s home.

## **Recommendations:**

- 1) Medi-Cal should seek federal approval to eliminate the asset test for all persons under age 65 as it can be readily bypassed by applying as a Medi-Cal MAGI eligible.
- 2) When the economy improves, the asset tests for seniors should be increased to a more reasonable level – i.e. increased from \$3000 for a couple to \$15,000 and indexed for inflation – as these asset tests have increased very little since 1975 while the CPI has grown by over 400%. We should encourage savings for the range of seniors’ post retirement needs.
- 3) An alternative is to apply the asset tests only to individuals of all ages, needing long term care.

### *Eligibility determinations and process*

Medi-Cal eligibility is determined by well-trained eligibility workers in county social services offices. While some progress has been made in automating the eligibility determination processes, the primary mode of application is in person. This is an expensive and time-consuming process for the applicant and program administration. Eligibility workers must sift through documentary evidence of the applicant’s income, assets, residence, citizenship, categorical qualifications and family composition. After 6 months or a year, and whenever the applicant reports any changes in status or income, the process is repeated.<sup>97</sup>

Face to face interviews are typically required.<sup>98</sup> There is an opportunity to apply by mail or Internet. Because of the complexity of the Medi-Cal programs, eligibility is determined differently from county to county even though the eligibility rules are the same. Eligibility determinations must be completed within 45 days, except for disability determinations, which must be completed in 90 days.<sup>99</sup> Often eligibility is denied or deferred due to failure to collect and submit all the paperwork required to prove one's eligibility. There are provisions to expedite determinations of eligibility, for example for pregnant women, infants and children.<sup>100</sup> Despite these improvements, over half of all uninsured children are eligible for but not enrolled in the Medi-Cal and Healthy Families public programs.

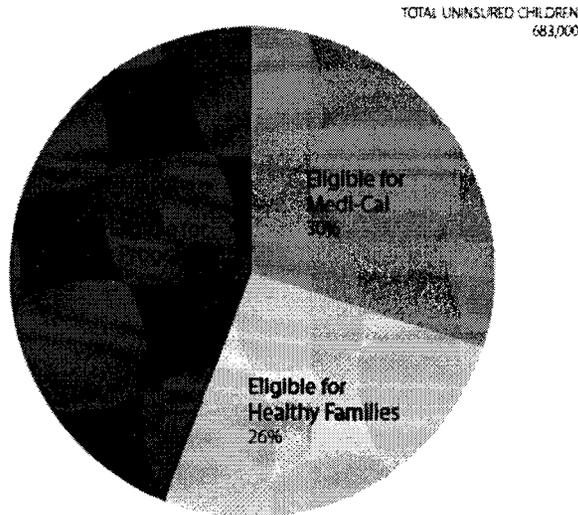


Figure 11. Eligible But Unenrolled Children, 2007.

Source: California HealthCare Foundation, California Health Care Almanac: Medi-Cal Facts and Figures, September 2009.

The ACA requires states to establish a system that supports applications by mail, by Internet, by phone or in person.<sup>101</sup> Pursuant to ACA, the federal government will fund and the state must establish a computer system that cross checks the income, citizenship, legal permanent residency eligibility requirements, rather than sending applicants through the current paper chase maze.<sup>102</sup> Income eligibility will be determined based on an individual's federal income tax form. Eligibility will be determined by the computer system in real time for Medi-Cal, Healthy Families or the Exchange.<sup>103</sup> After one year, eligibility will be reassessed only for the eligibility issues that change.<sup>104</sup> Individuals may be assisted by county eligibility workers, by navigators, by providers, by CAAs, brokers and others to file and complete their applications.<sup>105</sup>

### Recommendations:

- 1) California should move as quickly as possible to establish the computerized eligibility system envisioned by ACA for families and individual adults.
  - a. There should be no wrong door and seamless eligibility so that applicants are not lost in administrative cracks and crevasses.
  - b. There should be multiple avenues, sites and venues to enter the eligibility system and adequate assisters available for those who seek to qualify.
- 2) California should preserve its county eligibility system for the more complex judgments associated with splitting of incomes and transfers of assets for seniors, those in long term care and those seeking to file disability applications where significant independent judgment is necessary.

<sup>1</sup>Shana Lavareda and Livier Cabezas, Two thirds of California's 7 Million Uninsured May Obtain Coverage Under Health Care Reform (UCLA Center For Health Policy Research, February 2011) at [www.healthpolicy.ucla.edu/pubs/publication.aspx?pubID=478](http://www.healthpolicy.ucla.edu/pubs/publication.aspx?pubID=478)

<sup>2</sup> Mercer, Exploring the Financial Feasibility of Basic Health Plan in California (California HealthCare Foundation, May 12, 2011) at [www.chcf.org](http://www.chcf.org)

<sup>3</sup> Long P, Gruber J, "Projecting the Impact of the Affordable Care Act on California," Health Affairs 30, No. 1 (2011): 63-70 project Medi-Cal participation at 1.7 million and California's Exchange participation at 4 million. Sommers, B. and Epstein, A, Medicaid Expansion, the Soft Underbelly of Health Care Reform (November 25, 2010) N Eng J of Med 2010; 363:2085-2087. Massachusetts and Pennsylvania had a 80% participation rate, California a 60% participation rate and Oregon and Florida a participation rate of slightly over 40%. The Lewin Group projects added California Medicaid enrollment of 2.3 million due to the ACA. Sheils, J. et al. The Impact of the Medicaid Expansions and Other Provisions of Health Reform on State Medicaid Spending (The Lewin Group, December 9, 2010) at [www.lewin.com](http://www.lewin.com)

<sup>4</sup> Ibid.

<sup>5</sup> One recent projection is that state governments would save \$92-129 billion over the five-year period from 2014-2019. See Buettgens, Dorn and Carroll, Timely Analysis of Immediate Health Policy Issues: Consider Savings as Well as Costs (Urban Institute, July 2011) at [www.urban.org](http://www.urban.org). The savings occur in county health, county mental health, moving from Medicaid coverage for individuals over 138% of FPL into Exchange coverage and the higher federal match for Medicaid coverage of adults with incomes of less than 133% of FPL. The increase in Medicaid costs occurs due to increased participation of the eligible but not enrolled and the small state match for new eligibles beginning in 2017. Not discussed in the paper are the added state savings from the higher match for CHIP children beginning in 2015. The Lewin Group projects added California Medicaid costs of 2.2% due to the ACA. Sheils, J. et al. The Impact of the Medicaid Expansions and Other Provisions of Health Reform on State Medicaid Spending (The Lewin Group, December 9, 2010) at [www.lewin.com](http://www.lewin.com)

<sup>6</sup> [www.ca.gov/enacted/stateagencybudgets/4000/4260/department](http://www.ca.gov/enacted/stateagencybudgets/4000/4260/department)

<sup>7</sup> Ibid.

<sup>8</sup> Legislative Analyst's Office, California's Fiscal Outlook: 2012-13 Budget (November 2011) at [www.lao.ca.gov](http://www.lao.ca.gov)

<sup>9</sup> Ibid. Medi-Cal has experienced both benefit cuts -- dental, vision, hearing and adult day health -- and provider rate cuts of 10% for most medical professionals.

<sup>10</sup> See Yoo, 2006-2008 Overview of California's Uninsured (insure the Uninsured Project, November 2010) at [www.itup.org](http://www.itup.org) There are several different funding streams for county care to the uninsured: health realignment, mental health realignment, DSH (disproportionate share hospitals, SNCP (safety net care pool), county mandatory match, county discretionary match and tobacco settlement funds. The latter two are at county discretion.

<sup>11</sup> For example, counties are required to fund the local match for mental health and required to pay for the local share of DSH, SNCP and inpatient care in public hospitals. See Dam and Wulsin, A Summary of Health Care Financing for Low Income Individuals (ITUP, 2008) at [www.itup.org](http://www.itup.org)

<sup>12</sup> See Yoo, 2006-09 Overview of California's Uninsured (Insure The Uninsured Project, November 2010) and Sara Watson, Mental Health Report ?? (Insure the Uninsured Project, 2011) at [www.itup.org](http://www.itup.org)

<sup>13</sup> Affordable Care Act §2001. Counties have an option to match current spending on their care to low income uninsured adults under the state's §1115 waiver. See Wulsin and Yoo, ITUP Summary of California's §1115 Medicaid Waiver (Insure the Uninsured Project, January 18, 2011) at [www.itup.org](http://www.itup.org)

<sup>14</sup> Yoo, Before and After Reform, A County by County Comparison and Analysis (Insure the Uninsured Project, March 2010) at [www.itup.org](http://www.itup.org) This report describes only county indigent health spending for the uninsured and it relies on 2006 data; there have been no data updates since that date. There is no data that we are aware of that summarizes county mental health spending on the uninsured. We believe county spending on the uninsured for health and mental health in 2011 is at least \$2.6 billion -- an increasing share of funding for these services will be federal matching funds under California's §1115 waiver.

<sup>15</sup> For example, virtually all the county indigent program expenditures in most "payor" counties will shift into the Medi-Cal expansion or the Exchange while "provider" counties are likely to continue their existing role of provider of last resort to the residually uninsured. In those counties, which do serve the undocumented, there is no clear data to show to what degree they use county health services in a given county. The UCLA CHIS study suggests that 15% of California's uninsured would be undocumented or new permanent legal residents. The federal government deducts about 14% from the Safety Net Care Pool on the assumption that reflects non-emergency care to the undocumented in the "provider" counties.

<sup>16</sup> All counties will have strong financial incentives to enroll those who already use county indigent health in ACA funded program expansions -- "in reach". Not all counties will be equally effective in outreach to those uninsured who are not using county health services. Some will be more effective than others, and the transition to ACA coverage may range from prompt to slow, depending on the extent of local collaborative efforts.

<sup>17</sup> See Yoo, The California Health Benefit Exchange and Public Program Integration (ITUP, July 26, 2011) at [www.itup.org](http://www.itup.org) This includes components of Medi-Cal (medically needy program and maternity coverage), ADAP

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(AIDS Drug Assistance Program), CCS (California Children's Services), GHPP (Genetically Handicapped Persons Program), Breast Cancer Screening and Treatment, MRMIP, AIM, and Family PACT. We asked CHIS for the numbers of Medi-Cal program eligibles with incomes in excess of 133% of FPL, and it responded over one and a half million. Some programs like AIM and MRMIP are likely to have very small use by new legal permanent residents and the undocumented, while Family PACT and Medi-Cal maternity coverage would have a higher rate of use. State programs are eligible for a federal match under the waiver, which may help estimate a baseline of potential coverage under ACA.

<sup>18</sup> SB 335 (Hernandez) and AB X 1 21 (Blumenfeld); Klutz and Rosenstein, Role of Health Care-Related Provider Taxes and Fees (California HealthCare Foundation, November 2009) at [www.chcf.org](http://www.chcf.org)

<sup>19</sup> SB 335 (Hernandez) Assembly Floor Bill Analysis at [www.leginfo.ca.gov](http://www.leginfo.ca.gov)

<sup>20</sup> Role of Health Care-Related Provider Taxes and Fees, Appendix A. The list includes emergency ambulance providers, outpatient prescription drugs, doctors, dentists and other health professionals. Health professions have often balked at these fees since many do not treat large percentages of Medi-Cal patients in their practice. California has not adopted provider fees, except with agreement of the affected provider association. Minnesota and the state of Washington applied a sales tax to medical services to help fund their state's programs for low-income residents. The advantage of provider taxes/fees is that they increase with the rate of medical spending. Minnesota will be phasing out its 2% tax on providers over the next seven years as the ACA extends coverage.

<sup>21</sup> Democratic and Republican members of the Super-Committee and President Obama all put forward some version of restricting/eliminating Medicaid "provider fees".

<sup>22</sup> See UCLA Center for Health Policy Research, Lavarreda SA and Cabezas L. "Two-Thirds of California's Seven Million Uninsured May Obtain Coverage Under Health Care Reform," February 2011, at <http://www.healthpolicy.ucla.edu/pubs/files/twothirdspb-2-16-2011.pdf> and Long P, Gruber J, "Projecting the Impact of the Affordable Care Act on California," Health Affairs 30, No. 1 (2011): 63-70.

<sup>23</sup> By 2009, hospitals' bad debt and charity care costs had increased to \$2.4 billion (3.3% of net patient revenue), a nearly 33% increase in one year due to recession induced layoffs and increases in the numbers of uninsured at the same time that county reimbursements for care to the uninsured fell from 3.0 to 2.8% of hospitals' net patient revenue. See Yoo, 2006-09 Overview of California's Uninsured.

<sup>24</sup> Provided uninsured rates fall by at least 45%, state DSH allocations from the federal government will be cut; the serious reductions do not occur until 2018 when federal DSH allocations to state are reduced by \$5 billion. ACA §2551.

<sup>25</sup> California with a high percent of the nation's uninsured and likely a disproportionate share of the nation's residually uninsured will need to seek an appropriate share of the reduced DSH funds. In our view, California should recalculate its statutory DSH distribution formula to compensate those hospitals, regions and communities with the highest proportions of residually uninsured.

<sup>26</sup> Joanne Kennen, Health Policy Brief: Medicaid Reform, Health Affairs, January 12, 2012.

<sup>27</sup> The incentives under existing opportunities for county match are primarily to increase county funding, not enhance program efficiency, improve patient outcomes or enhanced quality.

<sup>28</sup> Most county matches are currently designed with a strong up escalator – i.e. the matches strongly encourage increased spending – and a perilous down escalator which strongly discourages any decrease in county spending. We are suggesting that the matches should reward desired behavior: better quality and outcomes, increased enrollment and improved cost efficiency in delivering services.

<sup>29</sup> Under federal Medicaid law, federally funded community health centers and rural health clinics must be reimbursed at cost. Social Security Act 1902(bb). Hospitals treating a disproportionate share of Medicaid and uninsured must receive payment adjustments to compensate for their higher burden of uncompensated care. Social Security Act §1902a(13) and §1923. FQHC (also known as PPS in California) rates and DSH do not have adequate efficiency incentives or quality and outcome rewards that ought to be built in as part of re-thinking the safety net.

<sup>30</sup> See Bindman, Chu and Grumbach, Physician Participation in Medi-Cal, 2008 (UCSF, July 2010) at [www.chcf.org](http://www.chcf.org)

<sup>31</sup> See n. 26

<sup>32</sup> See Yoo, Overview of California's Uninsured, and Wulsin and Dam, Health Care Financing for Low-Income Californians, 1998-2008

<sup>33</sup> Social Security Act §1902a(13). Hospital payments were to be based on the reasonable and necessary costs of efficiently operated facilities until the repeal of the Boren Amendment. Prescription reimbursements are based on estimated acquisition costs or average wholesale prices plus a dispensing fee. See CBO, Medicaid Reimbursements to Pharmacies for Prescription Drugs (December 2004) at [www.cbo.gov.cfm?index=6038](http://www.cbo.gov.cfm?index=6038) In the Ninth Circuit, it appears that hospitals are assured reimbursement rates that "bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs." *Orthopedic Hospital v Belshe* 103 F.3<sup>rd</sup> 1491 (9th Cir, 1997)

<sup>34</sup> Physician and other health professionals' reimbursement rates must be adequate to assure comparable access to the general population. 42 USC 1396a (30). The Ninth Circuit in *Independent Living Center v. Shewry* 572 F. 3<sup>rd</sup> 644 (9th Cir. 2009) reiterated its interpretation of the federal statute: requiring findings and studies with respect to the costs of efficiently operated providers and declaring the rates must be reasonably related to those costs and cannot be arbitrarily reduced due to budget exigencies.

<sup>35</sup> The only significant increase since 1982 was the significant increase for OB services in the late 80's.

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<sup>36</sup> Physician reimbursement in Medi-Cal was 56% of Medicare payments in 2009. See California Health Care Almanac: Medi-Cal Facts and Figures (September 2009) at [www.chcf.org](http://www.chcf.org) Clinics in 2009 received about \$142 per visit as an all-inclusive rate. See Yoo 2006-09 Overview of California's uninsured (November 2010) at [www.itup.org](http://www.itup.org)

<sup>37</sup> Over half of all Medi-Cal enrollment is in managed care plans. Yoo, 2010 Health Care Financing Report (ITUP, Jan. 2011) at [www.itup.org](http://www.itup.org) The primary eligibility groups exempt from managed care are those in long term care, the undocumented (who are only eligible for emergencies and perinatal care), eligibility for pregnant women and the Medi-Medis or dual eligibles with both Medicare and Medicaid coverage. Depending on the decisions of the managed care organizations, physicians may be insulated from the state's low physician payments.

<sup>38</sup> Managed care is mandatory in the more populous rural counties, such as Fresno, Kern and Tulare, most of the less populous rural counties such as Imperial, Shasta or Humboldt are exempt. The advantages of managed care are better reimbursement for physicians, more reliable access to doctors for Medi-Cal patients and better-coordinated care.

<sup>39</sup> Forty-five percent of California's rural residents live in manpower shortage areas. California State Rural Health Association, Stats and Facts at [www.csrha.org](http://www.csrha.org)

<sup>40</sup> Rural communities have lower incomes and higher rates of unemployment and uninsurance. Ibid. In quite a number of rural counties, Medi-Cal enrollment is between 25 and 30% of the population under 65 and uninsured rates are between 20 and 30%. See ITUP Regional Workgroup Reports for the Central Valley, North Rural and Imperial Counties at [www.itup.org](http://www.itup.org).

<sup>41</sup> Some like the Open Door clinics have developed arrangements with local specialty physicians to treat Medi-Cal patients at the FQHC/RHC site.

<sup>42</sup> In many of California's small rural communities, there is a single hospital and its on staff physicians, market competition is an ineffective strategy where a single hospital or hospital system by design or circumstance is the dominant delivery system. See Melnick, G. et al, The Increased Concentration of Health Plan Markets Can Benefit Consumers through Lower Prices, Health Affairs (September 2011) 30:9 1728-1733. Hospital market power increases prices to consumers by 8% of more while health plan concentration reduced premiums by 2.5%.

<sup>43</sup> Only a quarter of Medi-Cal spending is for managed care; whereas 41% is for fee for service hospitals and long term care facilities. Only 6% is for fee for service physician services. Depending on the community, managed care plans reimburse physicians better than does Medi-Cal fee for service. Dual eligibles are also insulated due to the Medicare payments.

<sup>44</sup> ACA §3101

<sup>45</sup> ACA §2303

<sup>46</sup> California Department of Health Care Services, Health Care Reform and Cost Savings Estimate (December 4, 2009)

<sup>47</sup> Laugesen and Glied, Higher Fees Paid to US Physicians Drive Higher Spending for Physician Services Compared to Other US Countries, Health Affairs (September 2011) For example, earnings of US primary care doctors are about 42% of the earnings of orthopedic surgeons, while earnings of primary care doctors are 60+% in Germany, France and Canada. The earnings of US orthopedic surgeons are three times as high as orthopedic surgeons in Australia, Canada, Germany and England.

<sup>48</sup> Health Care Reform and Cost Savings Estimate (December 4, 2009)

<sup>49</sup> See [www.ihc.org/pay\\_performance.html](http://www.ihc.org/pay_performance.html) IHA suggests that payment differentials of at least 10 % are necessary and the pilots only achieved payment differentials of about 2% and they were uneven among payors.

<sup>50</sup> Ibid.

<sup>51</sup> Medi-Cal Facts and Figures (September 2009)

<sup>52</sup> Bindman, Chu and Grumbach, Physician Participation in Medi-Cal, 2008, Sacramento Legislative Briefing (UCSF, March 26, 2010) at [www.chcf.org](http://www.chcf.org)

<sup>53</sup> See California C-Section Rates by Hospital, 2008 at <http://www.theunnecesarean.com/blog/2010/4/9/california-cesarean-rates-by-hospital-2008.html>; California Watch, For Profit Hospitals Performing More C-Sections at <http://californiawatch.org/health-and-welfare/profit-hospitals-performing-more-c-sections-4069>

<sup>54</sup> <http://www.cdph.ca.gov/healthinfo/healthyliving/childfamily/Pages/CPSP.aspx>

<sup>55</sup> See California's Infant Mortality Rate Dips To New Low (October 21, 2011) <http://www.healthycal.org/archives/6324>

<sup>56</sup> Medi-Cal Facts and Figures (September 2009)

<sup>57</sup> Inland Empire Health Plan and Partnership Health Plan are good examples of successful regional models.

<sup>58</sup> See <http://itup.org/blog/2011/11/07/%C2%A71115-waiver-update-california-childrens-services>

<sup>59</sup> ACA §2021 and 2602 and SB 208 (Steinberg)

The federal government pays for hospitals, doctors and prescriptions while state government pays for supplemental wrap around coverage and most long-term care. Elderly and disabled patients face difficulties navigating the overlaps and gaps of the two systems. Over 30% of Medicare eligibles enroll in Medicare Part C, which has the advantage of combining their Medicare Part A, B and D coverage. The biggest challenges for managing costs and improving patient conditions for dual eligibles are their use of costly long-term care services. See Dougherty, Cost Containment Strategies for California's Dual Eligible Population (California Department of Health Care Services, July 2011) at [www.itup.org](http://www.itup.org)

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On June 1, 2011, the Department of Health Care Services submitted a request for information on pilot projects for the dual eligibles. See <http://www.dhcs.ca.gov/provgovpart/Pages/CaliforniaDEIRFIResponses.aspx> The County Organized Health Systems in Orange and San Mateo and LA Care Health Plan are particularly interested in these pilots. <http://www.cdcan.info/node/302>

An open question is whether Medicare Part C plans or Medi-Cal managed care plans are better designed to respond to the high health needs of the dual eligibles. See Feder, Clemans, Coughlin, Holahan and Waidman, Refocusing Responsibility for Dual Eligibles: Why Medicare Should Take the Lead (Urban Institute, October 2011) at [www.urban.org](http://www.urban.org) for an argument that Medicare should take the lead. Part C plans are well positioned to manage acute care costs; whereas well-managed Medi-Cal managed care plans would do a better job at managing acute and long term care costs.

<sup>60</sup> Weintraub, D. How California Ranks on Long Term Care (September 7, 2011) at [healthycal.org/archives/5360](http://healthycal.org/archives/5360) and Raising Expectations: a State Scorecard on Long-Term Services and Supports (2011) at [www.longtermscorecard.org](http://www.longtermscorecard.org) California ranks highly on affordability and access, choice of setting and provider, but poorly on quality of life and quality of care.

<sup>61</sup> The number of patients in long term institutional care services in California is about the same in 2011 as it was in the mid 80's – 65,000 patients.

<sup>62</sup> We spend 19% of the Medi-cal budget on long term care alternatives and only 13% of long term institutions and the spending growth has been principally for the alternatives, CHCF, California Health Care Almanac: Medi-Cal Facts and Figures (September 2009)

<sup>63</sup> See Beauchamp, J. The Effect of the Program of All Inclusive Care to the Elderly (PACE) on Quality (Mathematica, February 2008) at [www.mathematica-mpr.com/health/pace.asp#pubs](http://www.mathematica-mpr.com/health/pace.asp#pubs)

<sup>64</sup> For example, there could be two Bay Area regions: East Bay and West Bay; there could be two Central Valley Regions: North and South, and there might be a COHS for the entire North Rural region. The concept of a county-based managed care plan emerged in part because local counties have their own county hospitals. We are unsure whether we really need to have the administrative costs associated with six different local MCOs to serve the Bay Area and think the regional model such as Inland Empire Health Plan would be more efficient. In the Central Valley, there are public plans in Kern and San Joaquin, but none in between; we think the Kern plan should serve the Southern San Joaquin Valley and the San Joaquin Plan or the Central California Alliance for Health is the logical plan for the Northern San Joaquin Valley

<sup>65</sup> Beauchamp, J. The Effect of the Program of All Inclusive Care to the Elderly (PACE) on Quality (Mathematica, February 2008) at [www.mathematica-mpr.com/health/pace.asp#pubs](http://www.mathematica-mpr.com/health/pace.asp#pubs)

<sup>66</sup> 175,000 of state's 1.1 million dual eligibles are enrolled in some form of managed care. CDCAN Report 105-2011 [www.cdcan.info/node/302](http://www.cdcan.info/node/302)

<sup>67</sup> The state is testing four different models of integrating CCS and non-CCS medical care and the results will need to be evaluated. We think using managed care plans that subcontract with pediatric ACO's may be the best way to provide integrated and responsive care to CCS children. The ACO concept appears to be good way to organize the medical expertise to achieve the best outcomes; and the MCO would best combine the CCS and non-CCS services.

<sup>68</sup> See 22 CCR 51301 et seq.

<sup>69</sup> See Newman, M. and McMahon, T., County Indigent Programs for the Medically Indigent in California (California HealthCare Foundation, 2009) at [www.chcf.org](http://www.chcf.org)

<sup>70</sup> See Wulsin, Driscoll and Cohen, Summary of California's §1115 Waiver (Insure the Uninsured Project, January 2012) at [www.itup.org](http://www.itup.org); California Bridge to Reform Demonstration §63

<sup>71</sup> Social Security Act §1902 (a) (10)

<sup>72</sup> Ibid.

<sup>73</sup> 42 USC §11396a(a)(10)

<sup>74</sup> Twenty five percent of eligibles and 62% of program spending. Medi-Cal Facts and Figures (September 2009)

<sup>75</sup> ACA §1302 lists the following: hospitalization, emergency services, maternity and new born care, prescription drugs, mental health and substance abuse services, laboratory services, preventive and wellness services, pediatric care, rehabilitative and habilitative services and devices. HHS will give further definition to these services and draft regulations are expected soon. California has an existing set of requirements for group and individual health plans. See California Health Benefits Review Program, Health Insurance Benefit Mandates in California State Law (December 1, 2010) at [www.chbrp.org](http://www.chbrp.org) These are commonly referred to as state mandates and may differ to some degree from the essential benefits under ACA in ways that may become more apparent after the federal regulations are developed and finalized.

<sup>76</sup> ACA §10104(e)

<sup>77</sup> Sara Watson and Alison Klurfeld, California's Mental Health System (Insure the Uninsured Project, August 2011) at [www.itup.org](http://www.itup.org)

<sup>78</sup> Ibid.

<sup>79</sup> Mental Health Parity and Addiction Equity Act of 2008 and ACA Section §1302

<sup>80</sup> Wulsin, Section 1115 Waiver Implementation (Insure the Uninsured Project, October 5, 2011) at [www.itup.org](http://www.itup.org)

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<sup>81</sup> See discussion in Watson and Klurfeld, California's Mental Health System of ACA §1302 and the Mental Health Parity and Addiction Equity Act of 2008.

<sup>82</sup> 42 CFR 435

<sup>83</sup> 42 CFR 435.100 et seq.

<sup>84</sup> 42 CFR 435.200 et seq.

<sup>85</sup> 42 CFR 435.300 et seq.

<sup>86</sup> 42 CFR 435.236 and .725 and .726

<sup>87</sup> 42 CFR 435.139 and .406(c)

<sup>88</sup> ACA §2001

<sup>89</sup> ACA §1401

<sup>90</sup> See Kiwon Yoo, The Exchange and Public Programs (Insure the Uninsured Project, August 7, 2011) and Christina Vane, Medi-Cal Simplification (Insure the Uninsured Project, November 7, 2011). In our view, most of the current medically needy and optional categorically needy programs will become superfluous as the Medicaid and Exchange coverage expansions will cover these individuals. Individuals in these eligibility groups can be phased into the ACA coverage expansions and then the state legislature and Governor could decide whether to retain or eliminate these eligibility categories. The as yet unknown is to what degree the Medi-Cal benefits coincide and differ from the Exchange's essential benefits.

<sup>91</sup> Notices of Proposed Rule Making can be found at:

– The Exchange Eligibility and Employer Standards NPRM :

<http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20776.pdf>

– Treasury NPRM: <http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20728.pdf>

– Medicaid/CHIP Eligibility NPRM: <http://www.gpo.gov/fdsys/pkg/FR-2011-08-17/pdf/2011-20756.pdf>

<sup>92</sup> Proposed Medicaid §433.206.

<sup>93</sup> According to Ask CHIS, about 1.5 million individuals under age 65 reporting Medi-Cal enrollment had incomes in excess of 133% of FPL at a given point in time. This might be the result of income fluctuations or misreporting.

<sup>94</sup> See 42 CCR 50401 et seq.

<sup>95</sup> 42 CCR 50167

<sup>96</sup> ACA §§ 2001 and 2002

<sup>97</sup> 22 CCR 50189 and 50191

<sup>98</sup> 22 CCR 50157

<sup>99</sup> 22 CCR 50177

<sup>100</sup> Vane, Medi-Cal Simplification

<sup>101</sup> ACA §§ 1411 et seq. 1561 and 2201

<sup>102</sup> Ibid.

<sup>103</sup> Ibid.

<sup>104</sup> Ibid.

<sup>105</sup> ACA § 1311 et seq. Sarkin and Weinberg, Envisioning the Role of Navigators in the Health Benefits Exchange (Insure The Uninsured Project, March 2, 2011) at [www.itup.org](http://www.itup.org)

PROGRAM	INCOME	AGE	STATUS	SERVICES	COST SHARING	ENROLLED	FUNDING	STATE \$	FEDERAL \$
Access for infants and Mothers	Between 200% and 300% FPL	Pregnant women and infants 0-2 between 250% and 300% FPL	Pregnant	Physician, prescription, inpatient, outpatient, emergency, maternity, family planning, transportation, mental health, etc.	Premiums at 1.5% annual income	7,036	General Funds, Prop 99 Tobacco Tax, 2:1 Federal	\$55.7M	\$66.8M
California Children's Services	Less than \$40,000 or medical expenses that exceed 20% AGI	0-21	Designated special health problem	Case management, physician, hospital, surgery, physical/occupational therapy, tests, x-ray, etc.	Varies by family size and income	172,000	CCS State and CCS Health Families Program	\$166.25M	\$128M
Child Health & Disability Prevention	Less than 200% FPL or Medi-Cal recipient	0-21 for Medi-Cal, 0-19 for non-Medi-Cal	Based on EPSDT for Medi-Cal	Scheduled periodic physical, mental, vision and dental health assessments and services.	None	N/A	General Funds	\$2.5M	N/A
Family Planning Access Care & Treatment	Less than 200% FPL	All	Services not covered by insurance/ need for confidentiality	Family planning services.	None	1,754,000	90:10 federal match through §1115 Waiver	\$5.69M	\$512M
Healthy Families Program	Less than 250% FPL	0-18	Not eligible for Medi-Cal	Physician, prescription, inpatient, outpatient, emergency, maternity, family planning, transportation, mental health, etc.	\$15-\$20 for hospital visits, \$0-\$100/day (\$200 max) for inpatient hospital stays	900,000	General Funds, prop 10, Medi-Cal managed care tax, 2:1 federal match	\$264.8M	\$674M
Healthy Kids	Less than 300% FPL	0-18 or 0-5 (varies by county)	Not eligible for Medi-Cal or Healthy Families	Physician, prescription, inpatient, outpatient, emergency, maternity, family planning, transportation, mental health, etc.	Varies by County	86,000	Local Funding	N/A	N/A
Managed Risk and Medical Insurance Program	Any	All	Rejected by health plans based health status	Physician, prescription, inpatient, outpatient, emergency, maternity, family planning, transportation, mental health, etc.	\$500 annual deductible, \$75,000 annual cap, \$750,000 lifetime cap	6,700	Prop 99 Tobacco Tax	\$35.8M	N/A
AIDS Drug Assistance Program	Less than \$50,000 AGI	18+	AIDS or HIV positive with limited drug prescription coverage	Pays for some or all of the cost of HIV/AIDS related medications that other insurance does not cover.	No cost sharing for those under 400% FPL	34,287	General Funds, federal funds, and ADAP Special Fund	\$96.3M	\$88.4M
County Programs	Varies by county	Varies by county	Not eligible for federal/state programs	Hospital, doctors, drugs and other services that vary by county	Varies by County	N/A	Realignment, Prop 99, Tobacco Settlement, Gross DSH, County Funds, 50/50 Federal Match Under §1115 Waiver	N/A	\$2.15M

Appendix 1. Comparison Chart of Public Programs

COST/(SAVINGS) ELEMENT	FY 2018-19 SENATE VERSION (H.R. 3590) Patient Protection and Affordable Care Act	
	Total Funds	General Funds
Eligibility expansion (MIAs and Parents)	\$ 6,815,000	\$ 682,000
Healthy Families Shift (to Medi-Cal)	648,000	324,000
Coverage of eligible but unenrolled (Medi-Cal and Healthy Families)	1,400,000	700,000
Exchange coverage subsidies	\$11,130,000	
Administrative Costs (Ongoing)	16,000	8,000
Direct Costs (Savings)	(636,000)	(425,000)
Bright Line (Savings)	(954,000)	(477,000)
State Program (Savings)	(1,435,000)	(608,000)
County Program (Savings)		(1,440,000)
<b>Federal Reform Dividend for CA</b>	<b>\$16,984,000</b>	<b>(\$1,236,000)</b>
Outpatient rate increase (80% of Medicare)	4,318,000	1,974,000
Primary care rate increase (80% of Medicare)	537,000	255,000

#### Appendix 2. Cost and Savings of the Affordable Care Act

Source: Patient Protection and Affordable Care Act

	2006	2007	2008	2009	% Change ('06-'09)
<b>Hospitals</b>					
Bad Debt/Charity Care (adj)	\$1,766,916,419	\$2,201,135,438	\$2,344,688,484	\$2,717,741,147	53.81%
County Reimbursement	3.03%	3.21%	2.99%	2.83%	-6.64%
Gross DSH Fund	\$1,489,972,072	\$1,478,308,685	\$1,533,404,035	\$1,711,886,096	14.89%
<b>Community Clinics</b>					
Donations	\$82,729,206	\$85,648,639	\$84,757,174	\$84,287,269	1.88%
Federal	\$264,330,411	\$288,516,922	\$298,850,967	\$353,867,322	33.87%
State	\$86,828,083	\$106,235,805	\$73,493,632	\$51,623,703	-40.54%
County & Local	\$109,787,001	\$127,420,343	\$142,154,912	\$158,219,322	44.11%

#### Appendix 3. Hospital and Community Clinic Uncompensated Care, 2006-2009.

Source: Office of Statewide Health Planning and Development, "Hospital Annual Financial Selected Data: CY 2006;" "Hospital Annual Financial Selected Data: CY 2007;" "Hospital Annual Financial Selected Data: CY 2008;" & "Hospital Annual Financial Selected Data: CY 2009." Office of Statewide Health Planning and Development, "2006 State Utilization Data File of Primary Care Clinics;" "2007 State Utilization Data File of Primary Care Clinics;" "2008 State Utilization Data File of Primary Care Clinics;" & "2009 State Utilization Data File of Primary Care Clinics."

	<b>Bad Debt/Charity Care (adj)</b>	<b>Total Operating Expenses</b>	<b>% of Operating Expenses (2009)</b>	<b>% of Operating Expenses (2006)</b>	<b>% Change ('06-'09)</b>
City/County	\$392,312,230	\$7,349,749,755	5.34%	4.91%	8.65%
District	\$171,427,501	\$3,593,122,281	4.77%	4.66%	2.28%
Investor	\$321,416,691	\$8,707,038,236	3.69%	2.69%	37.43%
Non-Profit	\$1,838,004,942	\$57,030,815,427	3.22%	3.25%	-0.81%
State	\$0	\$1,918,662,490	0.00%	0.00%	
<b>Total</b>	<b>\$2,717,741,147</b>	<b>\$78,599,388,189</b>	<b>3.46%</b>	<b>3.27%</b>	<b>5.59%</b>

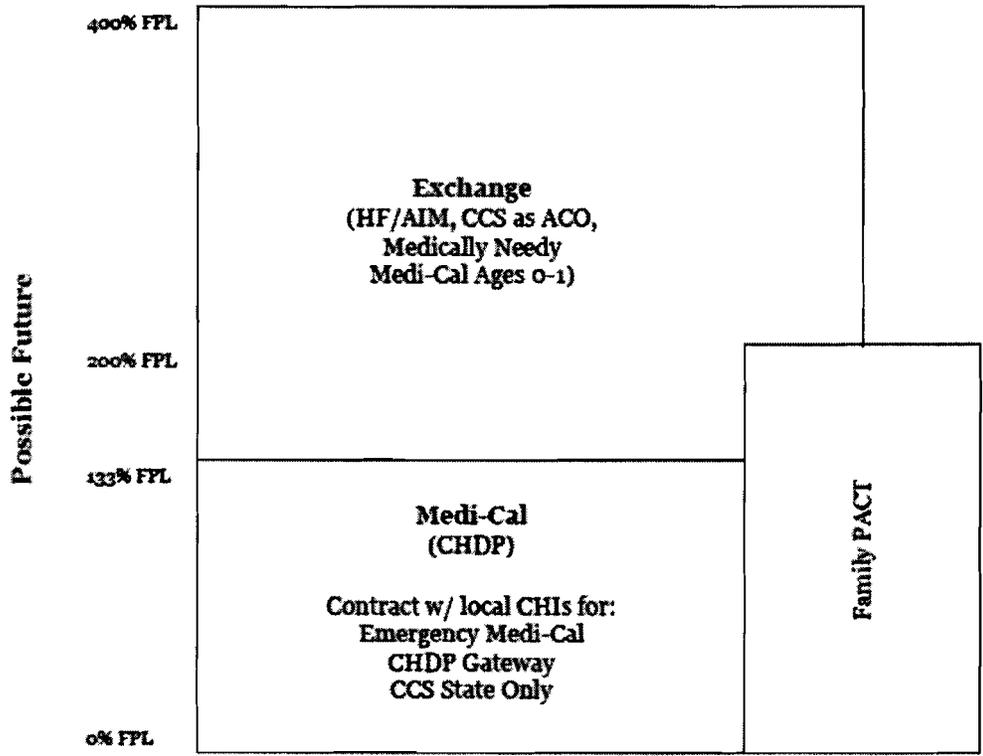
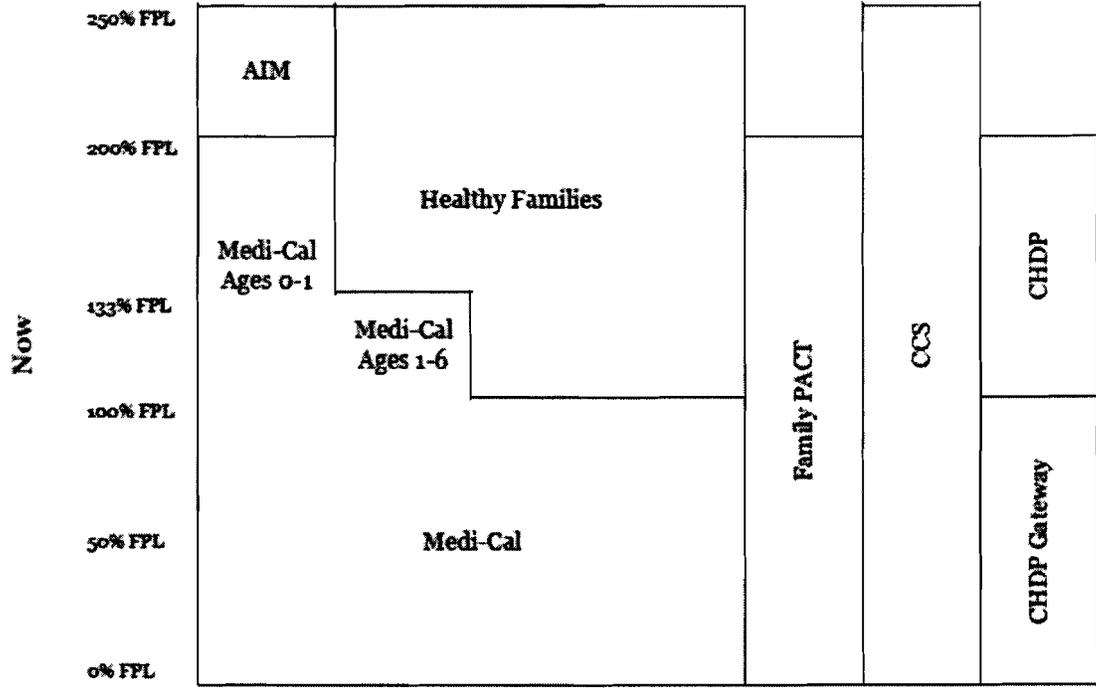
Appendix 4. Bad Debt/Charity Care by Hospital Type, 2009.

Source: Office of Statewide Health Planning and Development, "Hospital Annual Financial Selected Data: CY 2006;" "Hospital Annual Financial Selected Data: CY 2007;" "Hospital Annual Financial Selected Data: CY 2008;" & "Hospital Annual Financial Selected Data: CY 2009."

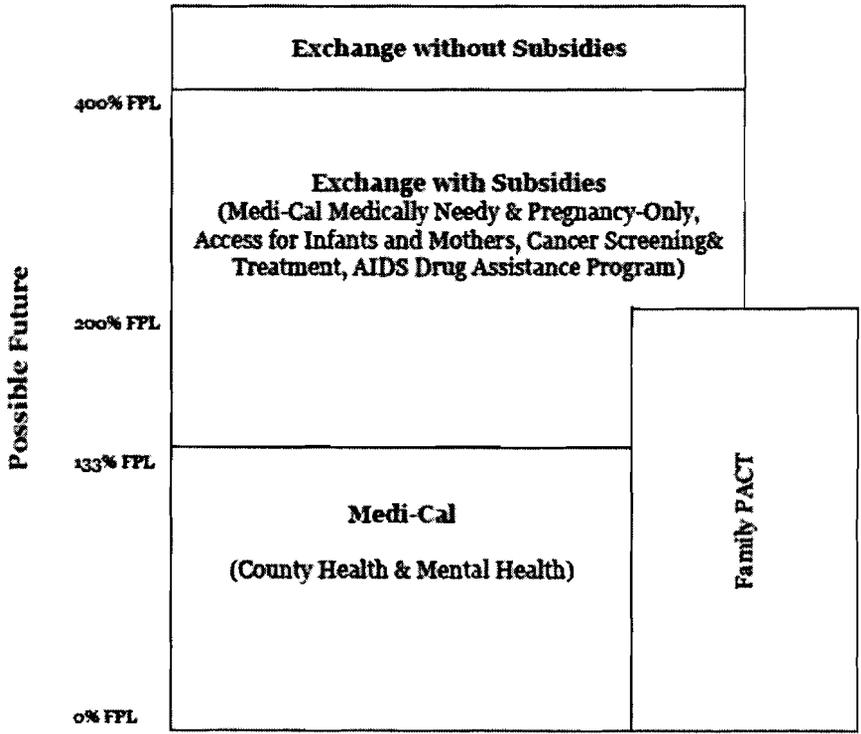
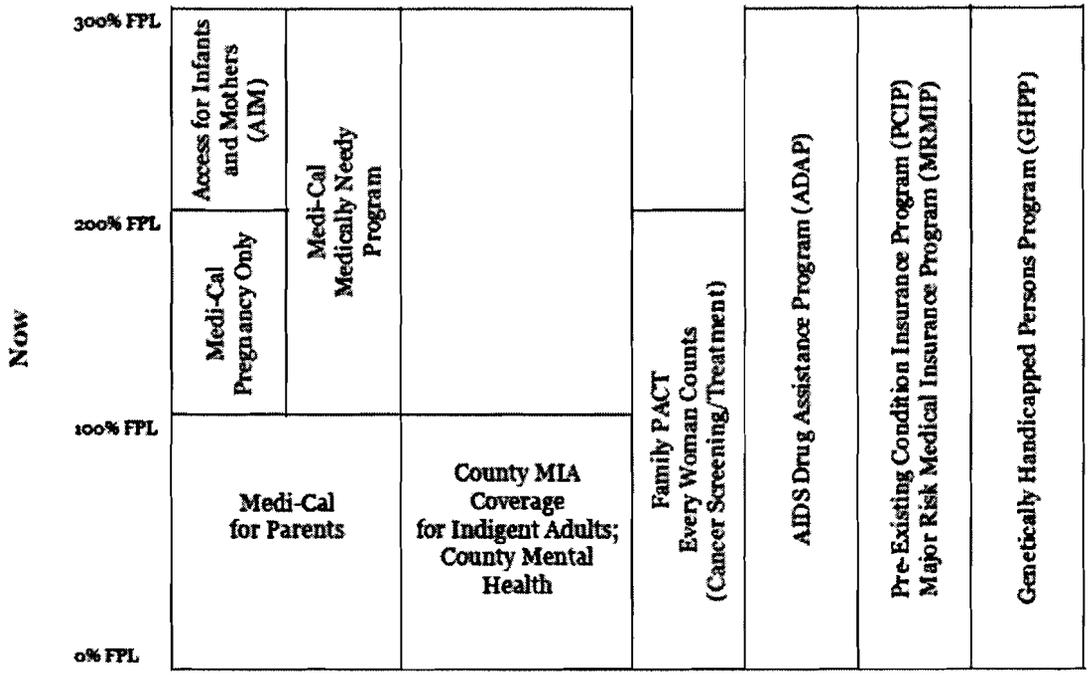
	<b>FY2006-07</b>	<b>FY2010-11</b>	<b>% Change</b>	<b>% Change in Share</b>
Professional	\$3,818,883,650	\$4,887,757,980	27.99%	-15.15%
Pharmacy	\$1,979,578,910	\$1,722,683,200	-12.98%	-42.31%
Hospital Inpatient	\$6,975,179,370	\$14,016,073,030	100.94%	33.21%
Long Term Care	\$4,295,755,270	\$4,517,730,050	5.17%	-30.28%
Other FFS	\$1,403,289,000	\$1,174,922,320	-16.27%	-44.49%
<b>Total FFS</b>	<b>\$18,472,686,200</b>	<b>\$26,319,166,580</b>	<b>42.48%</b>	<b>-5.55%</b>
Managed Care	\$5,700,061,350	\$11,002,116,780	93.02%	27.96%
Dental	\$566,079,390	\$563,863,730	-0.39%	-33.96%
Mental Health	\$1,448,883,610	\$1,811,182,830	25.01%	-17.13%
Audits/Lawsuits	\$12,332,180	\$10,859,230	-11.94%	-41.62%
Medicare Payments	\$3,274,385,000	\$3,705,499,880	13.17%	-24.98%
EPSDT	\$70,712,670	\$63,429,040	-10.30%	-40.53%
State Hosp/Developmental Centers	\$313,371,100	\$273,986,320	-12.57%	-42.04%
Misc Services	\$2,777,240,900	\$5,379,442,400	93.70%	28.41%
Recoveries	\$(262,023,440)	\$(296,527,140)	-13.17%	24.98%
<b>Grand Total Medi-Cal</b>	<b>\$32,373,728,960</b>	<b>\$48,833,019,650</b>	<b>50.84%</b>	<b>-</b>

Appendix 5. Medi-Cal Expenditures by Service Category, FY2006-07 and FY2010-11.

Source: State of California, Department of Health Care Services, Medi-Cal Local Assistance Estimates for FY 2009-10 and 2010-11, Report Date: May 2010.



Appendix 6. Future of Children's Public Programs



Appendix 7. Future of Adult Public Programs

State Controller's Office  
Division Of Accounting And Reporting  
Fiscal Year 2010-2011 Program Allocation  
(New Base For 2011-12 Fiscal Year)

County	Sales Tax			Vehicle License Fee			Vehicle License Collection	Total Programs
	Mental Health	Social Services	Health	Mental Health	Social Services	Health	Mental Health	Total Allocation
Alameda	\$ 35,644,345.73	\$ 62,684,832.27	\$ 12,572,151.45	\$ 12,191,504.59	\$ 1,749,079.82	\$ 39,701,657.05	\$ 264,714.10	\$ 164,808,285.01
Alpine	141,339.57	182,989.90	34,107.11	51,013.12	29,733.81	108,652.14	162.75	547,998.40
Amador	517,521.23	1,111,453.08	426,998.78	245,249.44	59,951.27	1,408,051.22	14,723.10	3,783,948.12
Butte	4,407,767.05	14,453,715.88	2,872,616.47	2,128,991.74	523,691.61	9,087,007.34	164,966.90	33,638,756.99
Calaveras	619,790.49	1,768,088.79	438,045.25	303,166.54	51,019.87	1,447,791.62	20,672.40	4,648,574.96
Colusa	501,660.89	1,008,994.09	343,526.87	186,613.22	53,633.06	1,148,144.37	2,667.00	3,245,239.50
Contra Costa	17,497,511.37	34,401,359.72	6,466,377.78	6,911,222.57	1,819,211.48	20,158,208.42	133,707.00	87,387,598.34
Del Norte	678,744.47	1,664,639.02	408,660.60	311,292.48	61,052.54	1,357,464.14	22,799.70	4,504,652.95
El Dorado	2,205,746.88	4,692,716.61	1,690,024.75	898,252.10	235,151.95	5,255,870.20	66,130.75	14,943,893.24
Fresno	18,096,566.77	41,580,522.10	8,177,704.10	11,526,104.13	1,595,971.94	24,621,091.70	727,543.25	106,325,503.99
Glenn	639,408.90	1,849,369.35	393,103.17	259,524.28	52,172.22	1,302,288.95	15,110.20	4,510,977.07
Humboldt	3,511,964.65	7,871,792.46	2,772,961.19	1,397,796.46	453,405.53	9,147,234.86	79,080.40	25,234,235.55
Imperial	2,965,873.48	8,507,191.93	2,829,385.78	2,041,116.81	221,054.63	9,064,158.46	111,662.95	25,740,444.04
Inyo	711,143.96	889,794.97	533,198.62	309,810.14	73,712.91	1,771,077.05	1,710.45	4,290,448.10
Kern	12,727,779.15	29,446,804.98	5,531,848.16	7,555,399.33	895,397.94	16,769,408.61	402,624.25	73,329,262.42
Kings	2,346,475.67	5,102,380.37	1,432,930.51	1,109,472.69	267,176.96	4,517,667.94	83,155.80	14,859,259.94
Lake	1,345,162.21	5,254,690.36	641,048.02	643,085.86	207,161.82	1,986,856.23	49,420.35	10,127,424.85
Lassen	673,991.35	1,716,368.71	430,725.96	301,655.45	53,007.80	1,423,612.35	23,323.65	4,622,685.27
Los Angeles	211,805,025.90	452,871,352.19	99,810,237.21	85,887,487.93	15,824,102.88	317,910,853.11	2,019,671.15	1,186,128,730.37
Madera	2,041,948.06	4,413,965.75	1,428,404.42	1,303,891.55	216,035.36	4,450,901.68	79,191.35	13,934,338.17
Marin	7,575,882.03	7,215,515.01	3,143,599.12	2,693,659.24	200,684.82	10,541,716.84	171,214.75	31,542,271.81
Mariposa	387,169.40	1,306,778.89	229,090.66	188,335.52	49,168.97	758,583.55	4,399.50	2,923,526.49
Mendocino	2,353,465.07	7,307,314.51	916,491.67	873,617.38	285,698.49	2,872,833.54	21,532.00	14,630,952.66
Merced	4,703,191.59	9,711,108.38	2,023,845.49	2,730,874.94	674,285.53	5,553,984.17	198,507.40	25,595,797.50
Modoc	375,765.13	603,648.11	254,286.45	141,990.06	50,119.60	836,679.77	2,608.90	2,285,098.02
Mono	297,425.99	475,387.65	366,834.12	129,036.49	48,750.06	1,194,151.54	379.75	2,511,965.60
Monterey	6,612,010.95	12,351,290.05	2,609,951.99	2,630,151.11	554,510.09	8,169,942.88	162,006.60	33,089,863.67
Napa	3,867,625.17	3,872,383.64	1,347,196.66	1,403,540.82	173,227.75	4,444,211.61	119,992.60	15,228,178.25
Nevada	1,573,939.25	3,274,291.52	887,675.75	605,214.92	191,430.55	2,818,641.99	39,771.55	9,370,965.53
Orange	39,725,272.95	59,699,678.79	20,710,368.64	19,899,214.93	2,270,011.36	53,459,796.92	970,909.45	196,735,253.04
Placer	3,109,337.94	9,300,872.43	1,223,351.24	1,339,932.07	321,488.50	3,475,002.90	80,526.95	18,850,512.03
Plumas	511,406.28	1,558,361.03	364,511.37	256,947.28	65,634.23	1,194,991.31	14,129.50	3,965,981.00
Riverside	21,898,101.43	75,979,020.11	10,571,220.35	14,164,954.83	2,095,541.91	31,320,157.93	625,522.80	156,654,519.36
Sacramento	25,760,172.43	85,373,304.73	11,073,547.81	14,905,220.23	2,491,577.20	32,428,453.58	865,936.75	172,898,212.73
San Benito	687,720.46	1,858,854.82	511,496.29	363,217.23	62,543.33	1,705,614.47	21,275.10	5,210,721.70
San Bernardino	28,681,700.70	72,732,633.98	12,845,581.98	18,989,593.43	2,928,390.16	34,790,086.20	1,060,067.75	172,028,054.20
San Diego	47,647,606.12	102,323,305.04	25,068,264.43	26,133,352.98	5,060,264.71	59,442,185.45	1,528,387.10	267,201,365.83
San Francisco	39,689,182.98	52,900,126.81	19,040,872.97	13,863,406.53	1,662,375.08	60,632,170.96	1,191,133.30	188,979,268.63
San Joaquin	12,727,343.56	28,767,169.95	4,914,565.61	5,762,879.35	1,149,958.53	13,694,782.17	491,068.90	67,507,768.07
San Luis Obispo	3,567,439.40	7,505,690.37	1,475,791.70	1,472,145.05	281,066.43	4,559,997.35	99,272.60	18,961,402.90
San Mateo	18,306,861.08	16,527,493.71	4,490,715.80	6,361,567.80	978,514.62	14,071,172.12	285,421.15	61,021,746.28
Santa Barbara	6,866,201.18	9,576,327.38	2,695,565.51	2,637,514.99	655,523.92	8,405,681.53	58,751.70	30,895,566.21
Santa Clara	32,453,161.48	58,015,542.00	10,903,431.08	12,971,837.44	2,259,398.34	33,830,394.01	299,048.40	150,732,812.75
Santa Cruz	4,172,075.53	7,488,996.60	1,789,681.53	1,667,643.93	325,780.68	5,700,623.35	38,863.30	21,183,664.92
Shasta	3,713,697.54	8,749,249.90	2,479,580.87	1,680,049.52	519,535.84	7,789,905.52	130,656.05	25,062,675.04
Sierra	197,175.59	491,483.12	86,054.25	91,282.63	40,646.98	277,028.46	550.90	1,184,221.93
Siskiyou	982,914.08	2,529,531.28	669,567.42	456,554.02	95,409.89	2,202,034.75	39,668.30	6,975,679.74
Solano	7,575,913.60	12,316,248.88	3,583,076.97	2,857,275.72	547,629.77	11,101,541.13	80,270.05	38,061,956.12
Sonoma	7,966,801.78	16,975,254.64	5,574,242.30	2,840,482.41	691,194.22	17,960,283.40	74,340.70	52,082,699.45
Stanislaus	8,095,542.31	14,668,626.36	3,756,009.76	4,737,825.66	908,808.84	11,132,596.16	321,338.15	43,620,747.24
Sutter	3,191,905.09	3,226,785.62	1,297,134.29	1,442,863.68	176,658.57	4,344,225.14	120,507.10	13,800,079.49
Tehama	1,448,736.25	3,760,177.04	881,675.23	595,123.11	110,751.41	2,925,949.18	37,162.65	9,759,574.87
Trinity	404,641.23	850,866.65	377,506.50	192,240.51	56,030.41	1,237,869.22	3,546.55	3,122,701.07
Tulare	8,127,574.58	15,936,236.04	3,602,469.94	5,074,521.62	872,503.58	9,913,485.66	349,345.50	43,876,136.92
Tuolumne	897,546.15	1,612,679.28	678,374.22	409,395.39	81,437.58	2,266,456.96	28,858.20	5,974,747.78
Ventura	10,693,596.80	14,105,478.16	4,288,377.78	4,497,741.75	802,308.80	13,140,385.08	150,019.10	47,677,907.47
Yolo	3,592,325.71	8,037,642.02	1,190,049.25	1,345,572.34	413,327.13	3,615,711.14	31,971.45	18,226,599.04
Yuba	0.00	4,401,919.52	1,137,867.76	0.00	284,293.07	3,545,321.21	0.00	9,369,401.56
Berkeley	1,388,617.78	0.00	462,090.69	807,129.39	0.00	1,193,716.91	0.00	3,851,554.77
Long Beach	0.00	0.00	2,071,842.25	0.00	0.00	5,416,486.38	0.00	7,488,328.63
Pasadena	0.00	0.00	683,298.42	0.00	0.00	1,817,116.15	0.00	2,500,414.57
Tri-City	1,645,290.36	0.00	0.00	1,691,906.60	0.00	0.00	0.00	3,337,196.96
<b>Total</b>	<b>\$ 692,552,204.73</b>	<b>\$ 1,424,860,296.55</b>	<b>\$ 321,391,212.12</b>	<b>\$ 316,468,463.33</b>	<b>\$ 54,878,206.35</b>	<b>\$ 968,419,966.03</b>	<b>\$ 14,000,000.00</b>	<b>\$ 3,792,570,349.11</b>