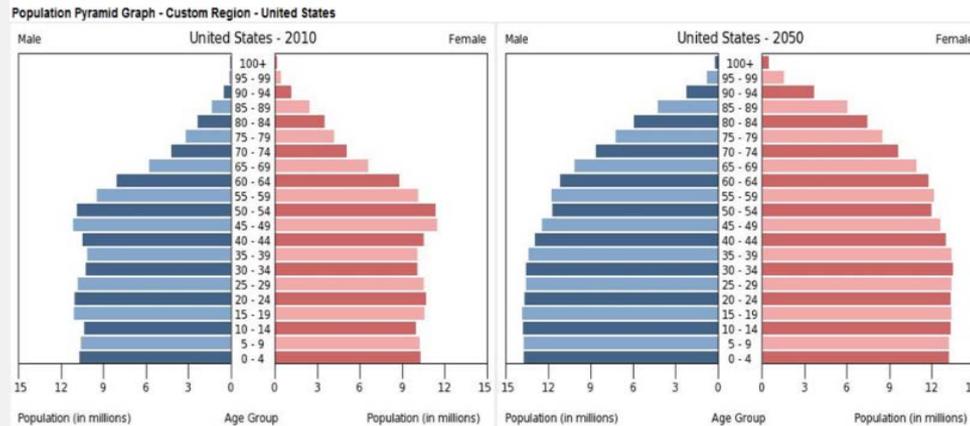


# The Aging Population: A Medi-Cal Perspective



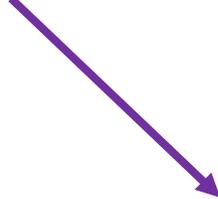
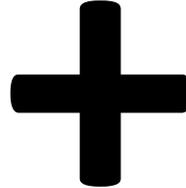
Created by the DHCS –  
Research and Analytic  
Studies Division



October 2016

Medi-Cal is a public health insurance program that provides free or low-cost health coverage for children and adults with limited income and resources.

*Medi-Cal is a State & Federal partnership.*

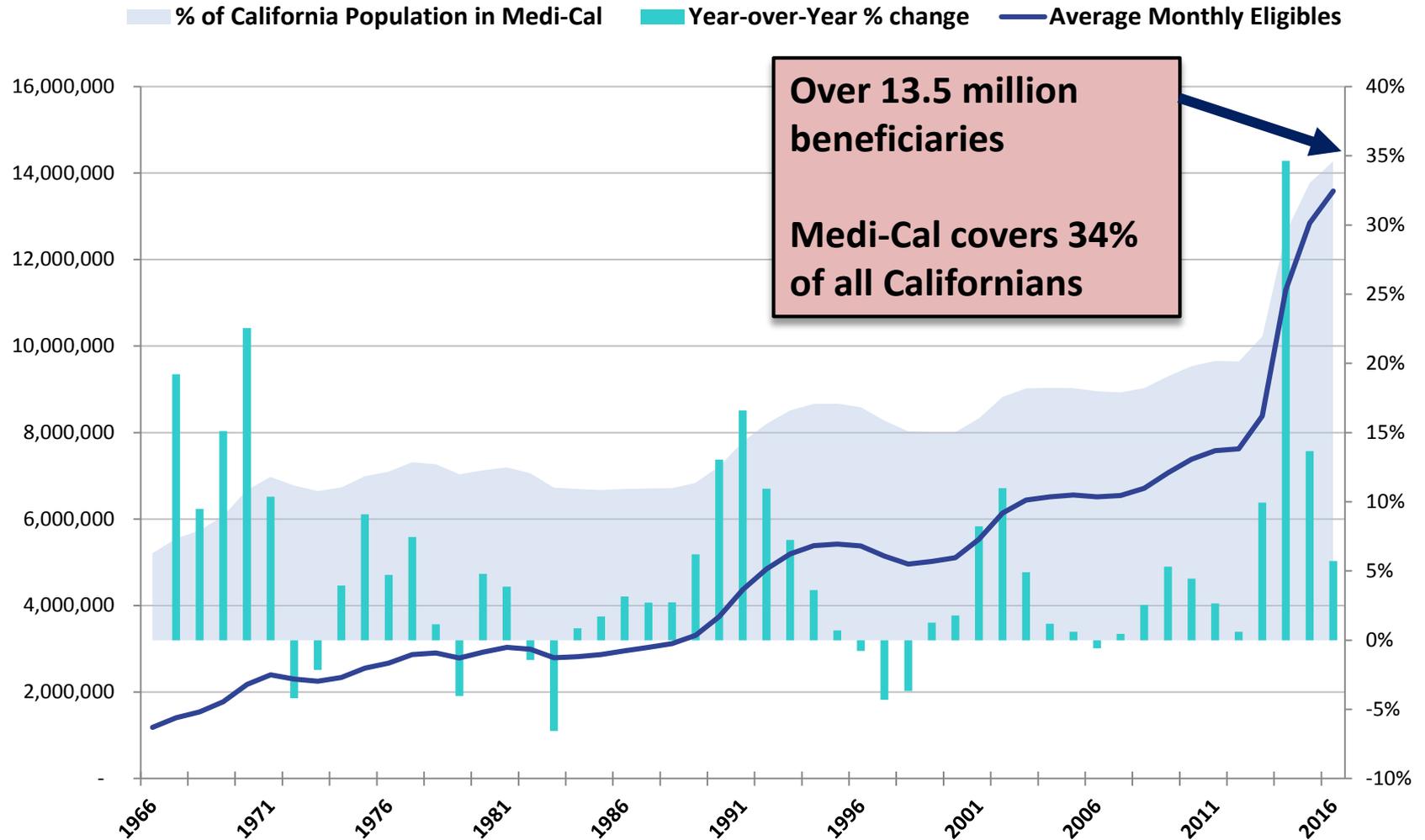


**Medi-Cal covers:**

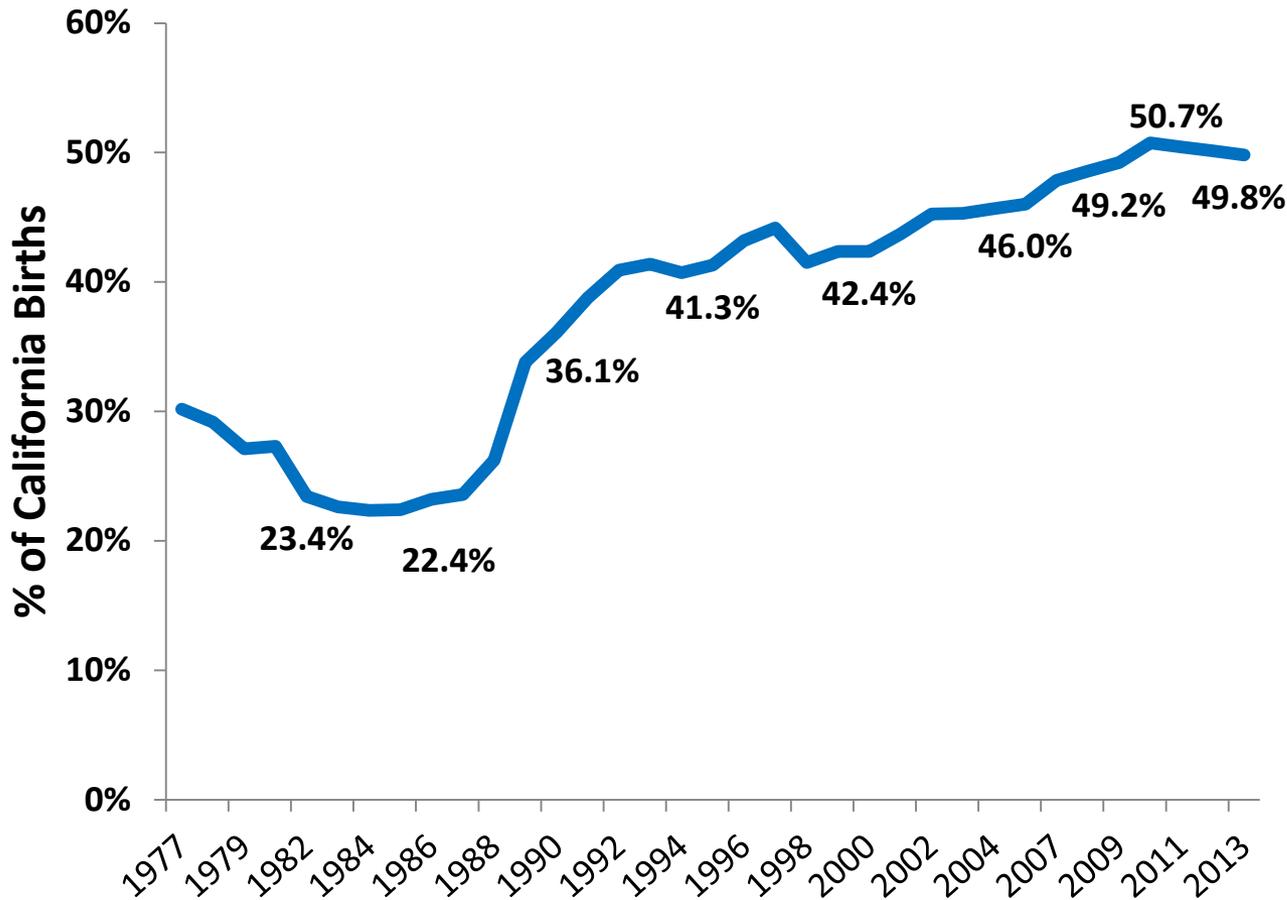
- low-income adults;
- families with children;
- seniors;
- persons with disabilities;
- children in foster care, as well as former foster youth up to age 26;
- pregnant women; and
- individuals with special health needs.



# How Many Californians Are Enrolled in Medi-Cal?



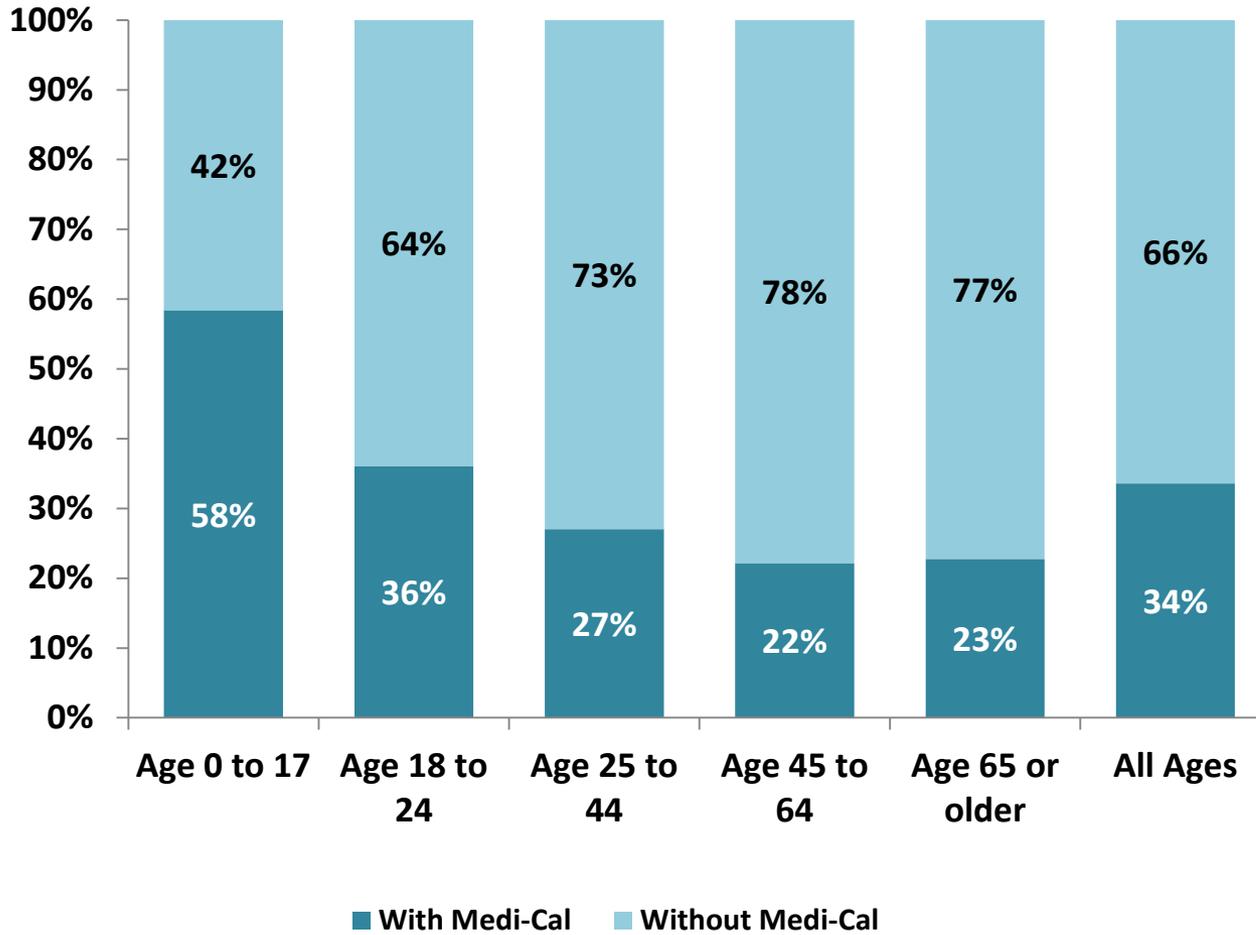
# Medi-Cal Covers Half of California Resident Births



Medi-Cal has covered more than 40% of California resident hospital births since 1992, and Medi-Cal proportions have increased even as total number of births has decreased.

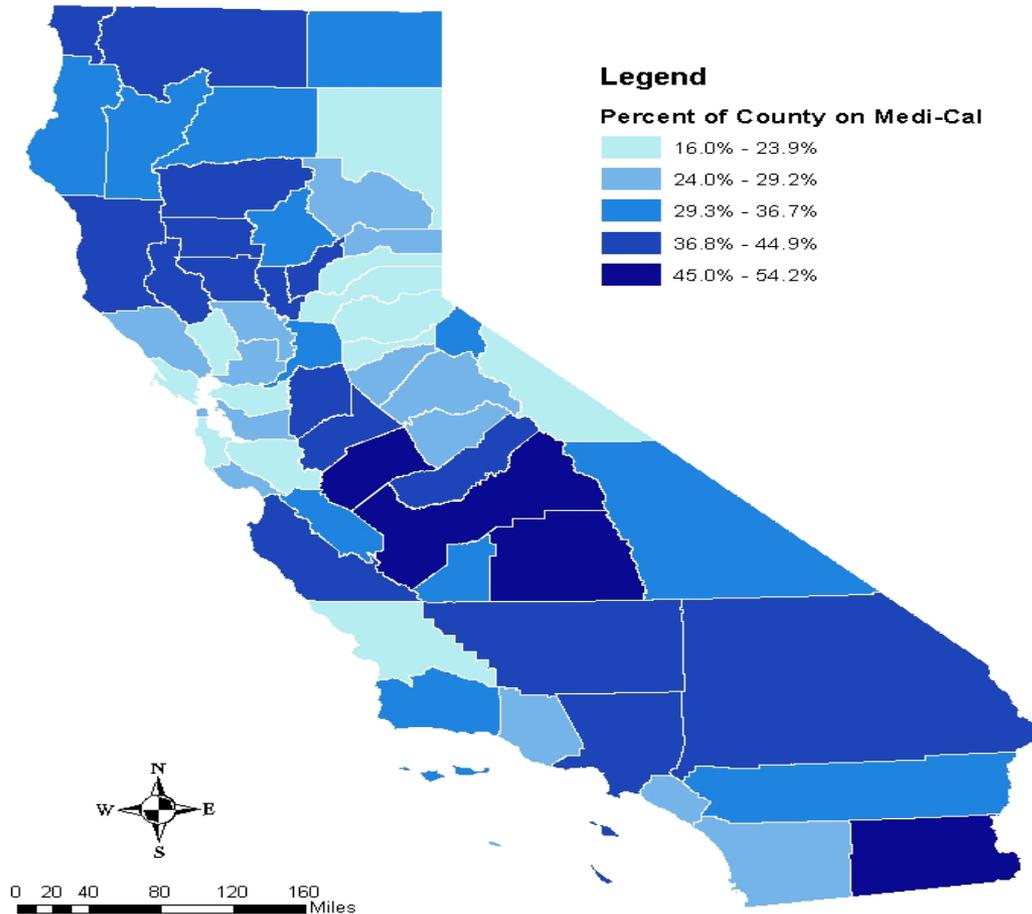
In 2010, the proportion of births financed by Medi-Cal in California was 50.7%. In 2013, it was slightly lower at 49.8%.

# Medi-Cal Covers More than Half of California's Children



Medi-Cal covers roughly six out of 10 children in the state. In some counties, Medi-Cal is the primary source of health care coverage for 80% of all children.

# Proportion of Californians Enrolled in Medi-Cal, By County (FFY 2013-14)

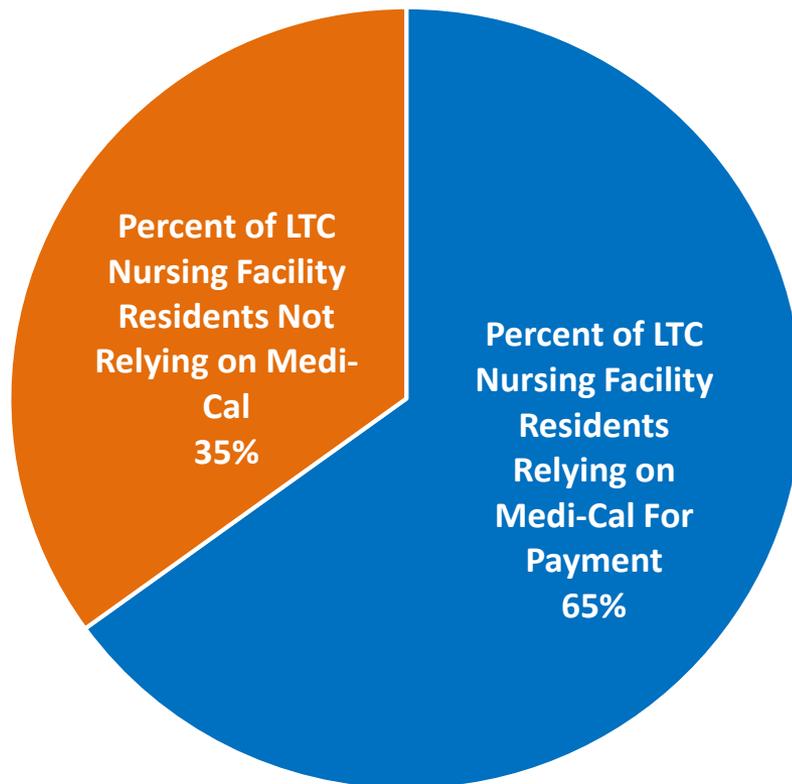


Medi-Cal is the primary health care coverage for many geographic regions of the state.

In some counties within the Central Valley, Medi-Cal provides coverage to more than 50% of the population.

Created by DHCS Research and Analytic Studies Division using data from the Medi-Cal Management Information System/Decision Support System and California Department of Finance Demographic Research Unit's Report P-2: State and County Population Projections by Race/Ethnicity and Age

# Medi-Cal's Role in Financing Long-Term Care Services



Among California's long-term care (LTC) residents, nearly two-thirds rely on Medi-Cal to finance their care.

Roughly 100% of individuals who reside in homes for the developmentally disabled rely on Medi-Cal to pay for their care.

Source: California Association of Health Facilities <http://www.cahf.org/AboutCAHF/ConsumerHelp/GuidetoLongTermCare.aspx>

# State Financing of Medi-Cal

# In The Headlines – Medicaid’s Financial Burden



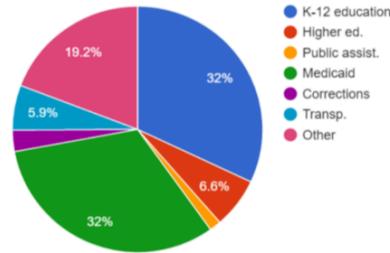
## Medicaid starting to eat up State of Indiana budget

When public school teachers complain to me about politicians/education spending, I tell them their real problem is Medicaid patients. The confused looks are priceless.

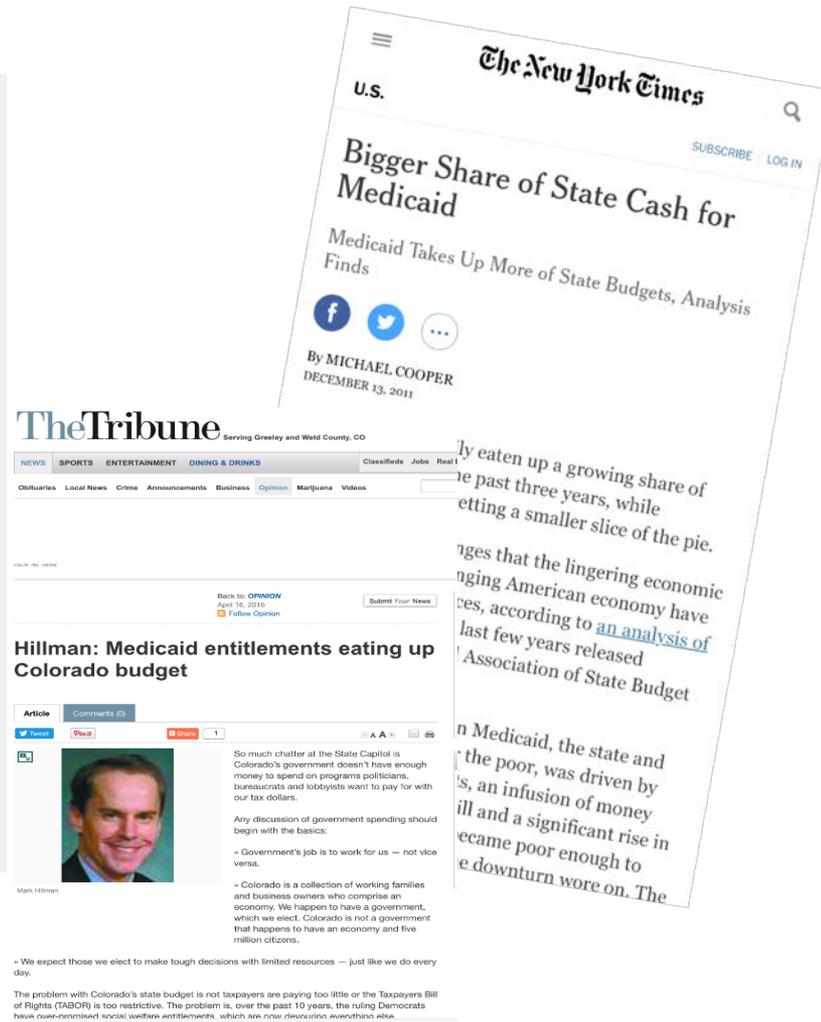
States spend money out of their budgets the same on Medicaid and education. When one increases, the other areas will see less revenue. Medicaid is demanding a lot more and education in Indiana will start seeing cuts because of it. Medicaid is the Trojan horse of Obamacare and has greatly expanded the last five years. Even before Obamacare, courts were loading up Medicaid via disability judgements.

In 2002 & 2003, the State of Indiana budget spending was only 13% for Medicaid. Fast forward 12 years it is now 32%. Education(k-12) in 2002/2003 was 47%. Now it's dropped to 32%.

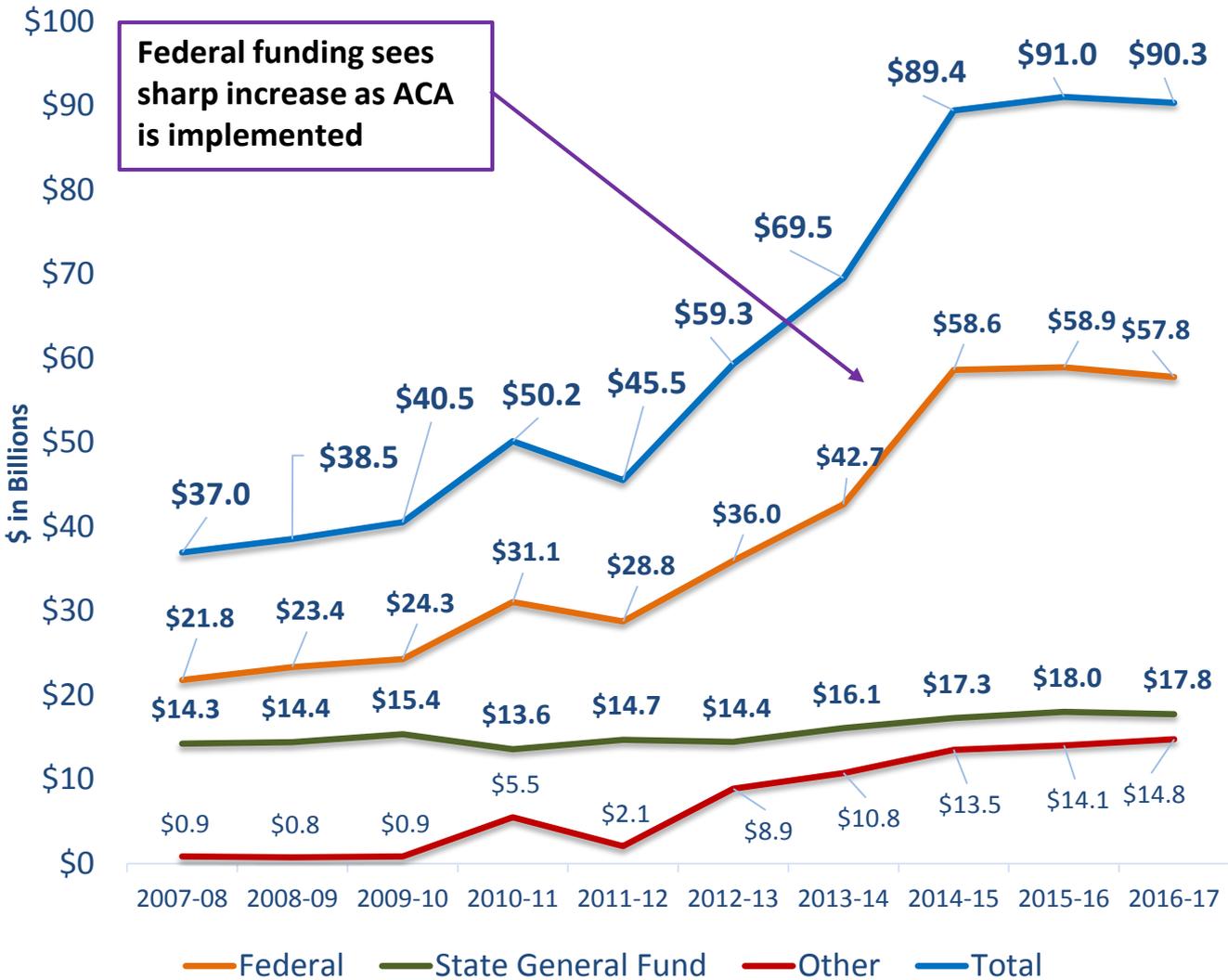
Indiana spending by function, FY 2014



No matter how you spin the math or try to talk your way out of it



# Medi-Cal's Funding Mix: How Has It Changed?



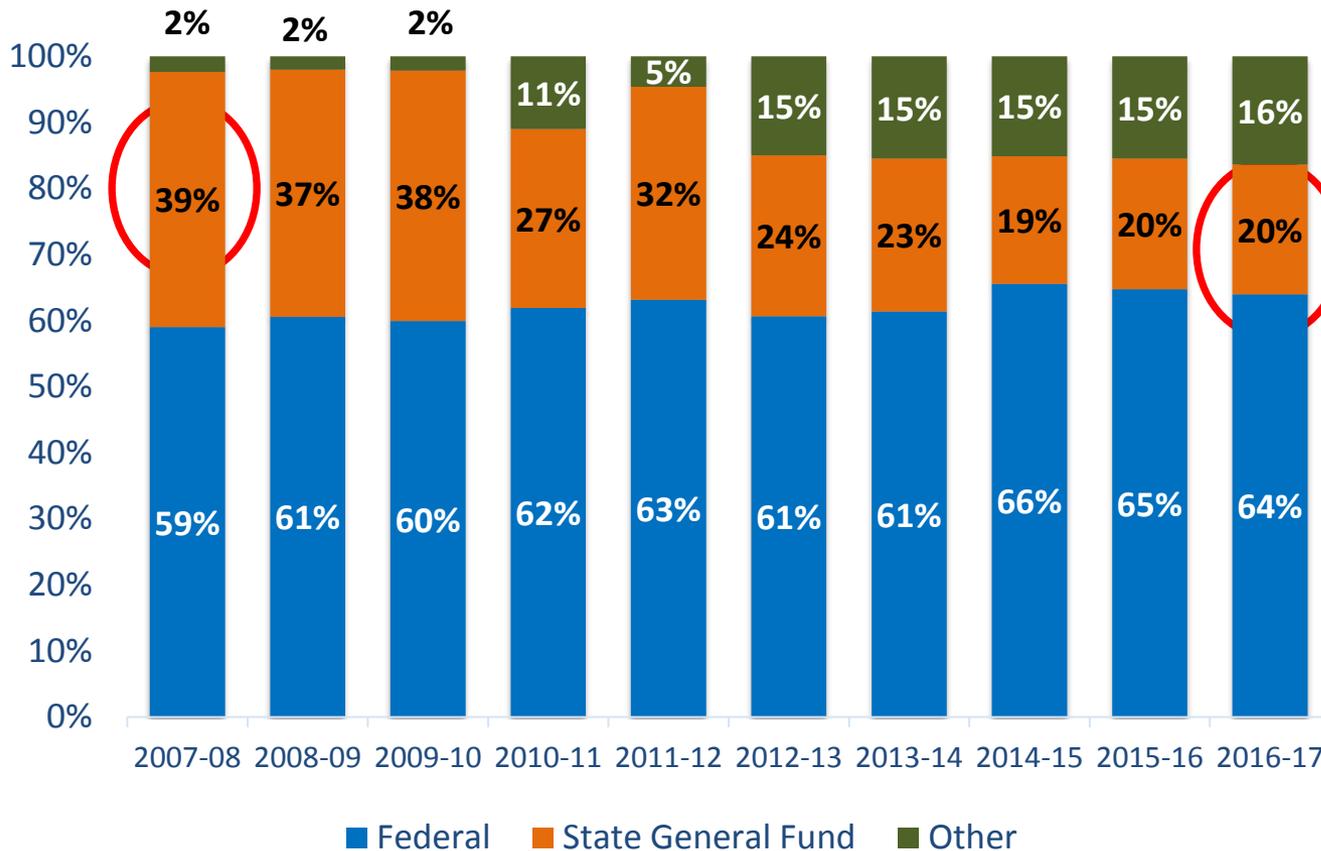
Federal funding has taken a larger role in financing Medicaid programs throughout the nation, and California is no exception.

The adoption of the Affordable Care Act (ACA), provider taxes, quality assurance fees, certified public expenditures, and other means have brought in additional federal funds that have allowed Medi-Cal to enhance the program and offer coverage to new populations.

Medi-Cal's new adult population, which began enrollment in CY 2014, is financed entirely by the federal government for the first three years, phasing down to 90% in 2020.

State general fund spending has grown modestly over the past nine years.

# Medi-Cal Budgeted Spending By Funding Source (SFYs 2007-08 Through 2016-17)

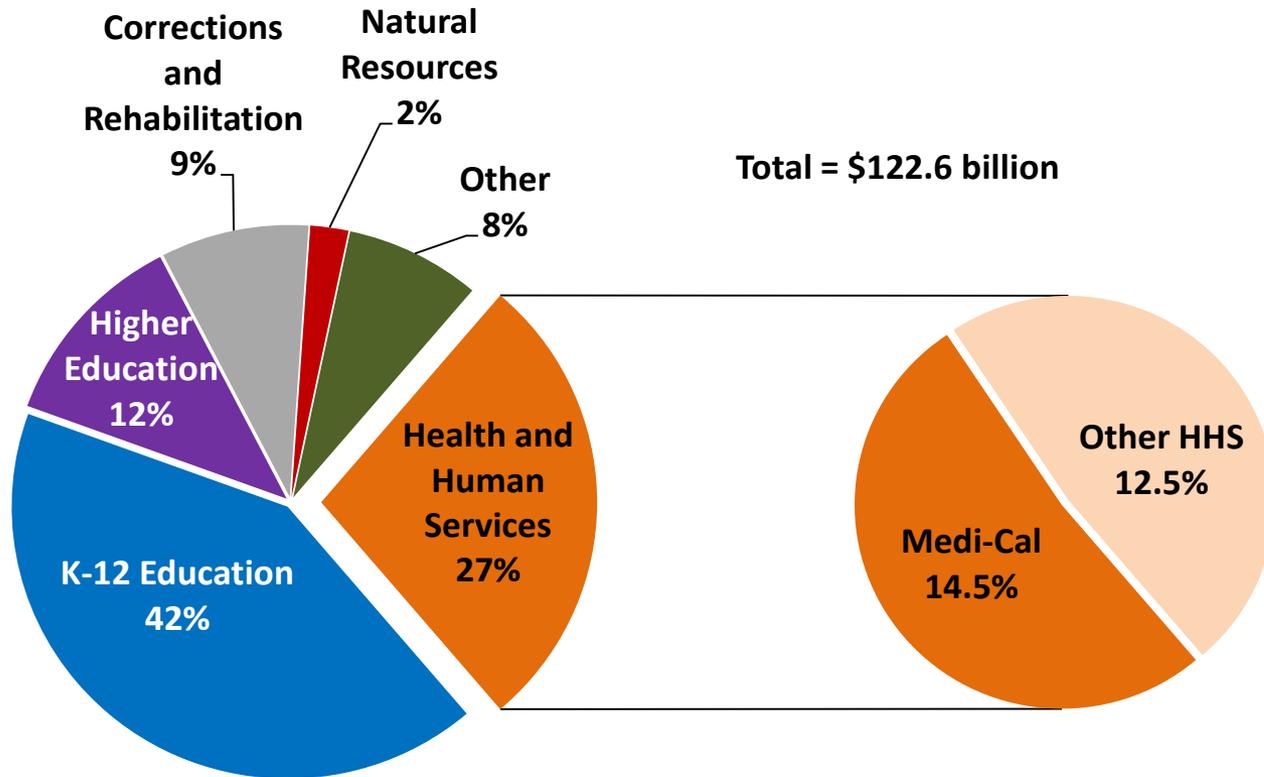


Budgeted federal funds financed 64% of Medi-Cal spending in SFY 2016-17, while state-budgeted general funds financed 20%, and other funds accounted for 16%.

The major shift in funding proportions has been primarily driven by the absorption of the Healthy Families Program into Medi-Cal in 2013 (representing a 65-35 split between federal and state dollars, respectively); implementation of the ACA in January 2014; and the use of other funds (e.g. provider taxes, quality assurance fees, CPEs, etc.).

Source: Medi-Cal Appropriation Estimate SFY 2016-17,  
[http://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2016\\_May\\_Estimate/M1601\\_Approp\\_Funding\\_Sum.pdf](http://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2016_May_Estimate/M1601_Approp_Funding_Sum.pdf)

# Medi-Cal Spending as a Percentage of California's Overall Budgeted General Fund Spending (SFY 2016-17)



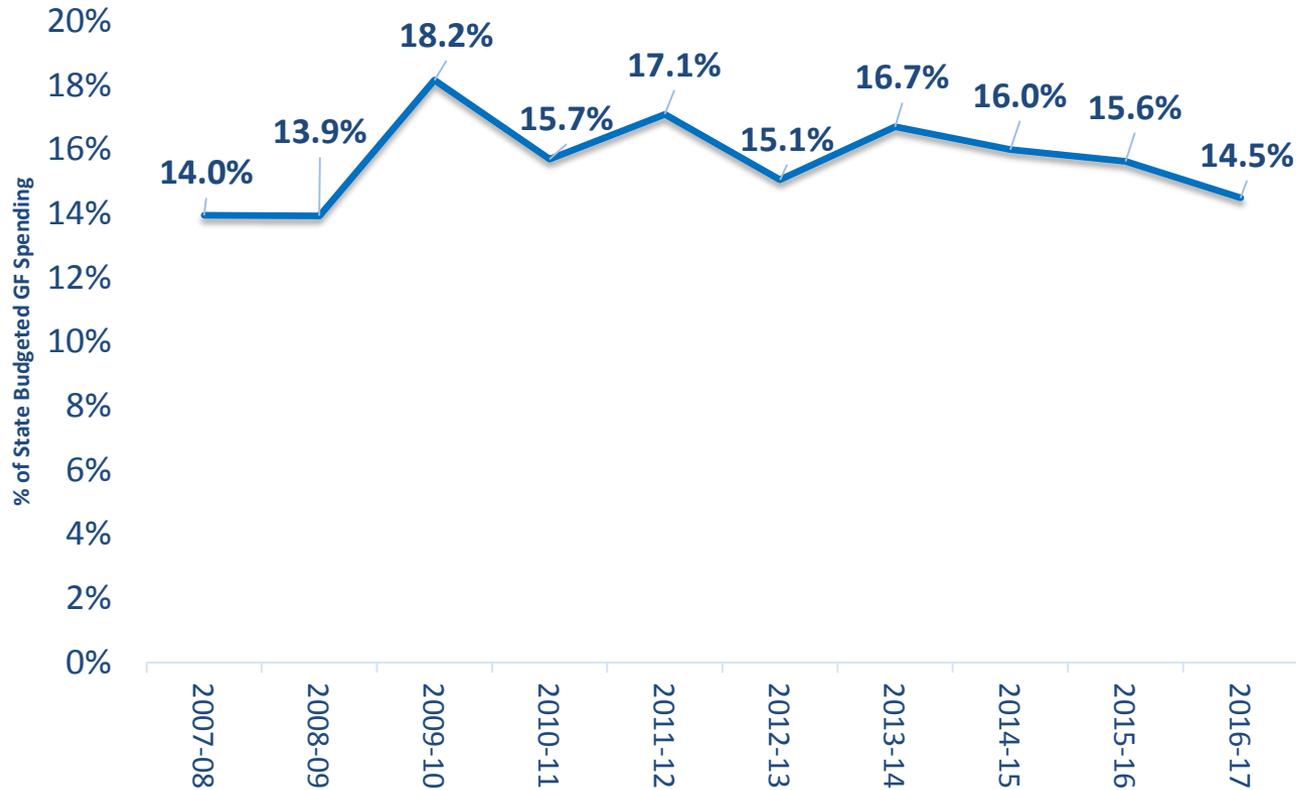
Medi-Cal spending accounts for roughly 14% of the state's general fund spending.

This is in line with U.S. averages that indicate that Medicaid represents roughly 14% to 18% of state general fund budgets.

State general funds consist of expenditures from revenues raised through income, sales, and other broad-based state taxes.

Sources: Medi-Cal Appropriation Estimate SFY 2016-17, Department of Finance – California's Enacted Budget SFY 2016-17  
<http://www.ebudget.ca.gov/2016-17/Enacted/BudgetSummary/BSS/BSS.html>

# Medi-Cal Budgeted Spending as a Percentage of State General Fund (SFYs 2007-08 Through 2016-17)

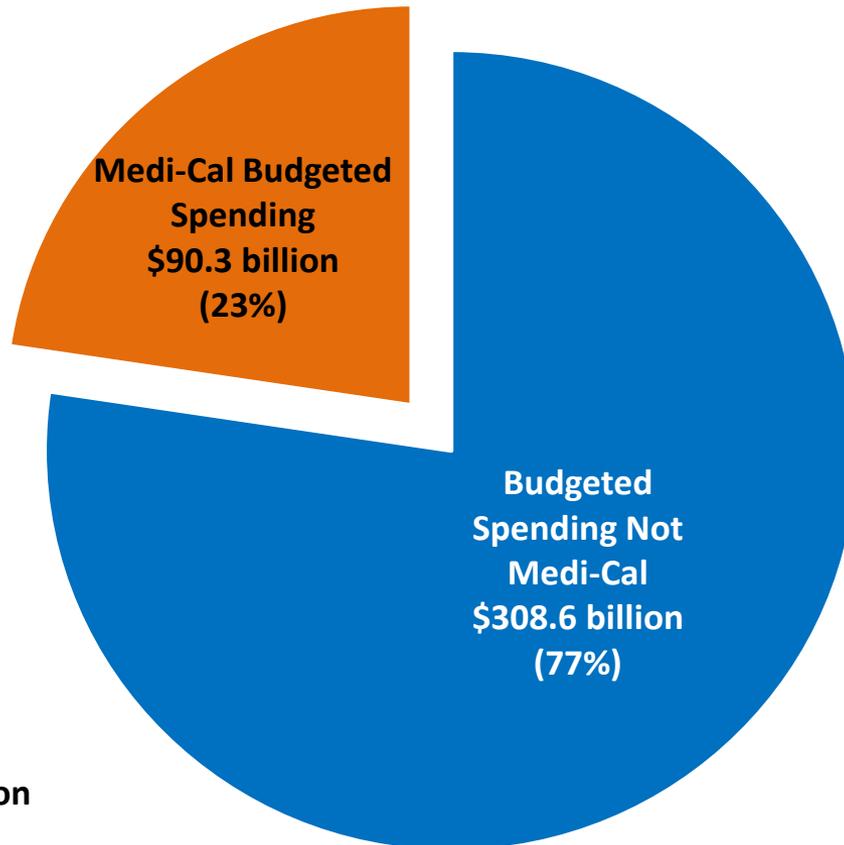


Medi-Cal spending as a percent of state-budgeted general fund spending has remained relatively stable over the past 10 years.

Medi-Cal has accounted for between 13.9% and 18.2% of budgeted general fund spending.

Sources: California Summary Charts, Figure – Sum – 03 for select years. <http://www.ebudget.ca.gov/>  
Medi-Cal Appropriation Estimates for select years.

# Medi-Cal Spending as a Percentage of California's Overall Budgeted Spending (SFY 2016-17)



**Total = \$398.9 billion**

Source: Medi-Cal Appropriation Estimate SFY 2016-17, Department of Finance – California's Enacted Budget Sfy 2016-17  
<http://www.ebudget.ca.gov/2016-17/Enacted/BudgetSummary/BSS/BSS.html>

Because Medi-Cal brings in substantial federal funds, another way to look at Medi-Cal in the context of state spending is to evaluate all state spending.

Medi-Cal spending accounts for roughly 23% of California's overall state spending. Nationally, Medicaid accounts for 25% of overall state spending.

Overall state-budgeted spending includes federal, state, and all other funds combined.

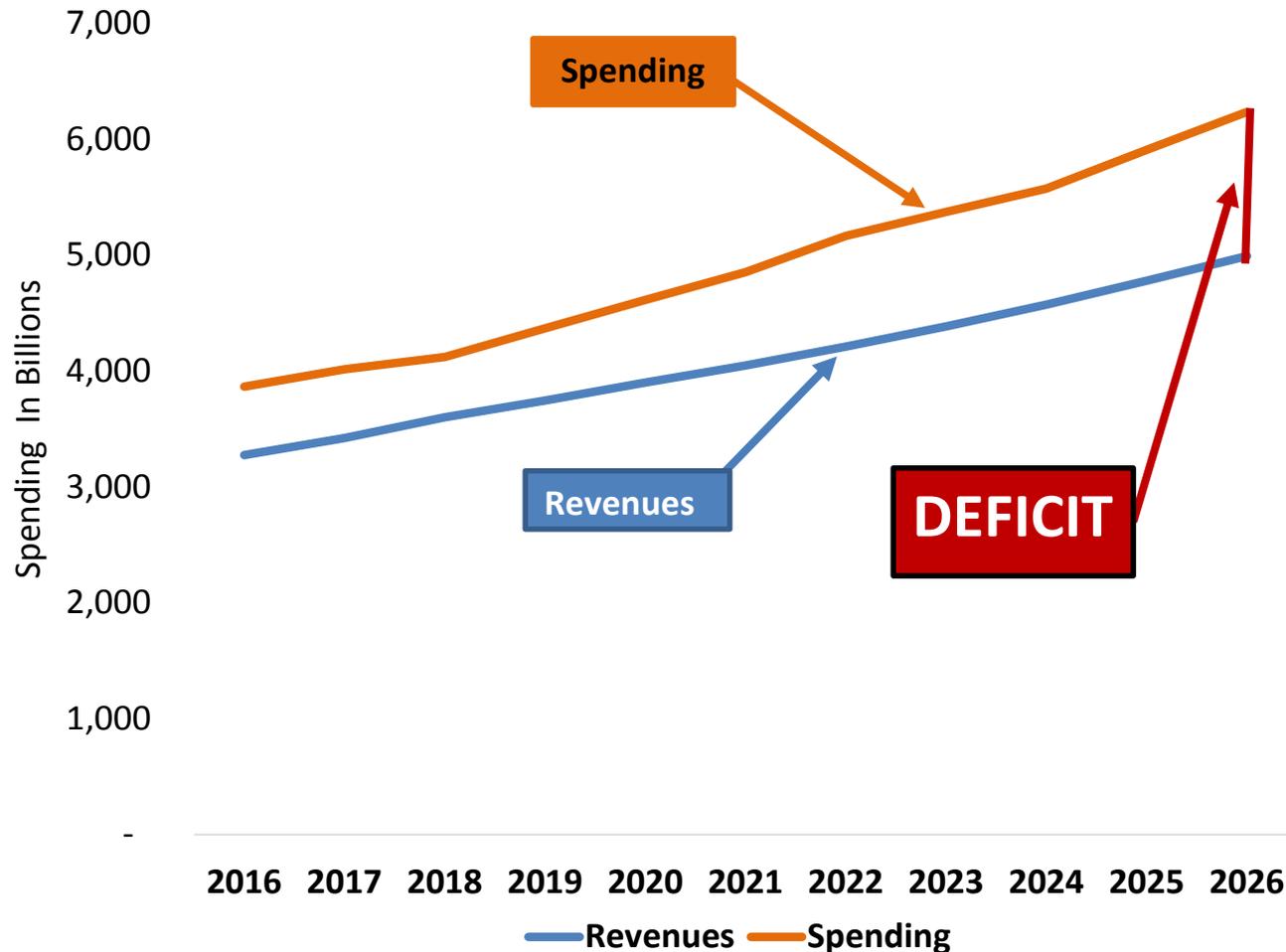
# Medi-Cal Is Heavily Dependent on Federal Funding



- Medi-Cal covers 34% of all Californians, including 58% of the state's children, and 50% of all resident births.
- Federal contributions have increased sharply, and now account for 65% of Medi-Cal's budget.
- Changes in federal policy in response to budgetary pressures or economic downturns may introduce complex and difficult funding decisions in the future.

# Federal Financing of Medi-Cal

# CBO Baseline Budget Projections 2016 Through 2026



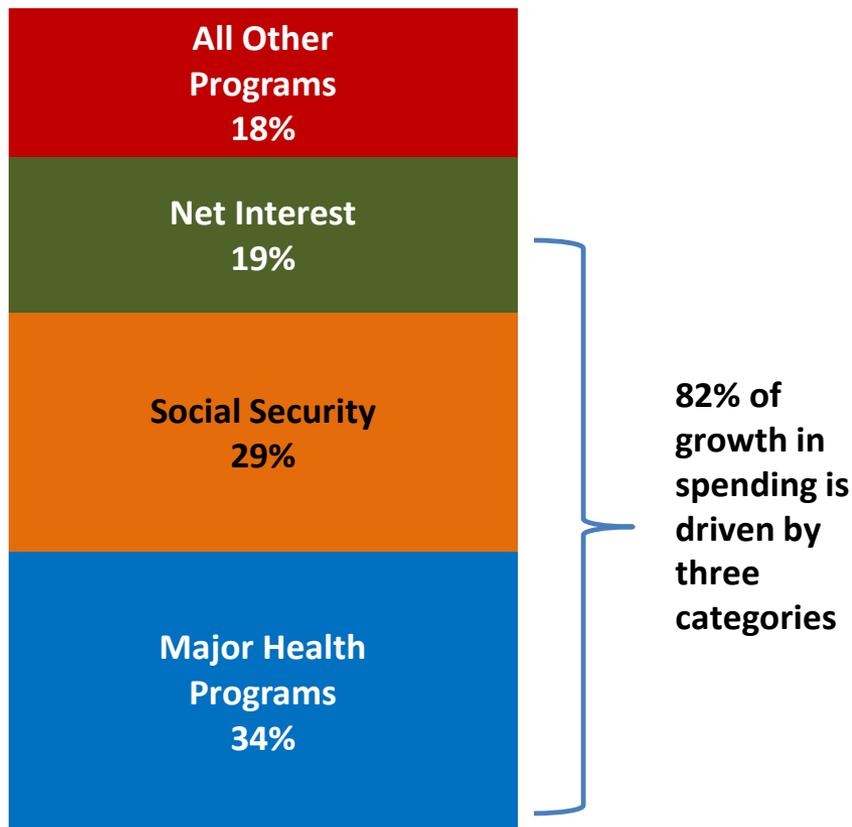
Federal spending is projected to exceed revenue from 2016 through 2026.

The Congressional Budget Office (CBO) predicts that spending for mandatory programs will rise nearly 70% in nominal terms from 2016 to 2026.

They attribute most of this increase to the aging of the population and rising health care costs per person.

Source: Congressional Budget Office, An Update to the Budget and Economic Outlook: 2016 to 2026  
[https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51908-2016\\_Outlook\\_Update-2.pdf](https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51908-2016_Outlook_Update-2.pdf)

# What Is Driving Federal Deficits?



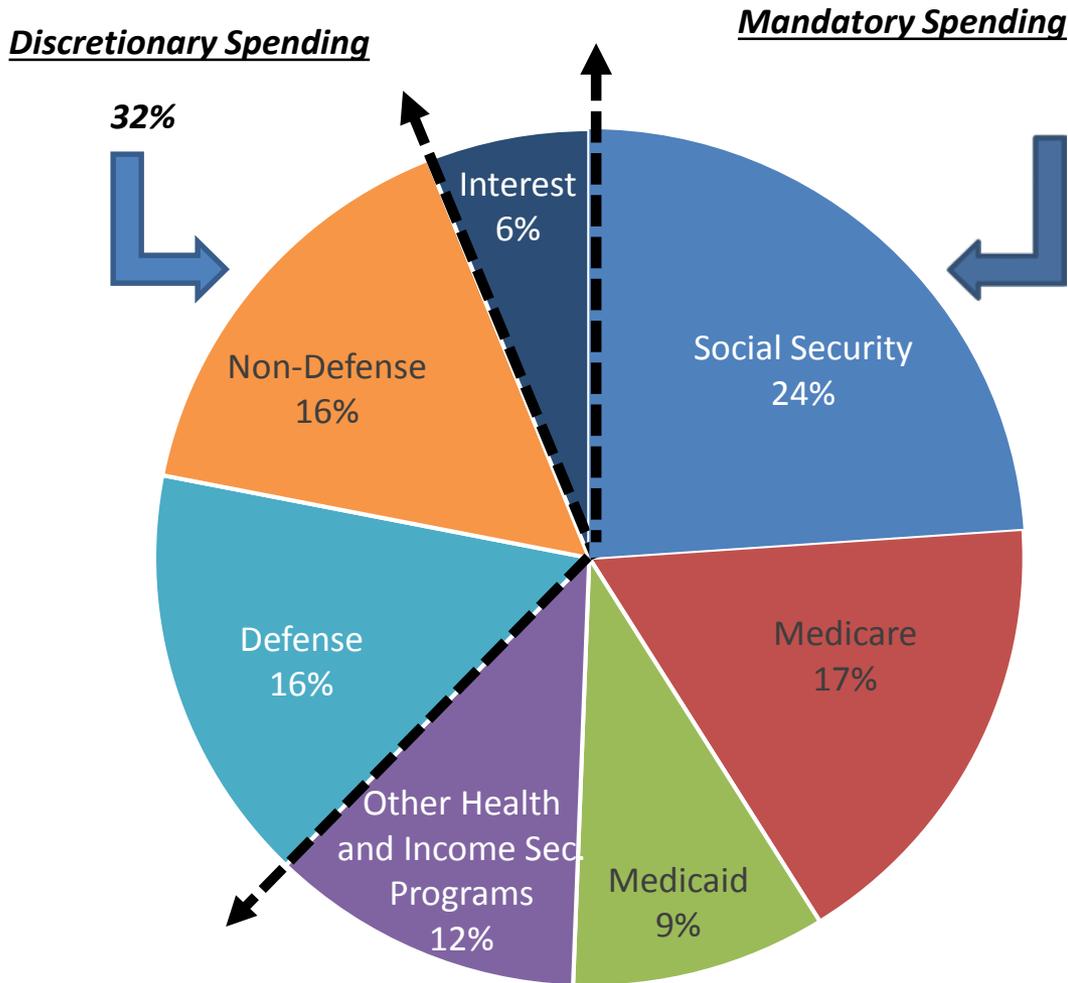
Federal spending is projected to grow substantially between 2016 and 2026.

The CBO estimates that 82% of the growth in federal spending will come from three major components: net interest; Social Security; and major health programs.

The major health programs include Medicare, Medicaid, Children's Health Insurance Programs, and health care subsidies for the ACA.

Source: Congressional Budget Office, An Update to the Budget and Economic Outlook: 2016 to 2026  
[https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51908-2016\\_Outlook\\_Update-2.pdf](https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51908-2016_Outlook_Update-2.pdf)

# 2015 Actual Federal Expenditures



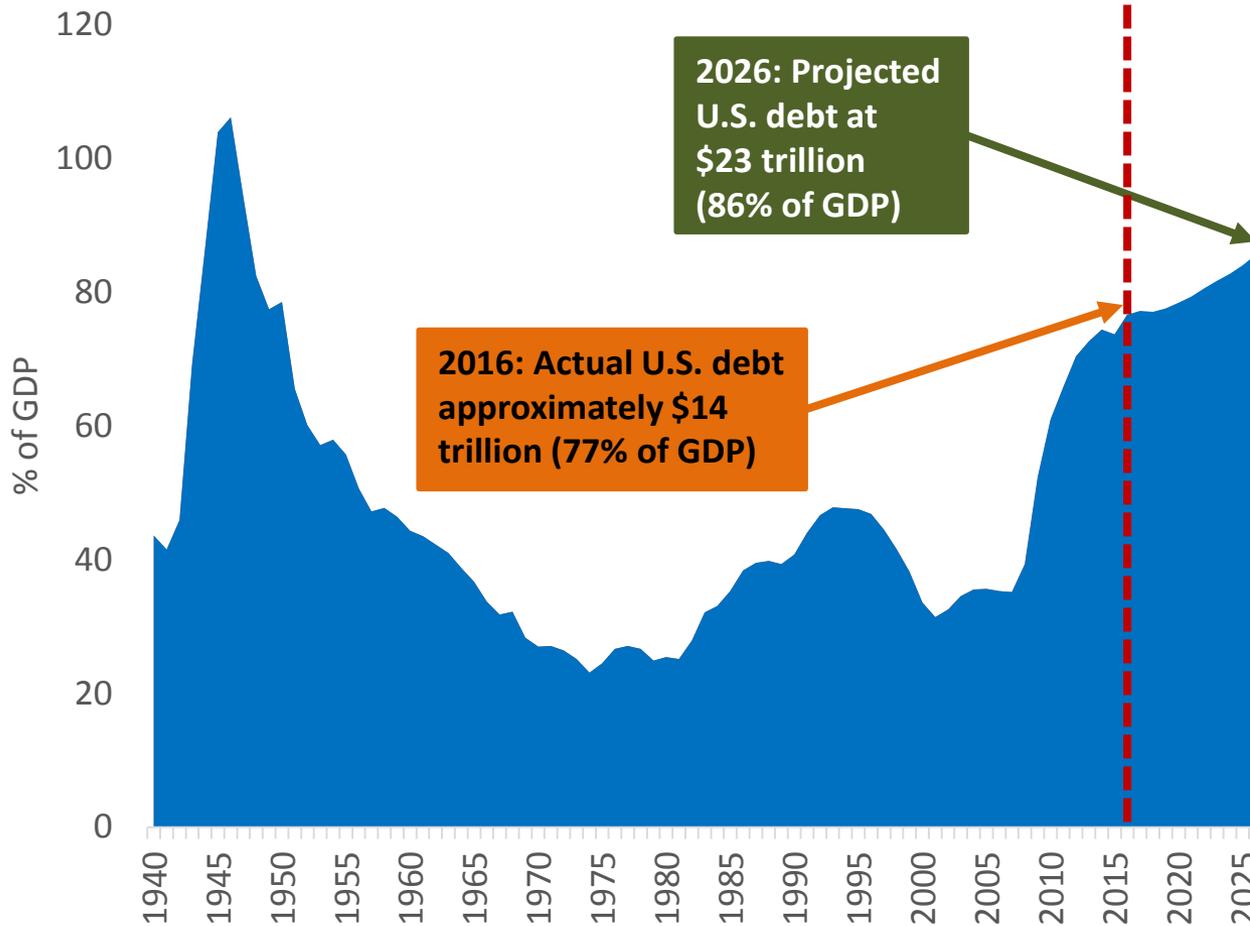
Mandatory spending accounts for 62% of all federal spending. When interest on the debt is added in, mandatory plus interest accounts for 68% of all federal spending.

Social Security, Medicare, Medicaid, and other health account for 50% of all federal spending.

By 2026, the Congressional Budget Office estimates that mandatory spending plus interest on the debt will account for 77% of all federal spending.

Source: Congressional Budget Office, An Update to the Budget and Economic Outlook: 2016 to 2026  
[https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51908-2016\\_Outlook\\_Update-2.pdf](https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51908-2016_Outlook_Update-2.pdf)

# Federal Debt Held By the Public



Federal debt held by the public is projected to rise from 77% of GDP in 2016 to 86% in 2026.

According to the CBO, when the debt as a percentage of GDP reaches 86%, it would be more than twice the average over the past 50 years.

The CBO predicts, assuming no changes in laws, that three decades from now the debt held by the public will be about twice as high relative to GDP. This would be higher than the U.S. has ever experienced.

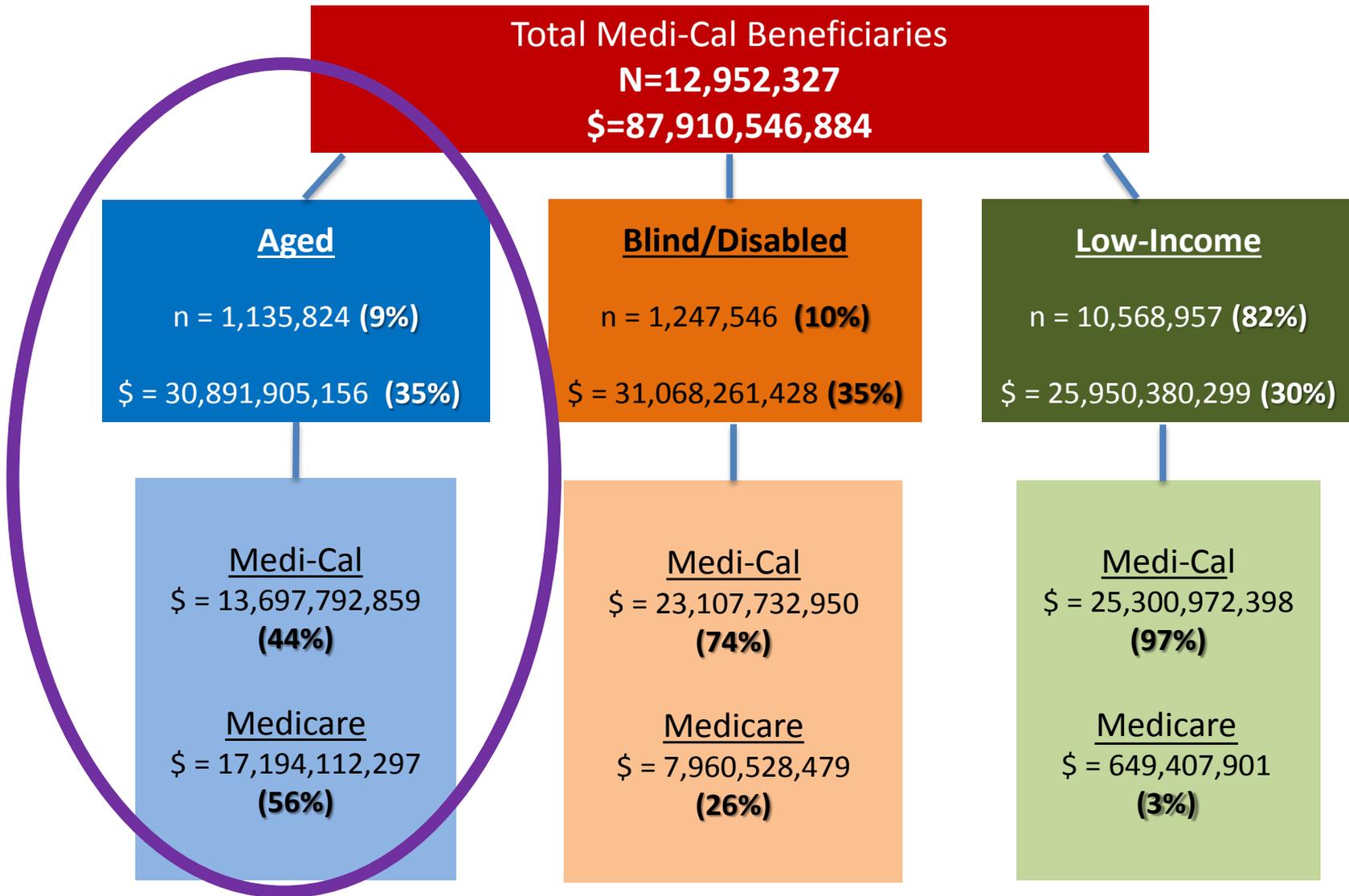
# Deficits & Debt May Necessitate Reforms



- The Medi-Cal program is highly dependent on federal funding.
- Policy changes at the federal level may greatly impact Medi-Cal in the future.
- Policymakers will have to consider a combination of tax, spending, and entitlement reforms.
- Federal and state governments, as well as Medicaid stakeholders, are going to have to work together and find more cost-effective ways to deliver health care.

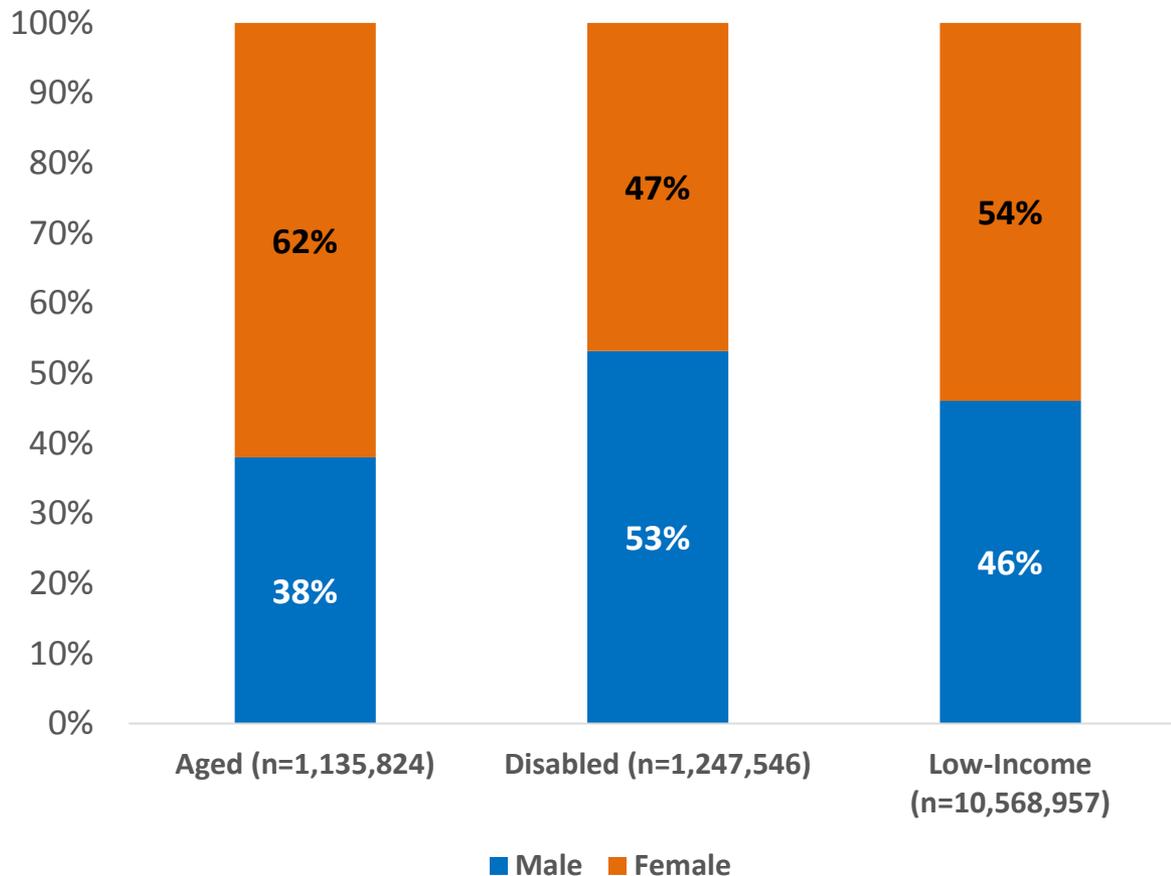
# **Actual Spending and Demographics: Medi-Cal in FFY 2013-14**

# The Medi-Cal Population in FFY 2013-14



# More Females in the Aged Eligibility Group

Distribution of Medi-Cal Population in FFY 2013-14, by Gender

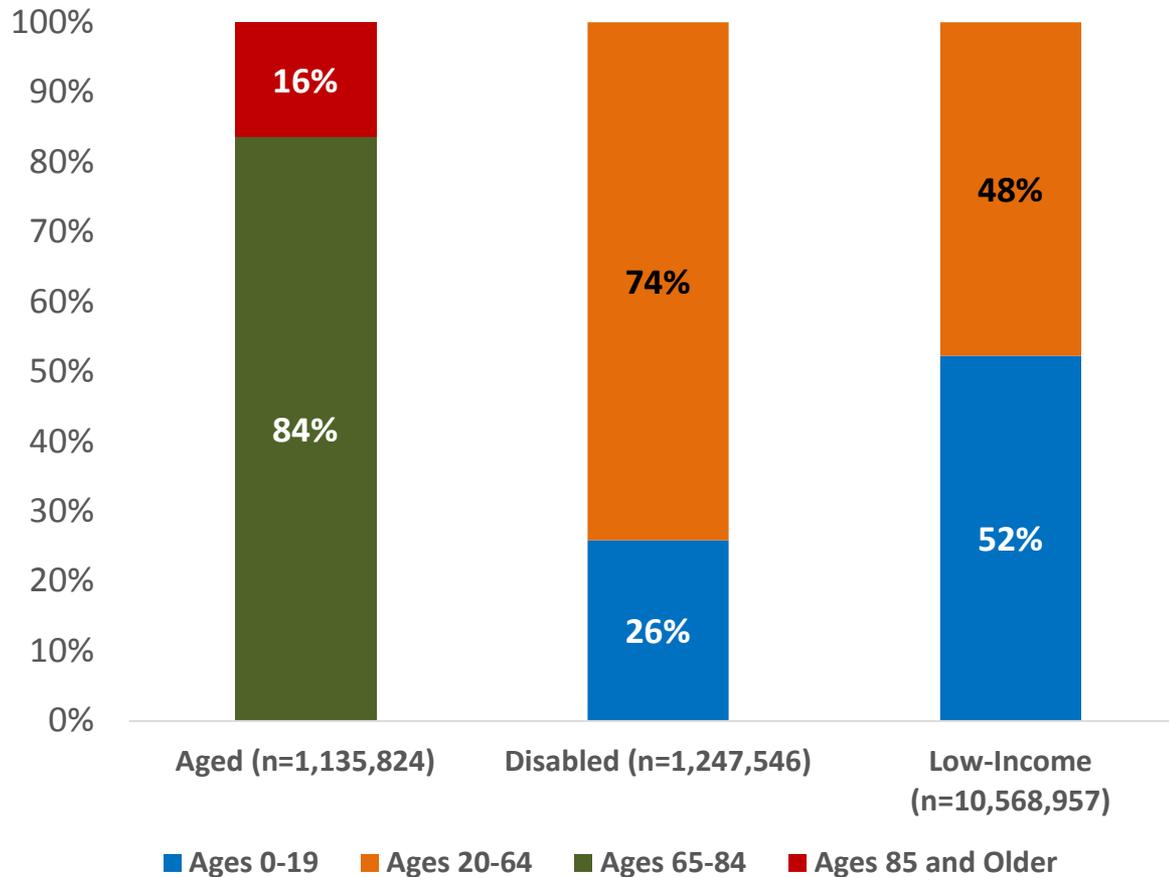


The Aged eligibility group included a much larger proportion of females (62%) vs. males (38%) compared to the other eligibility groups. This disparity is primarily driven by differences in life spans.

The Low-Income group also included a larger proportion of females compared to males, due to the fact that Historically, Low-Income eligibility pathways focus on women of child-bearing age, though this has changed.

# Sixteen Percent of Aged Eligibility Group is Ages 85 and Older

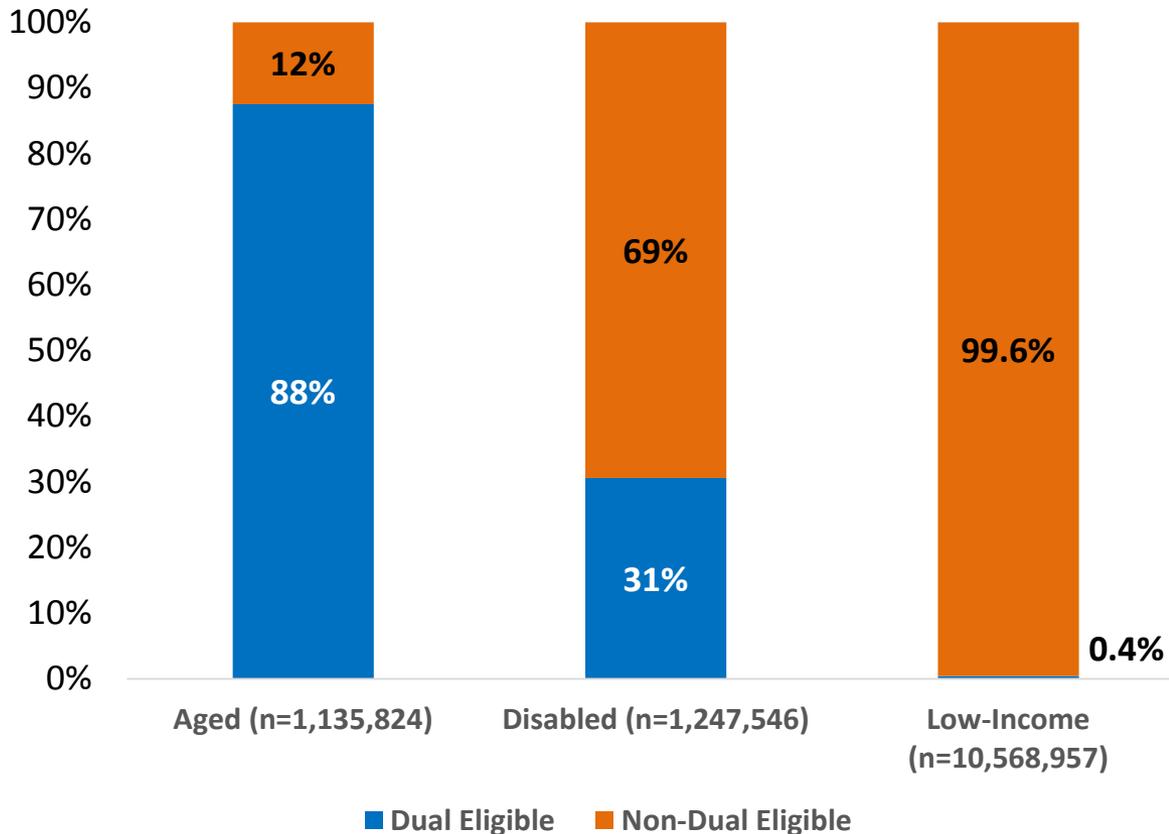
Distribution of Medi-Cal Population in FFY 2013-14, by Age Group



The Aged eligibility group was predominately comprised of individuals ages 65-84 (84%), with 16% being ages 85 and older. The Disabled group included a much larger proportion of eligibles ages 20-64 (74%) compared to the Low-Income group (48%).

# Aged and Disabled More Likely to Be Dually Eligible

Distribution of Medi-Cal Population in FFY 2013-14, by Dual Status

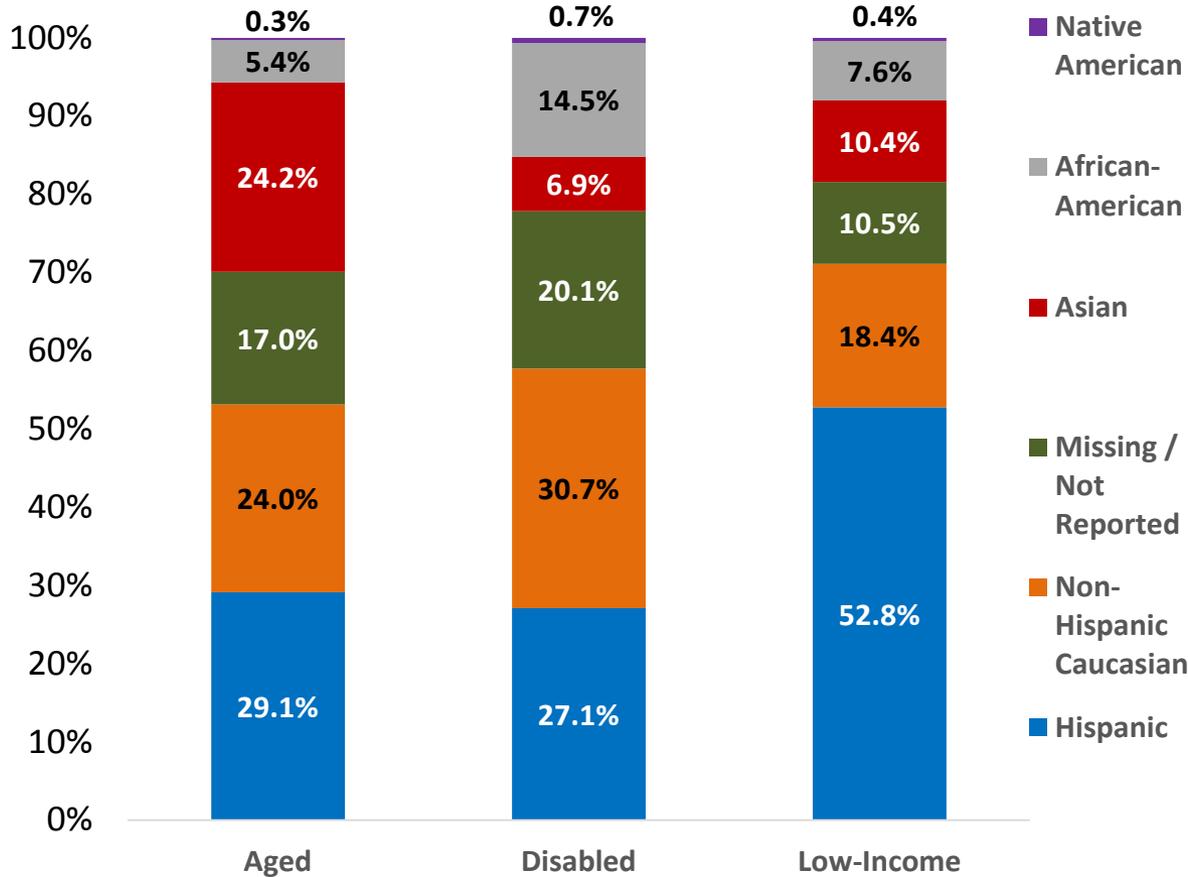


Dual Eligibles comprised a majority of the Aged eligibility group (88%), while the Low-Income group was comprised almost entirely of non-Dual Eligible individuals.

Close to one-third of the Disabled eligibility group was dually eligible, and many were within the two-year disability waiting period.

# Race/Ethnicity Vary by Eligibility Group

Distribution of Medi-Cal Population in FFY 2013-14, by Race/Ethnicity

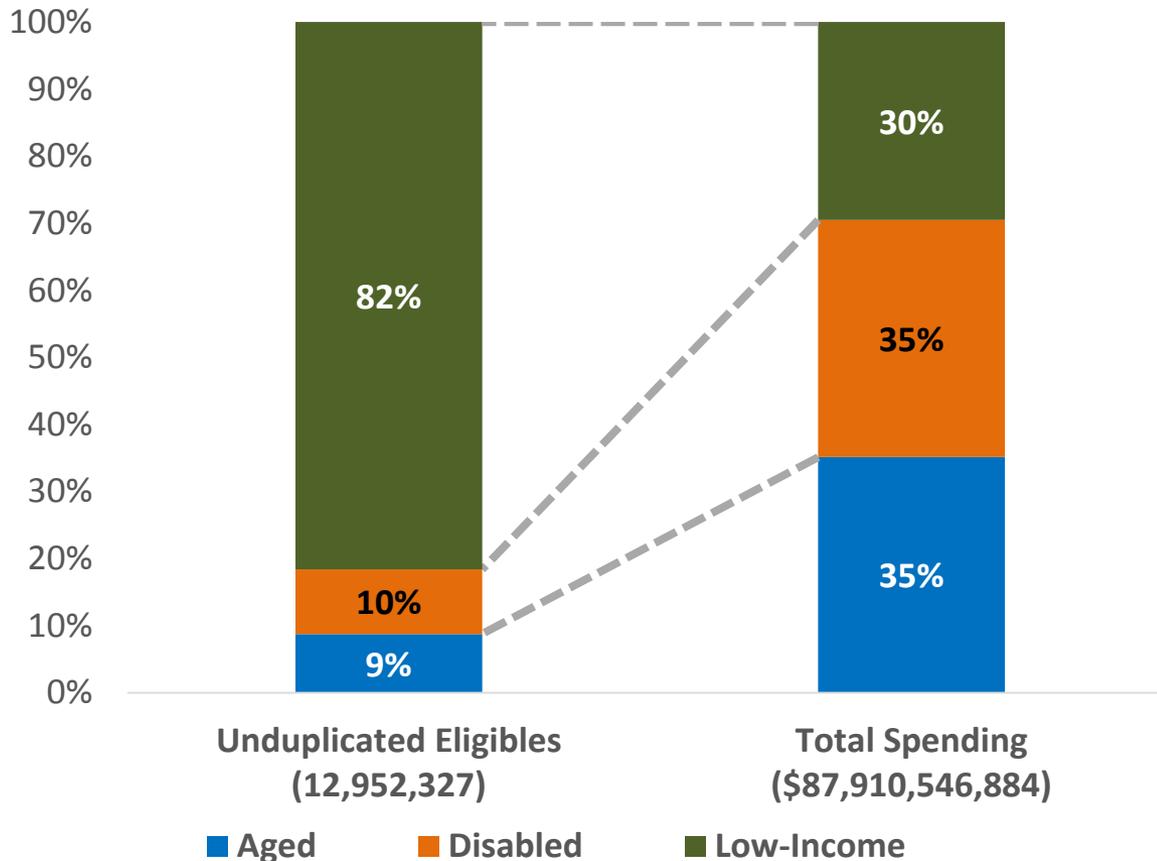


All Medi-Cal eligibility groups are ethnically/racially diverse. Hispanics and Non-Hispanic Caucasians represent the largest proportion of eligibles overall, and Native American eligibles represent the smallest proportion.

The demographic characteristics of elderly Medi-Cal beneficiaries are different from those of other Medi-Cal groups. For example, elderly Medi-Cal beneficiaries in the Aged eligibility group are 3.5 times more likely to be of an Asian race/ethnicity compared to the Disabled group, and 2.3 times more likely to be Asian compared to the Low-Income group.

# Aged, Disabled Eligibility Groups Generate Disproportionate Spending

Medi-Cal Spending By Eligibility Group  
FFY 2013-14 Dates-of-Service



Source: Medi-Cal and Medicare Eligibility data

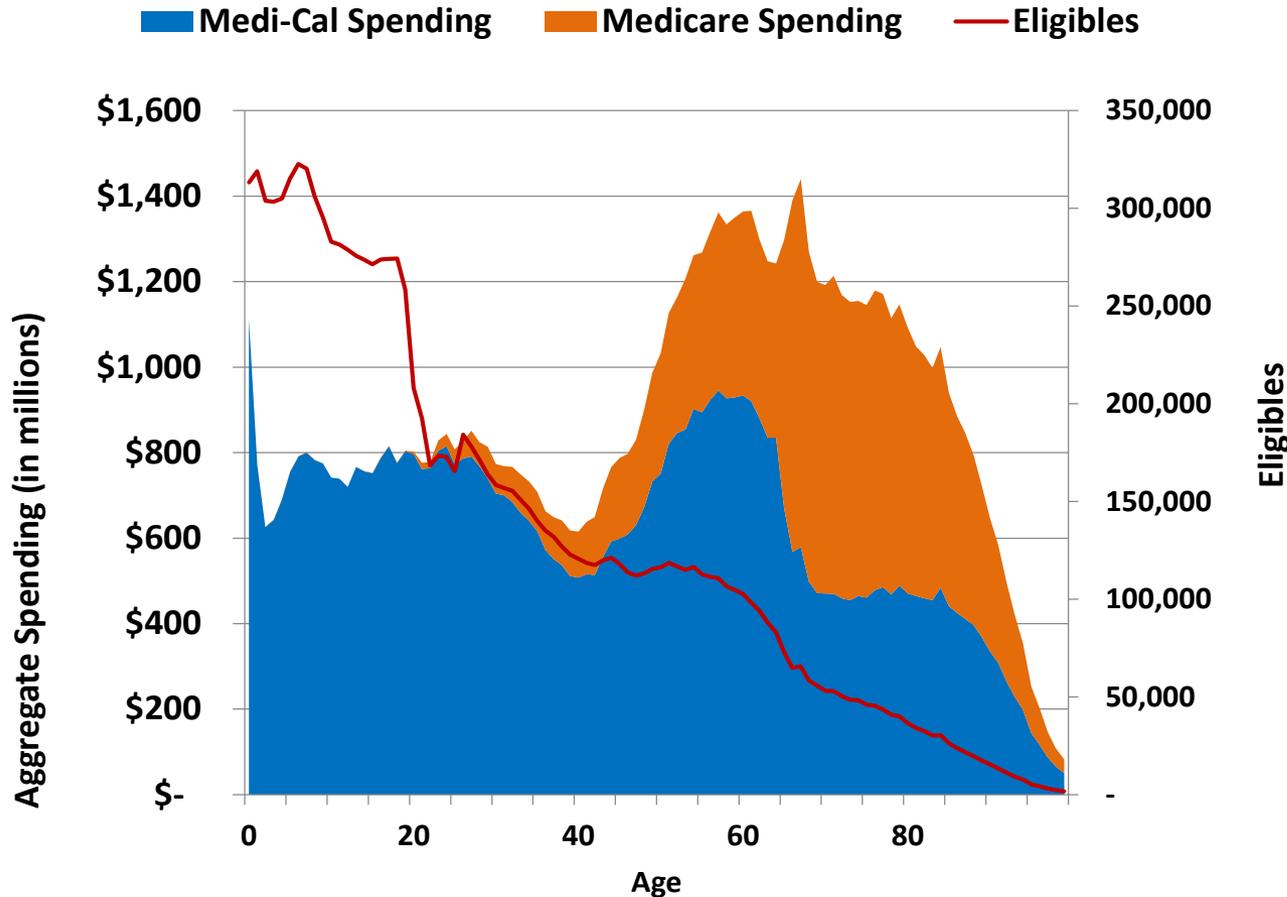
Medi-Cal spending is not equally distributed relative to population shares.

Medi-Cal's Low-Income population constituted 82% of the overall population, but accounted for only 30% of total spending.

In contrast, Medi-Cal's Aged population represented 9% of the overall population, but accounted for 35% of total spending.

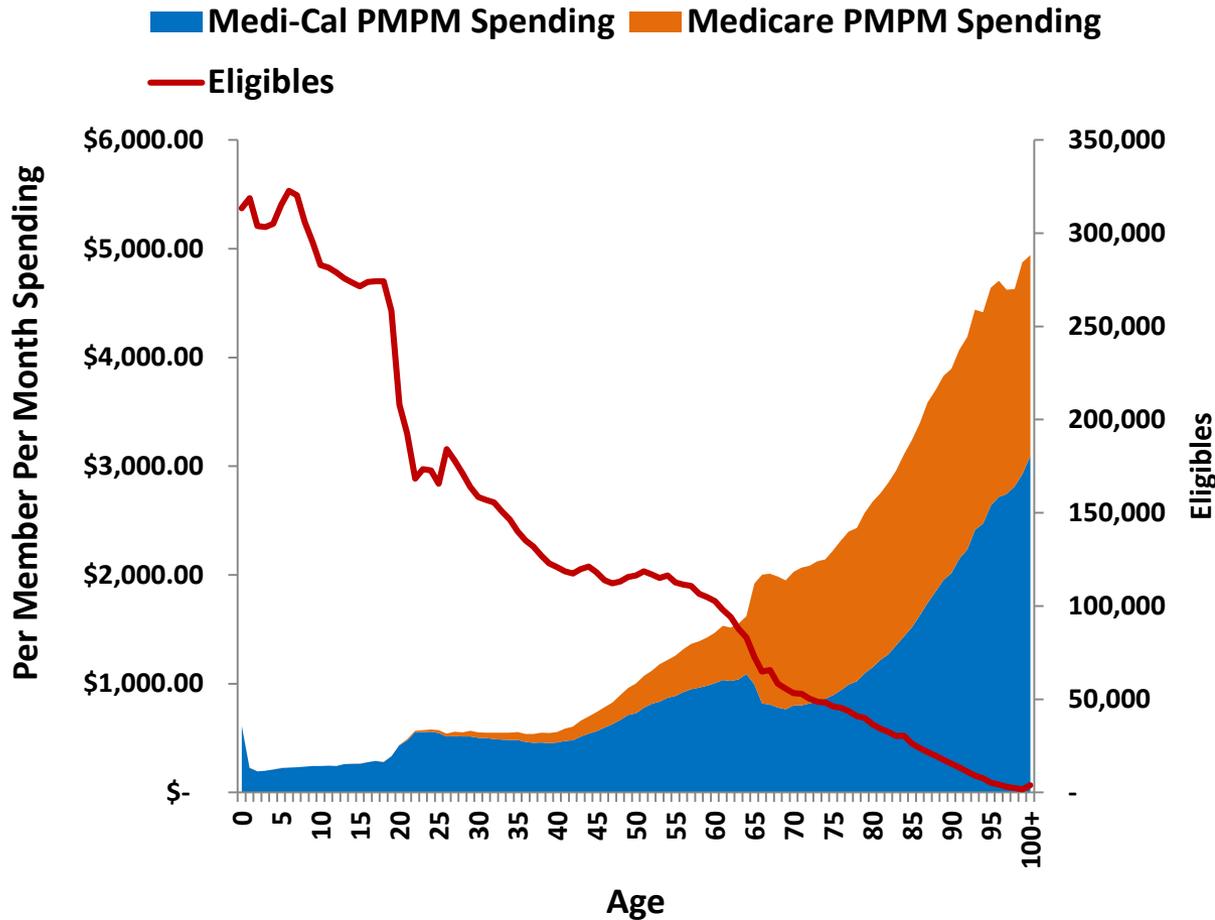
Similarly, Medi-Cal's Disabled population constituted 10% of the overall Medi-Cal population and accounted for 35% of overall spending.

# Age and Health Care Spending – Aggregate Medi-Cal and Medicare Expenditures (FFY 2013-14)



A substantial amount of overall Medi-Cal spending is generated by children and young adults, reflecting their greater numbers in the program. Medi-Cal spending rises sharply between ages 40 and 64, reflecting increasing numbers of disabled individuals in that age range. At age 65 Medi-Cal costs fall, reflecting the transition of responsibility for most coverage to Medicare. However, Medi-Cal's costs do not fall completely, as Medi-Cal is still responsible for providing Long-Term Services and Supports (LTSS).

# Age and Health Care Spending – PMPM Spending

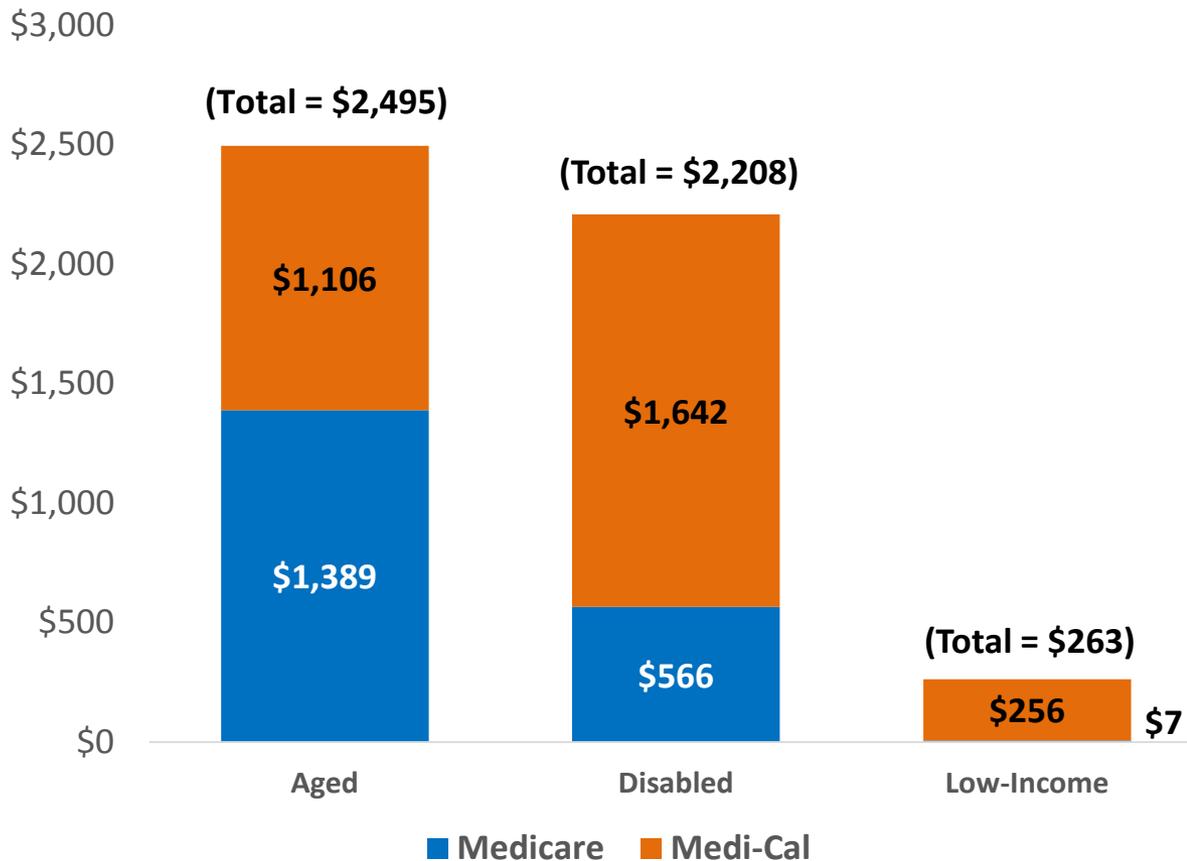


As displayed, “per member per month” (PMPM) spending is low in childhood and increase somewhat during young adulthood, reflecting the increased frequency of pregnancy and delivery.

Spending increases more after age 40, reflecting the increased frequency of disability and chronic disease. Medi-Cal PMPM spending declines somewhat after age 65, but begins steeply rising again at age 75 as the need for LTSS increases.

# How Do PMPM Costs Vary by Eligibility Group?

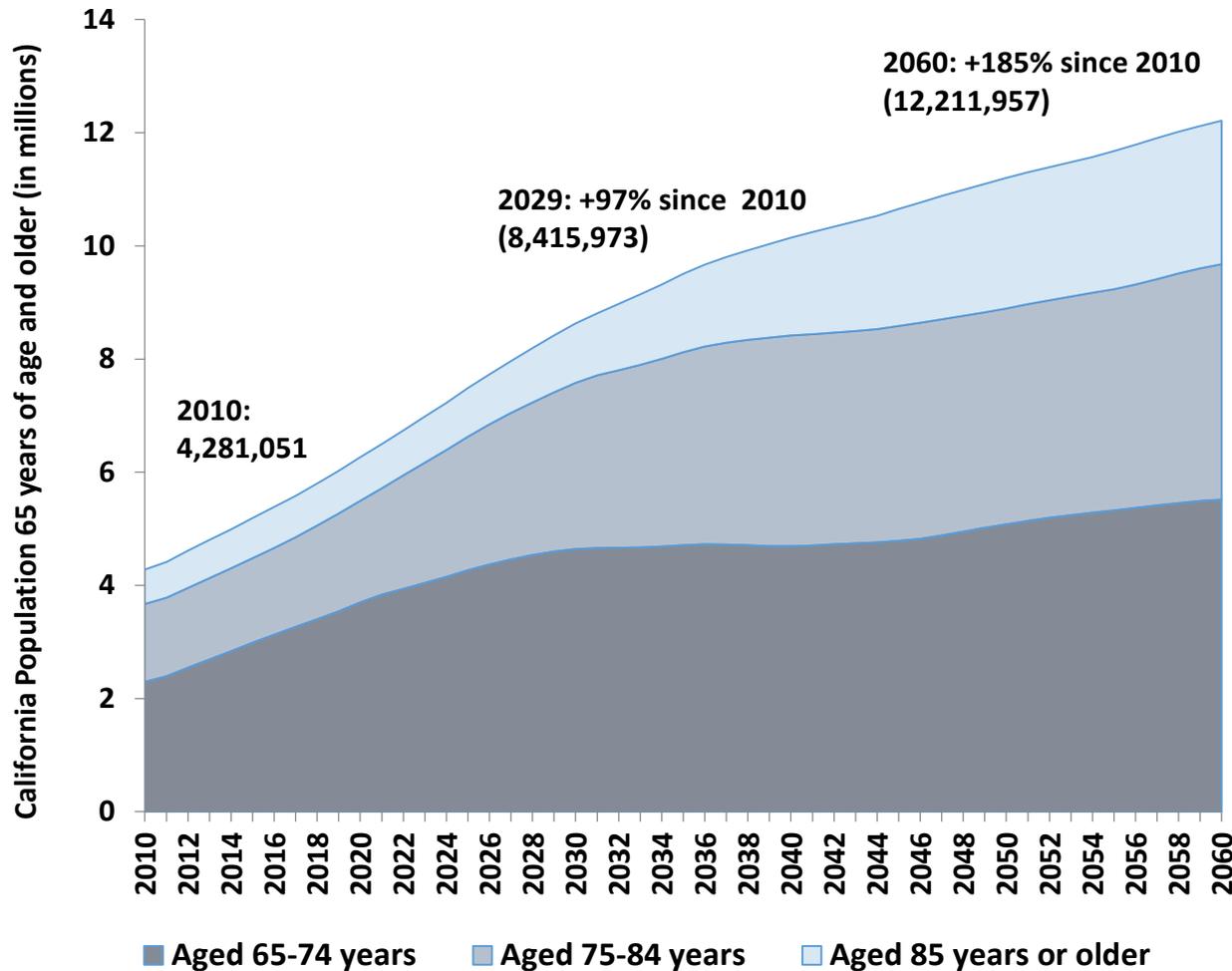
Comparison of PMPM Spending in FFY 2013-14,  
by Eligibility Group



The Aged and Disabled eligibility groups generated the highest combined Medi-Cal/Medicare PMPM spending, illustrating the complex conditions associated with these eligibles.

# Medi-Cal's Aged Population

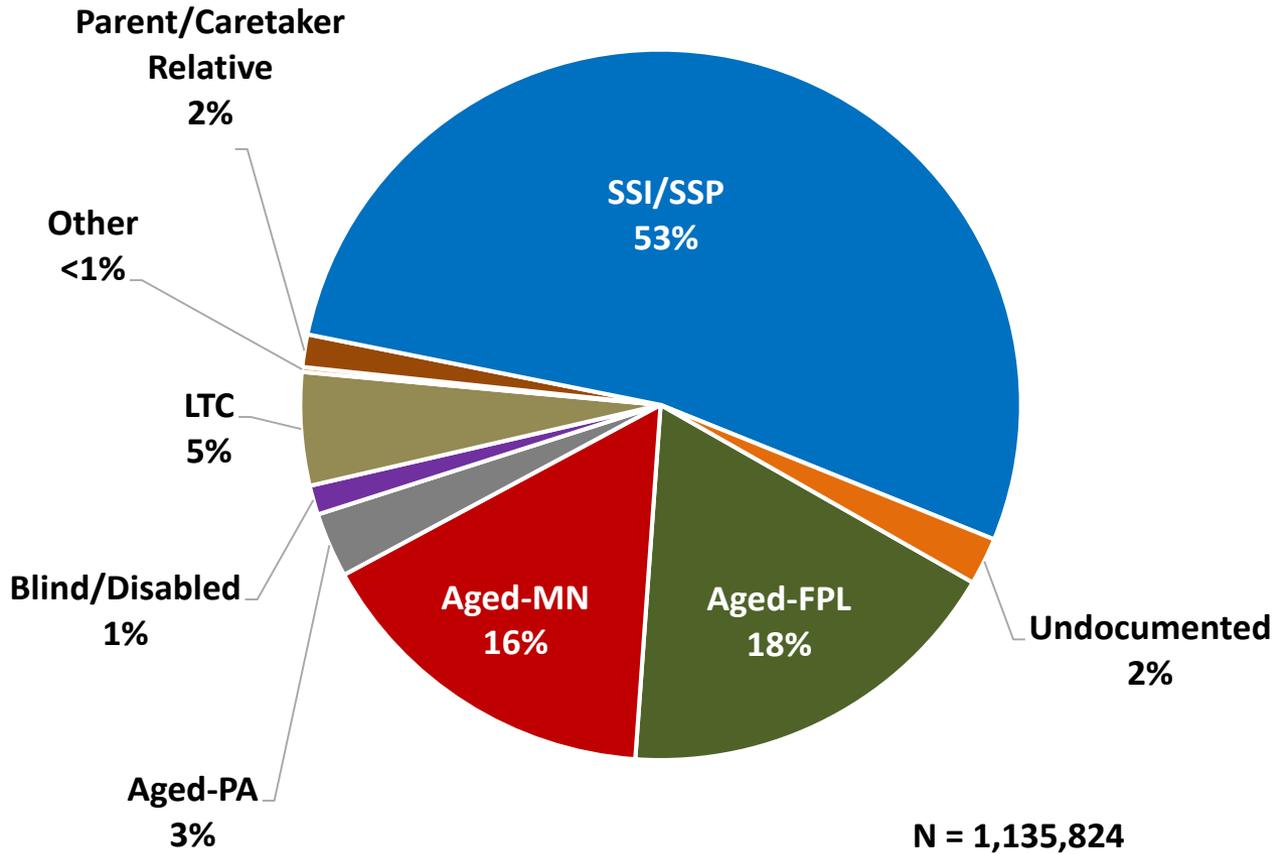
# Projected Growth of the California Population Ages 65 and Older



The California Department of Finance estimated that there are 5.4 million Californians ages 65 and older in 2016. The number increases to 6.2 million by 2020, 8.6 million by 2030, 10.1 million by 2040, and 11.2 million by 2050.

While the number of individuals ages 65 to 74 increases at a lower rate after 2030, the 75-84, and 85+ cohorts will continue to grow at a steeper rate through 2060.

# Eligibility Pathways for Medi-Cal's Aged Population



Source: Medi-Cal and Medicare Eligibility data

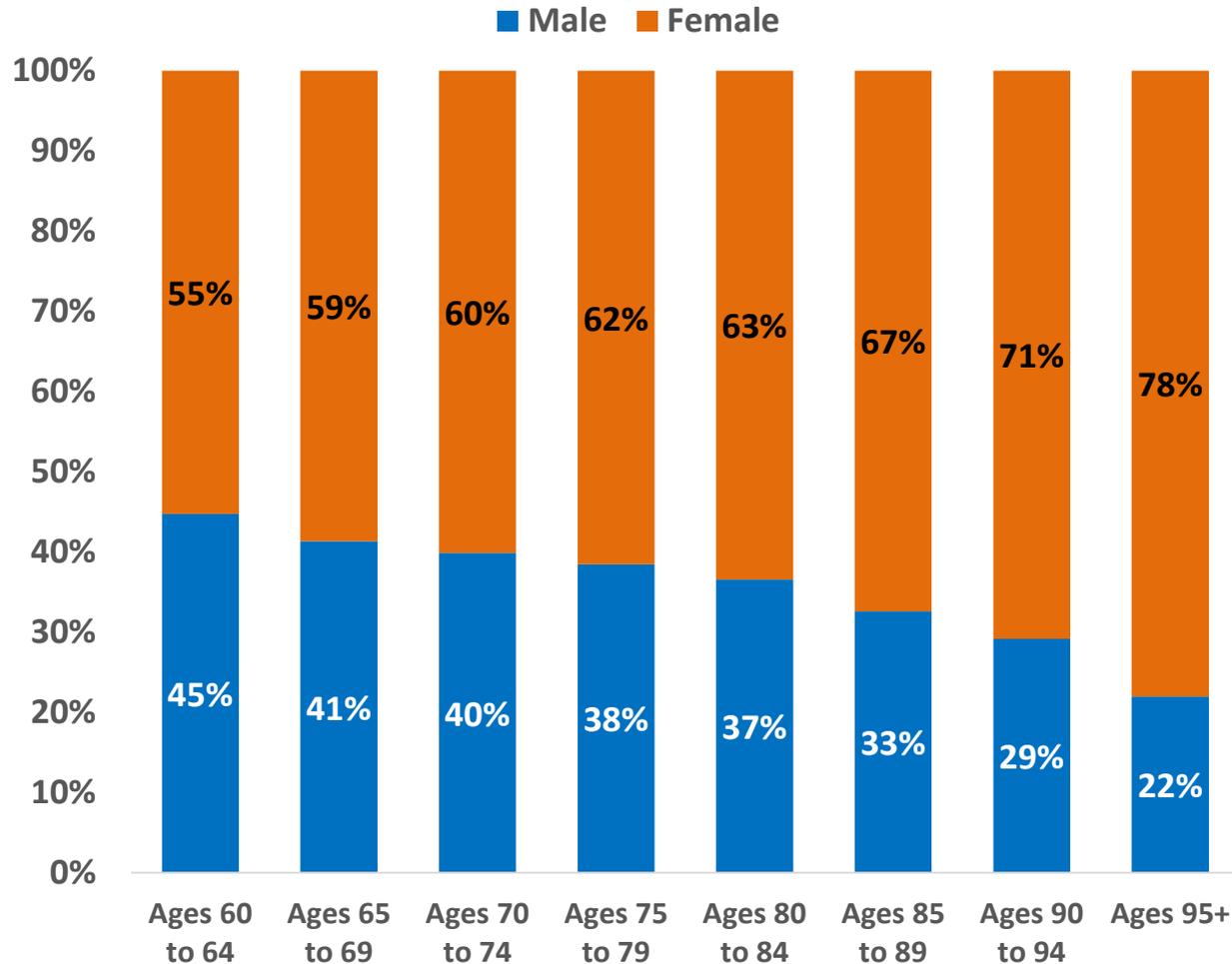
Medi-Cal provides low-income seniors with vital health care coverage.

Fifty-three percent (53%) of the Aged population are categorically eligible because they receive Supplemental Security Income/State Supplemental Payments (SSI/SSP).

Another 18% are eligible because they are enrolled through the Aged Federal Poverty Level program. Sixteen percent (16%) are eligible because they qualify under one of Medi-Cal's medically needy programs. Five percent (5%) qualify because they require LTC services and are unable pay for it. Three percent (3%) qualify through public assistance; 2% qualify as parent/caretaker relatives; 1% qualify due to disability status but do not qualify for SSI/SSP; and a small group qualifies under one of the program's other categories.

# Gender Distribution Changes with Age

Gender Distribution By Age Group

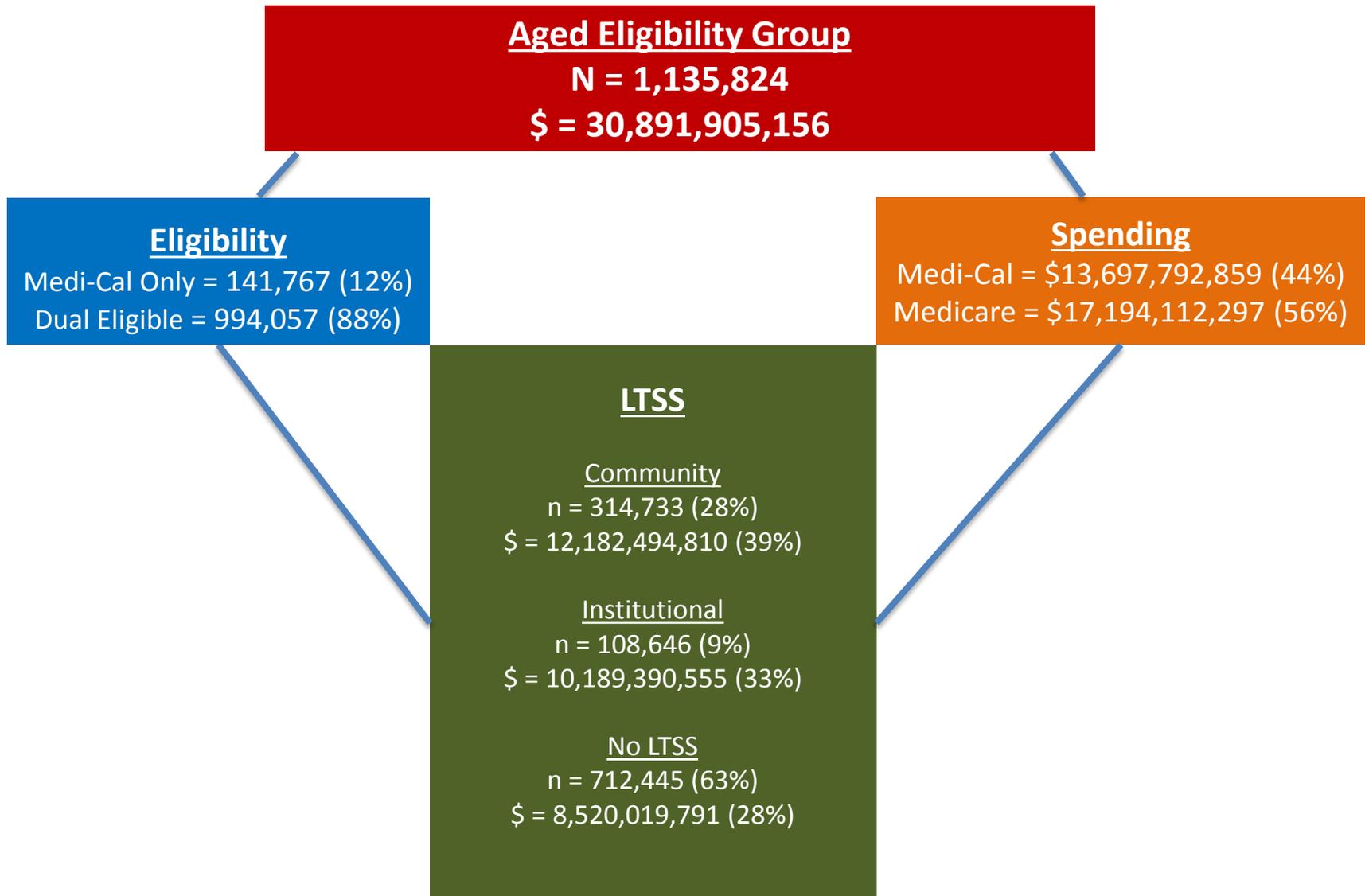


California's aging population consists of more females than males, and this disparity increases with age.

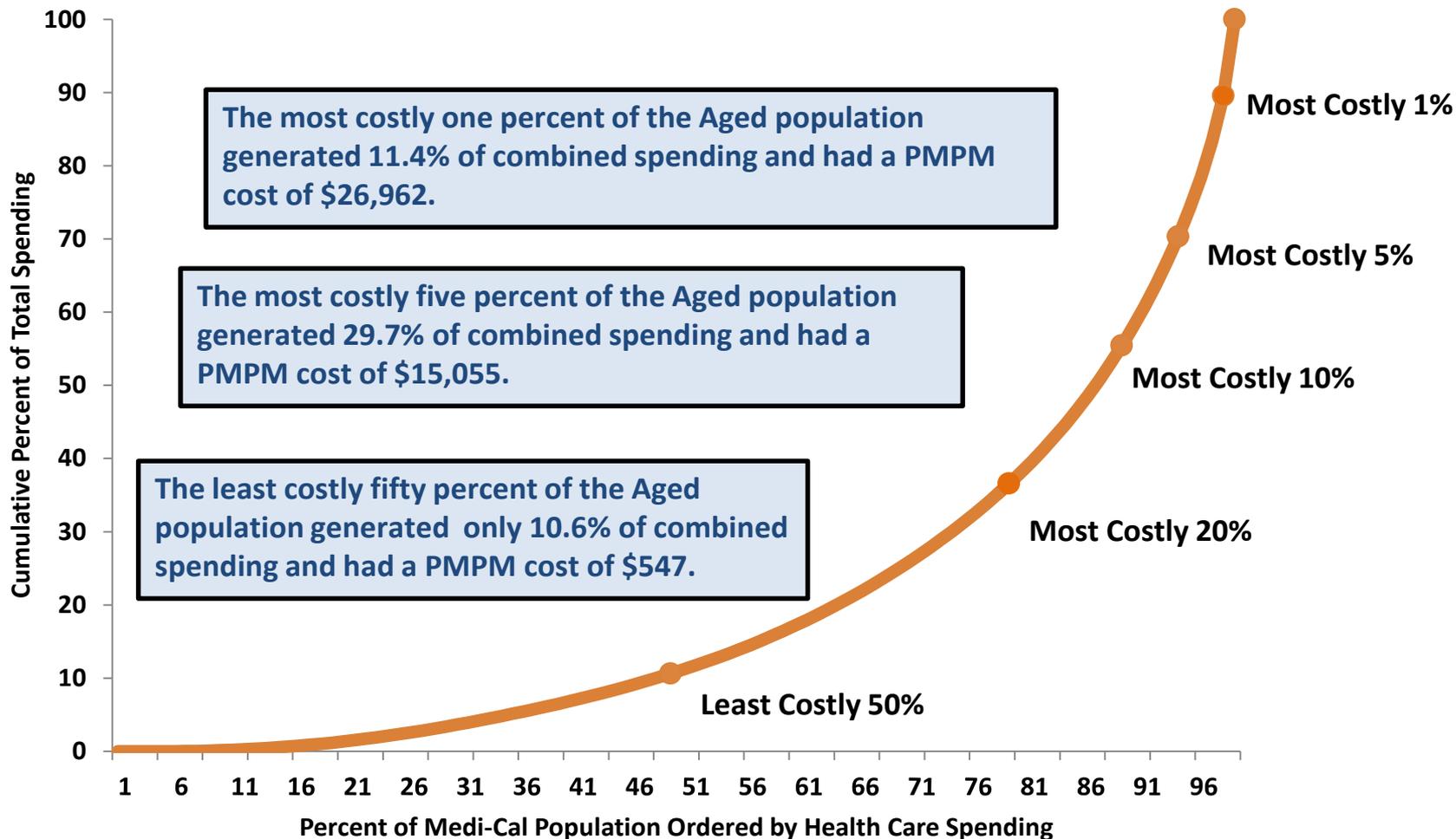
More than any other socioeconomic group, women are disproportionately affected by LTC.

The reason behind this lies in the fact that women live longer than men, on average, and are more likely to develop the functional ailments that require LTC services. Two-thirds of residents in LTC facilities are women.

# The Aged Eligibility Group in FFY 2013-14



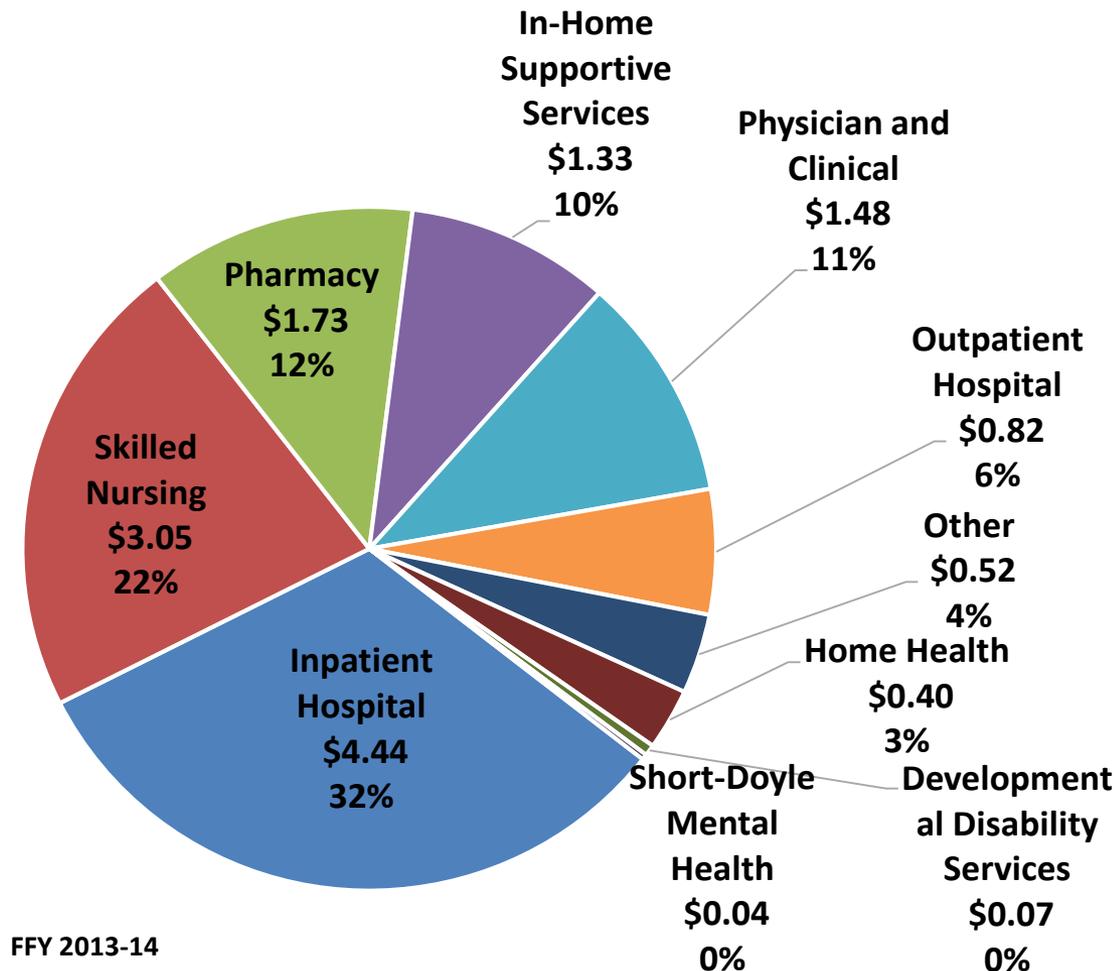
# Concentration of Health Care Spending Within the Aged Eligibility Group



# Combined Spending for Medi-Cal's Aged Eligibility Group, By Service Category (FFS); FFY 2013-14

As displayed, spending for inpatient hospital services account for 32% of all spending.

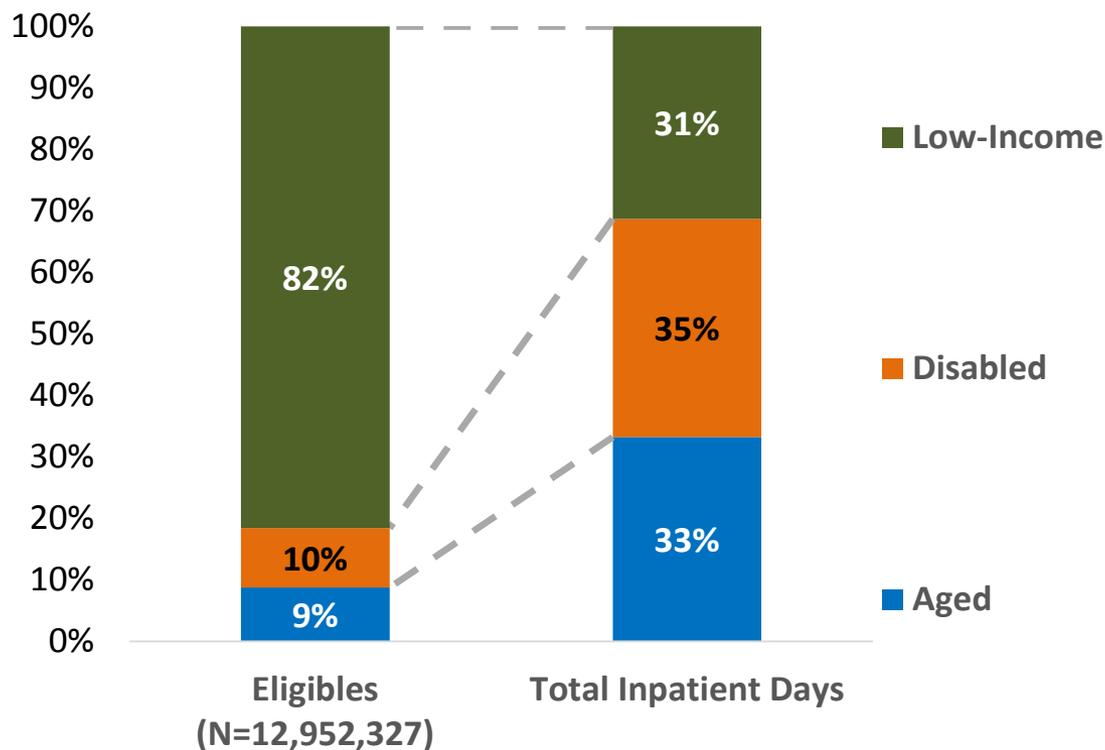
Payments for skilled nursing account for another 22% of spending, pharmacy accounted for 12%, and in-home supportive services account for 10%.



FFY 2013-14

# Aged, Disabled Eligibility Groups Generate Disproportionate Acute-Care Inpatient Hospital Days

Inpatient Acute Hospital Days By Eligibility Group  
FFY 2013-14 Dates-of-Service



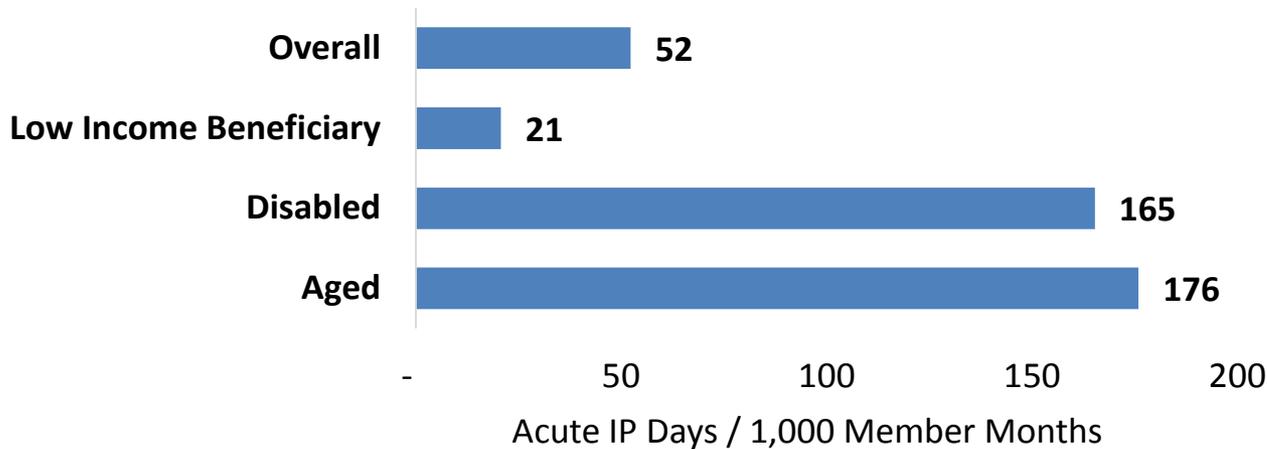
The distribution of acute-care inpatient hospital days generated by each of the three eligibility groups closely mirrors the distribution of overall spending. This is not surprising, since inpatient hospital care is a major driver of spending.

Medi-Cal's Low-Income Eligibility group constituted 82% of the overall population, but accounted for only 31% of hospital days. In contrast, Medi-Cal's Aged eligibility group, representing only 9% of the overall population, accounted for 33% of hospital days.

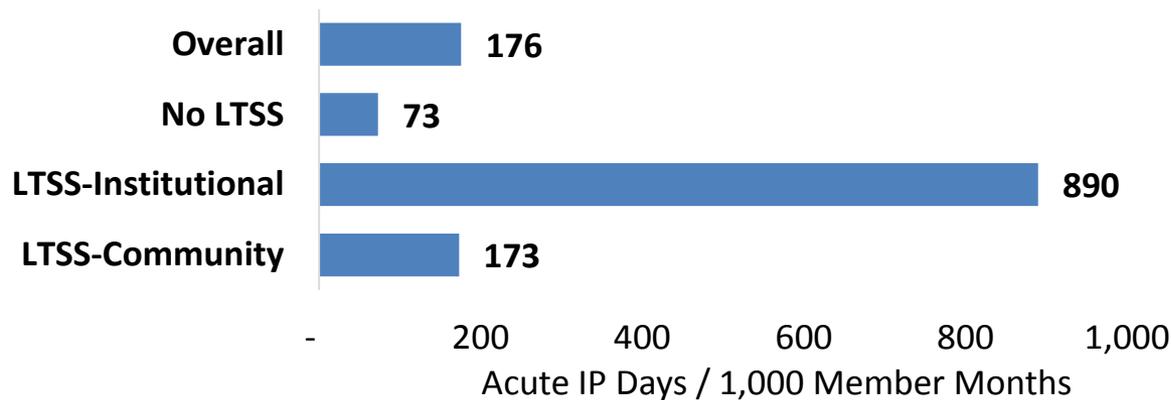
Source: Medicare and Medi-Cal Claims and OSHPD Patient Discharge data

# Acute-Care Inpatient Hospital Days per 1,000 Member Months

Days / 1000 MM By Eligibility Group



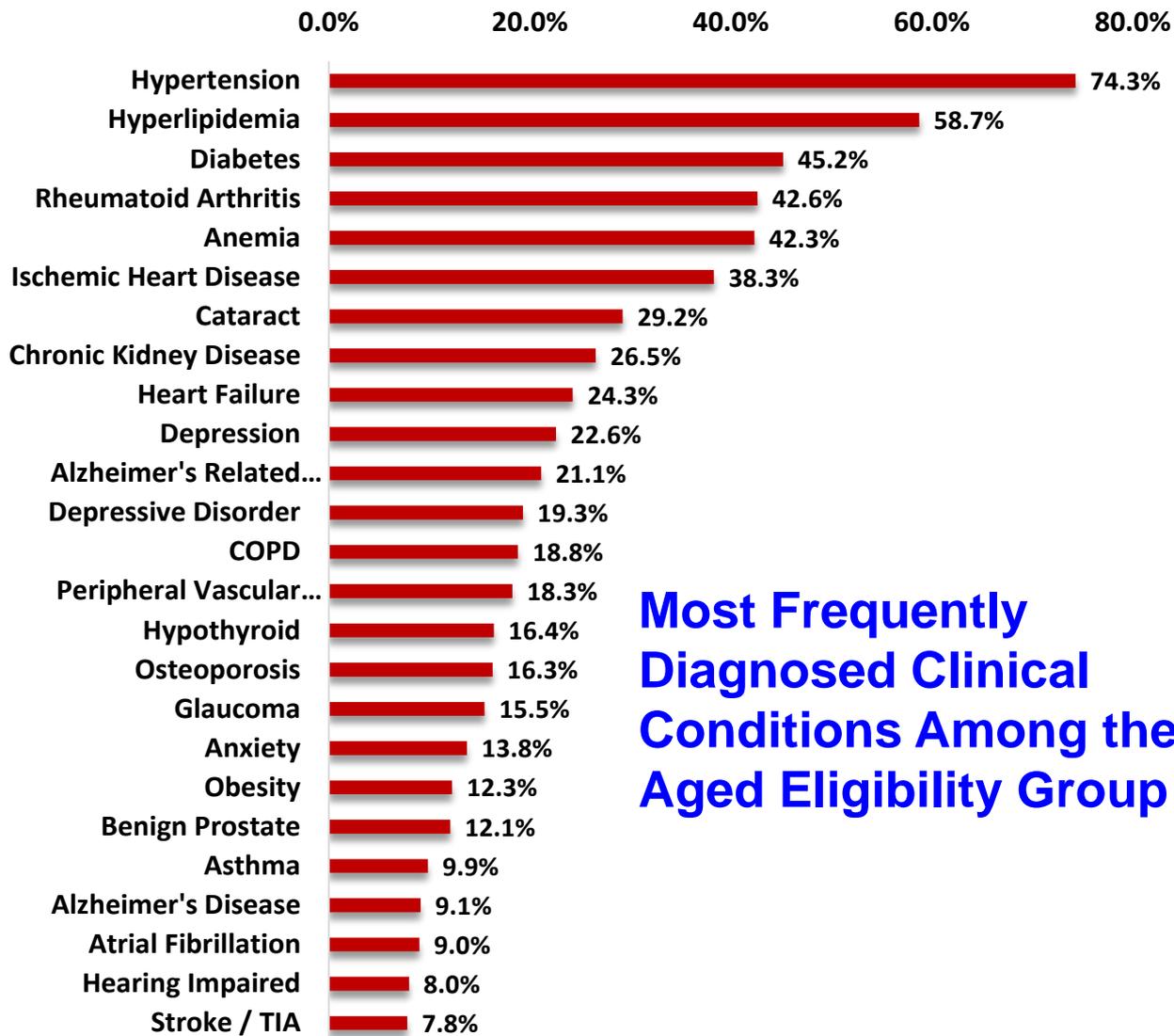
Aged - LTSS Status



Acute-care inpatient hospital use is highest among Medi-Cal's Aged eligibility group.

The Aged eligibility group generated an acute-care inpatient hospital days per 1,000 member months rate that was 3.3 times greater than Medi-Cal's rate overall, and more than 8 times greater than the rate seen in Medi-Cal's Low-Income eligibility group.

Aged individuals residing in LTC facilities had the highest rate (890 days/1,000 member months).



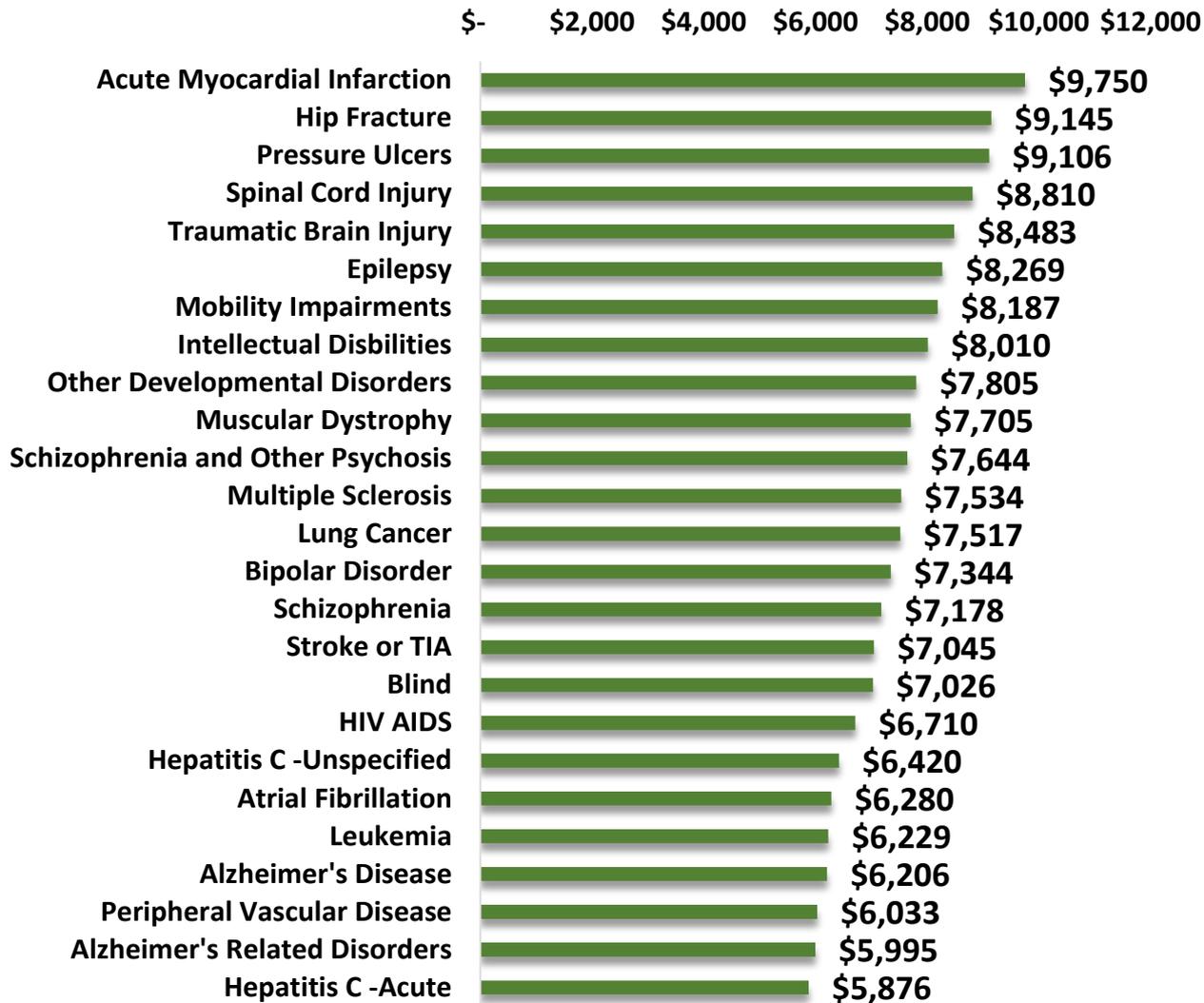
## Most Frequently Diagnosed Clinical Conditions Among the Aged Eligibility Group

Among the Aged eligibility group, the most frequently diagnosed clinical conditions include hypertension (74.3%), hyperlipidemia (58.7%), and diabetes (45.2%).

Alzheimer's and other related disorders were also prevalent among the population (21%).

Source: FFS Medicare and Medi-Cal claims and encounter data for calendar years 2013 and 2014.

# Most Costly Clinical Subpopulations

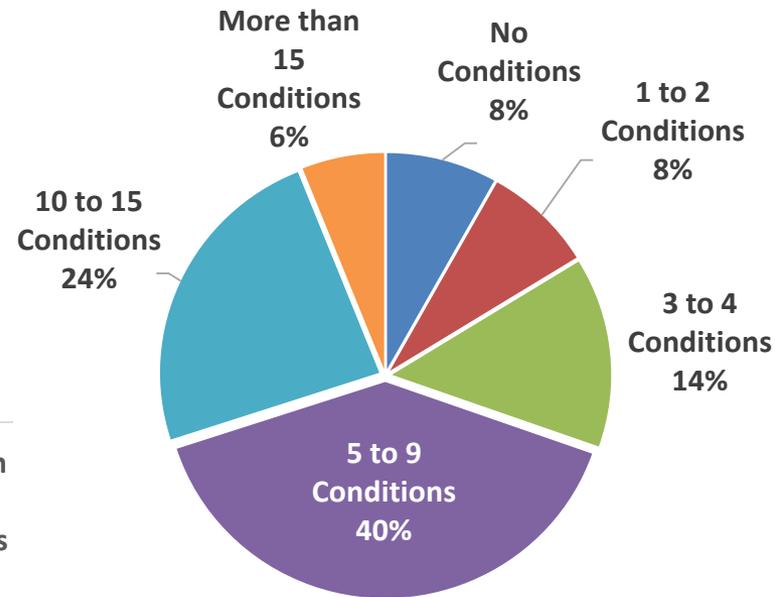
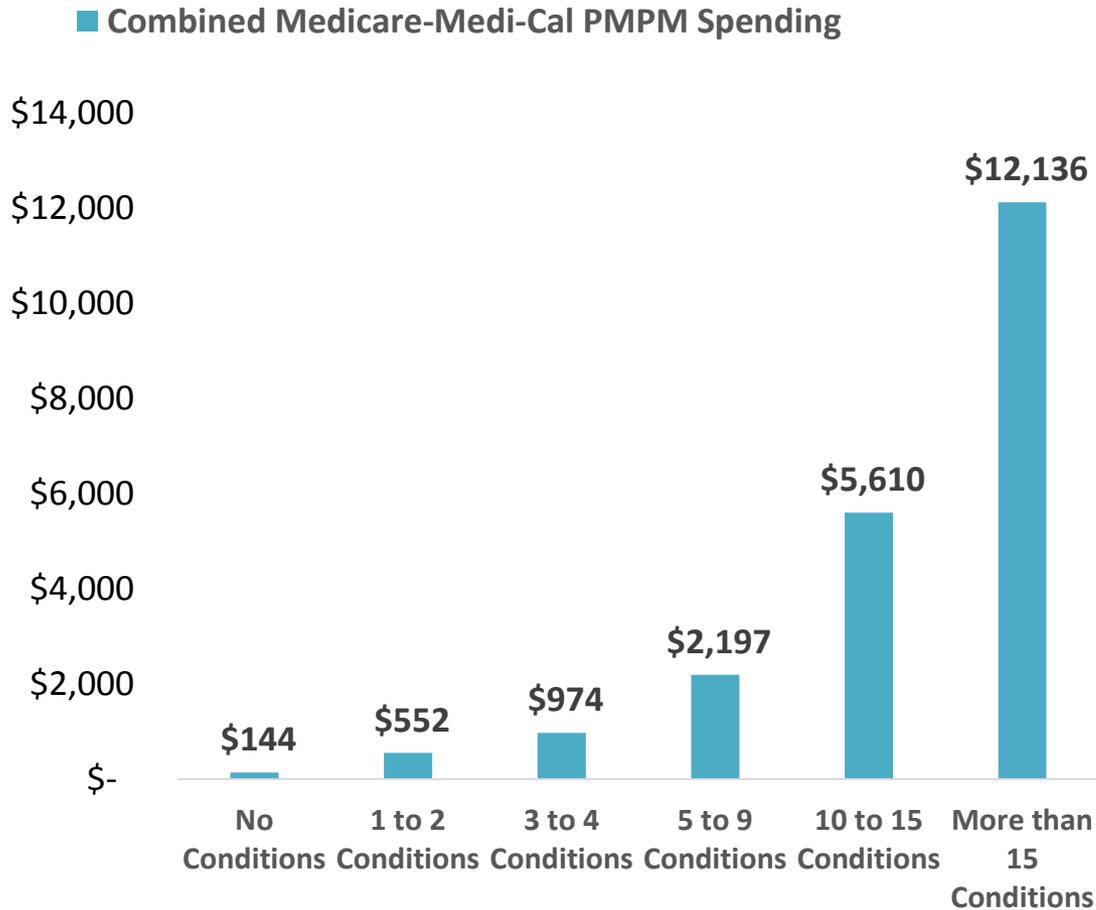


In terms of combined Medicare and Medi-Cal PMPM spending, the most costly clinical subpopulations among the Aged eligibility group included acute myocardial infarction (\$9,750), hip fracture (\$9,145), and pressure ulcers (\$9,106).

Source: FFS Medicare and Medi-Cal claims and encounter data for calendar years 2013 and 2014.

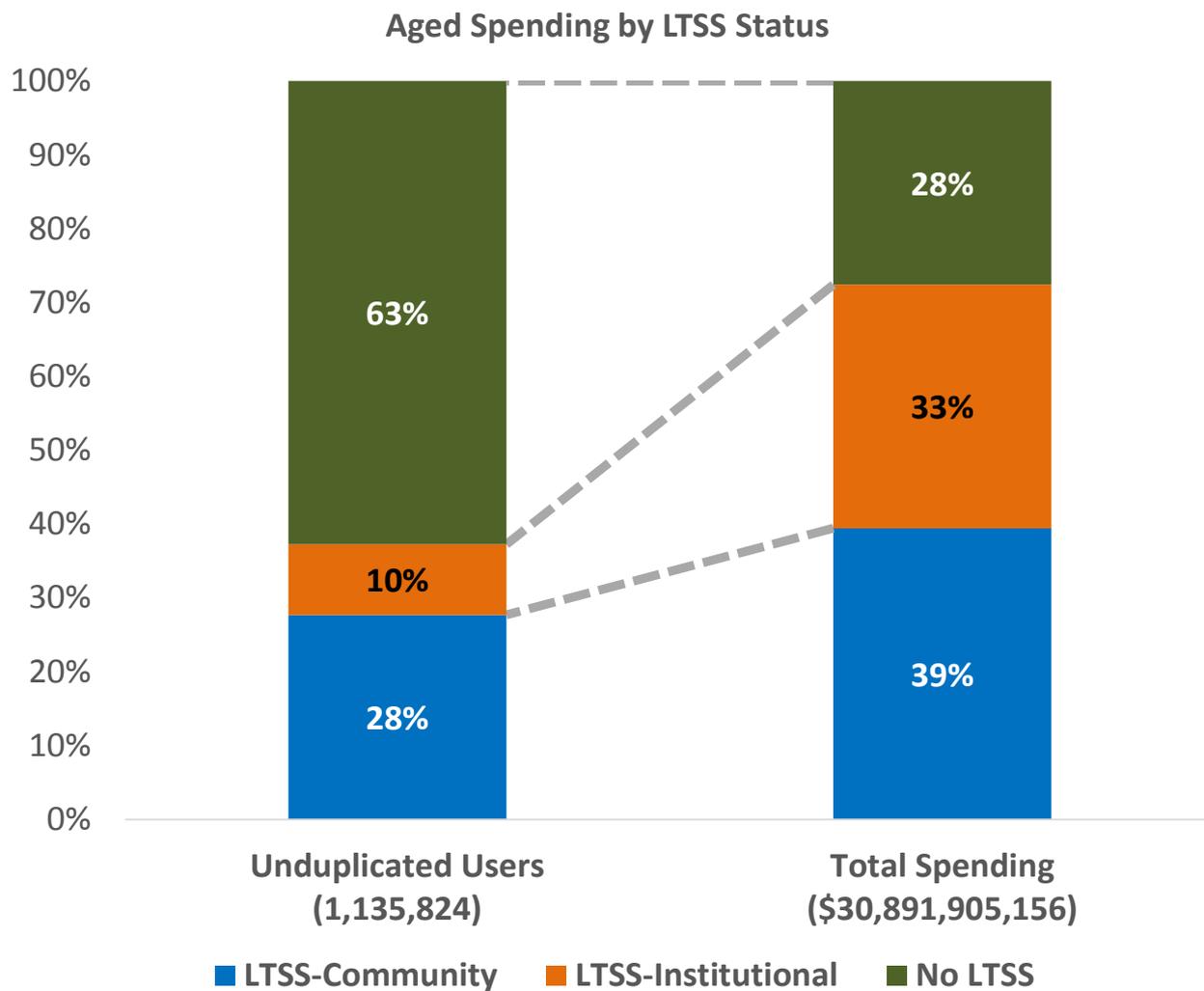
# Impact of Multiple Concurrent Clinical Conditions

The CMS Chronic Condition Warehouse (CCW) algorithm identifies 60 different chronic and potentially disabling clinical conditions.



Source: Medicare claims and encounter data for calendar years 2013 and 2014; CMS Chronic Condition Warehouse (CCW) algorithms utilized to create chronic conditions. PMPM spending represented combined Medi-Cal and Medicare.

# Distribution of Spending for Aged Eligibility Group by LTSS Status



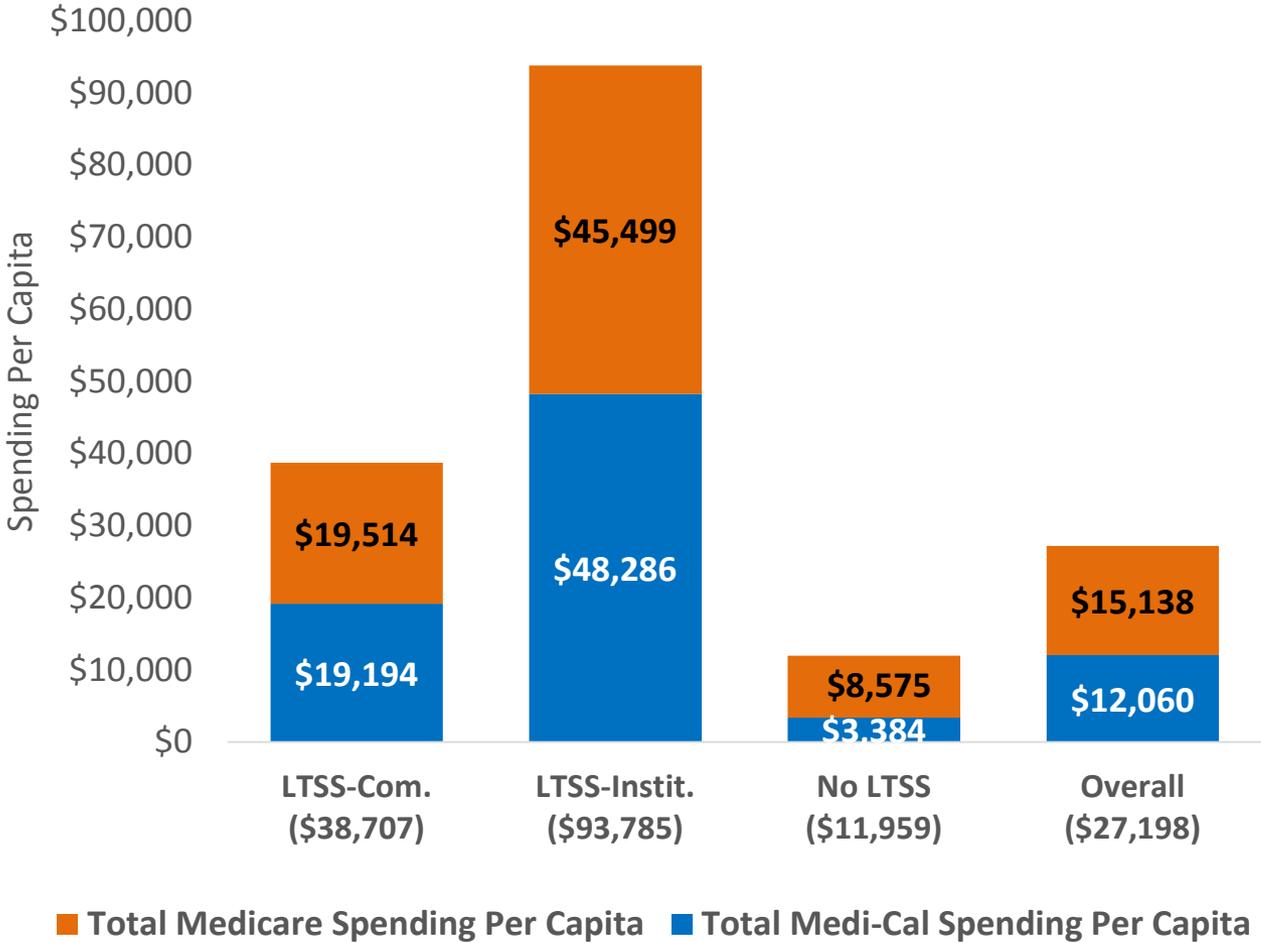
Combined health care spending among Medi-Cal's Aged population is concentrated among those who are institutionalized.

Individuals who were LTC institutional utilizers represented 10% of the Aged population, but accounted for 33% of total combined Medi-Cal and Medicare spending.

Aged individuals who did not use LTSS throughout FFY 2013-14 comprised 63% of the Aged population and accounted for only 28% of overall combined spending.

Members of the Aged population who utilized LTSS not classified as institutional accounted for 28% of the Aged population and generated 39% of overall combined spending.

# Combined Per-Capita Spending for the Aged Eligibility Group by LTSS Status



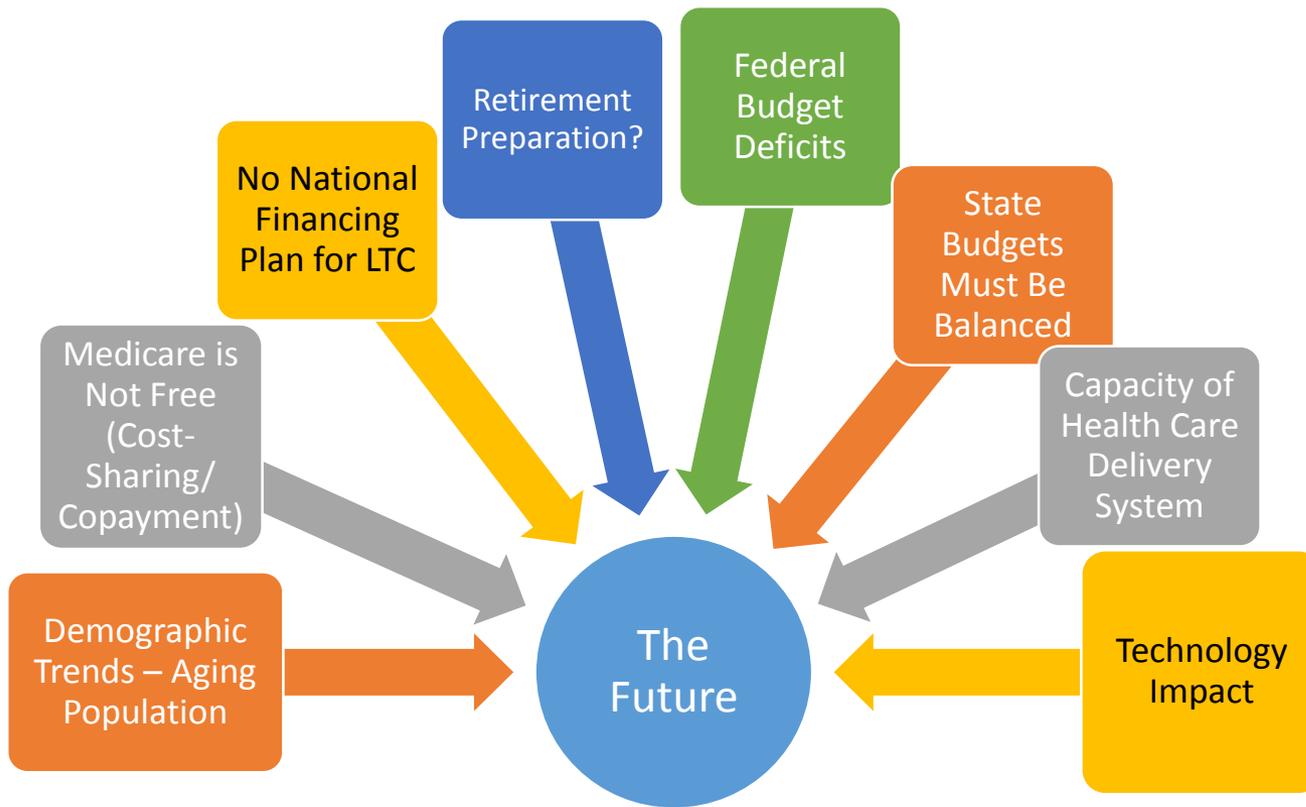
Health care spending per-capita varied significantly based on whether the individuals needed LTSS.

Individuals who utilized institutional LTSS had the highest per-capita cost (\$93,785). Individuals who utilized LTSS not classified as institutional generated per-capita costs of \$38,707. Aged individuals who utilized no LTSS generated a per-capita cost of \$11,959.

Differences in per-capita costs were the result of a number of factors, including age and health conditions.

Source: Medi-Cal and Medicare Eligibility data

# Future of Health Care Faces Pressures



Medicaid, like the nation's entire health care system, will be challenged in the future. The aging population, budget deficits, and competition among limited resources will all require innovative and creative approaches to achieve sustainability.