

Chapter 1: Introduction to the Medi-Cal Program

The Basics of the Medi-Cal Program

Medi-Cal is California's version of the Medicaid program. In the United States, Medicaid is the primary safety net program that provides health care benefits to individuals with low incomes and limited assets, including children, parents, pregnant women, elderly people and those with disabilities.¹ The Medicaid Program should not be confused with Medicare, which is a federal program that serves the health care needs of elderly and some non-elderly individuals with disabilities without regard to their financial circumstances.²

The Medicaid program was established in 1965 as part of President Johnson's War on Poverty.³ Now implemented in all fifty states and U.S. territories, Medicaid provides comprehensive health care coverage to low-income individuals. At the time of publication, Medicaid covered approximately 59 million individuals in the United States.⁴ In California, Medi-Cal provides coverage to about ten million individuals.⁵

Structural Framework

Medicaid is a federal and state cooperative program. This means that both the federal government and the state government provide payment for the provision of services covered under the state's Medicaid plan as well as administrative costs. The federal portion is called "federal financial participation" (FFP) and the rate at which it is paid, which varies state to state, is called the Federal Medical Assistance Percentage" (FMAP).⁶ Currently, California receives FMAP at the rate of 50% for services covered under Medi-Cal.⁷ This means that for most Medi-Cal costs, for each dollar that the state pays, the federal government pays another dollar of the cost of the program.

Additionally, the laws governing the Medicaid program originate from both the federal and state governments. Federal law sets some broad standards and requires states to cover certain "mandatory" groups and offer a basic set of "mandatory" services, while also offering states matching funding to cover "optional" groups of beneficiaries and "optional" services. States with Medicaid programs must follow the federal requirements in implementing their programs, including adoption of minimum standards regarding administration, eligibility, scope of services, and procedural protections.⁸ Agencies that

¹ See Title XIX of the Social Security Act, codified at 42 U.S.C. § 1396 *et seq.*

² See Title XVIII of the Social Security Act, codified at 42 U.S.C. § 1395 *et seq.*

³ See Pub.L. 89-97 (July 30, 1965), Title I §121(a), 79 Stat. 343.

⁴ Kaiser Family Foundation, State Health Facts, Medicaid Enrollment FY 2005, *available at* <http://www.statehealthfacts.org/comparemaptable.jsp?ind=198&cat=4>.

⁵ *Id.*

⁶ See 42 U.S.C. § 1301(a)(8). See also Kaiser Family Foundation, State Health Facts, Federal Matching Rates (FMAP) for Medicaid and Multiplier, *available at* www.statehealthfacts.org/comparetable.jsp?cat=4&ind=184.

⁷ See *id.* Note that a few Medi-Cal services may be eligible for a higher FMAP.

⁸ See, e.g., *Schweiker v. Gray Panthers*, 453 U.S. 36-37, 101 S.Ct. 2633, 69 L.Ed.2d 460 (1981); *Wilder v. Virginia Hosp. Association*, 496 U.S. 498, 500, 110 S.Ct. 2510, 2513, 110 L.Ed.2d 455 (1990).

establish and implement Medicaid policy are found in both the federal government and state governments. At the federal level, the Centers for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration or HCFA) within the U.S. Department of Health and Human Services are responsible for enforcing the statutes and developing regulations for the Medicaid Program.

States voluntarily participate in the Medicaid program, and if a state chooses to participate, it must follow certain broad federal rules. Each state must develop a “state plan” and submit that plan to CMS for approval.⁹ The state plan is the blueprint for how the state will carry out its Medicaid program and includes assurances of how the state will implement the rights and guarantees found in federal law. From time to time, a state will amend its state plan to reflect changes in the law or addition or deletion of Medicaid programs or services. If the federal government approves the state plan, the federal government is agreeing to share the cost of the program in return for the state’s promises to follow the federal requirements.

While the federal government largely sets broader policies for the program, most day-to-day operations are left to the state. In order to carry out the daily operations, each state must name a single state agency that is responsible for overseeing the state’s Medicaid program.¹⁰ In California, that agency is the Department of Health Care Services (prior to July 1, 2007, it was called the “Department of Health Services”) and is housed in the California Health and Human Services Agency.¹¹ This is an important feature of the Medicaid program because, in essence, at the state level, the single state agency is “where the buck stops.”

Unlike many other states, California delegates much of the daily administration of Medi-Cal eligibility processing to its 58 counties.¹² While the qualifying criteria are identical, there are slight variations in eligibility processing procedures in individual counties. Counties may have different names for the agencies that determine Medi-Cal eligibility, may possess different operations manuals or use different computer systems for determining eligibility and recording updates on individuals’ eligibility. In the end, however, a person who is eligible for Medi-Cal in one California county, with the same income, assets, and other relevant criteria, should be eligible for Medi-Cal under the same program in another county.

Provision of Medi-Cal Services

While Medi-Cal eligibility processing is handled by California counties, the provision of services is carried out by health care providers on a Fee-For-Service basis and by managed care plans on a capitated basis. In a Fee-For-Service framework, providers furnish health care services to Medi-Cal beneficiaries and are reimbursed directly by the state government. Providers are paid for each covered service they provide to a beneficiary. In managed care, providers contract with managed care plans which, in turn, contract with the state.¹³

⁹ 42 U.S.C. § 1396a(a).

¹⁰ See 42 U.S.C. § 1396a(a)(5); 42 C.F.R. §§ 431.10 - 431.11.

¹¹ Cal. Health & Safety Code §§ 100100, 100150.

¹² See All County Welfare Directors’ Letters.

¹³ See generally 42 C.F.R. § 438 *et seq.*

Providers are paid by the managed care plan and the managed care plan is paid by the state. Unlike Fee-For-Service, however, managed care plans are not paid for individual services the plans offer. Rather, they are paid on a capitated basis, meaning that the state pays a set monthly amount for each Medi-Cal beneficiary enrolled in the managed care plan regardless of the actual cost of the services the managed care plan provides in a month. Similarly, primary care providers who contract with managed care plans are paid on a capitated basis; specialists, however, tend to be paid on a fee-for-service basis by managed care plans.

As advocates learn how Medi-Cal covers the provision of health care services, it is important to keep in mind that Medicaid is a vendor payment program. This means that health care providers, including hospitals, physicians and others, are vendors whom the California Department of Health Care Services reimburses, or pays, for health care services the providers offer to Medi-Cal beneficiaries. These providers are independent, mostly private, entities who do not work for the federal, state or local government, but voluntarily accept Medicaid reimbursement in exchange for providing services. By establishing Medicaid as a vendor payment program, its founders wanted to enable Medicaid patients to see private providers who also serve privately-insured patients and not create a separate system whereby Medicaid patients would be limited to only government-paid doctors and hospitals.

Legal Framework

The Medicaid Act is part of the larger Social Security Act. Medicaid provisions can be found in Section 1902 of the Social Security Act, codified in 42 U.S.C. § 1396 *et seq.* A table in the Appendix to this Manual outlines where major provisions of the Medicaid Act may be found, both in the Social Security Act as well as in the United States Code. Much of the guidance provided to states about how they must run their Medicaid programs is found not in the Medicaid Act, but in the federal Medicaid regulations, found at 42 C.F.R. § 430 *et seq.* Additional policy guidance from the federal government is found in CMS issued policy manuals, such as the State Medicaid Manual, and policy letters to state health officials.¹⁴ CMS regularly publishes letters such as the Dear State Medicaid Director letter and the Dear State Health Official letter to alert Medicaid directors to news affecting their state's administration of the Medicaid program and also changes in federal law or policy, which often follow Supreme Court decisions or changes in the Medicaid Act or Regulations.¹⁵ It is critical to remember that the Medicaid Act, Regulations and policy manuals and letters explain must comply with the Federal Constitution. Thus, nothing in the way the Medicaid program is run can or should violate the U.S. Constitution. The program must also comport with laws related to the federal Spending Clause, such as those that prohibit discrimination in federally funded programs.

While the federal statute, regulations and policy guidance provide general directives to all states, California has its own statute, regulations and policy guidance governing how

¹⁴ See CENTERS FOR MEDICARE & MEDICAID SERVICES, STATE MEDICAID MANUAL, available at www.cms.hhs.gov/Manuals/PBM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS021927&intNumPerPage=10.

¹⁵ Dear State Medicaid Director Letters and Dear State Health Official Letters by the Center for Medicare and Medicaid Services may be found at: www.cms.hhs.gov/SMDL/.

Medi-Cal specifically should operate. The Medi-Cal statute can be found in the California Welfare and Institutions Code §14000 *et seq.* and the regulations at Title 22 of the California Code of Regulations Section 50000 *et seq.* Policy guidance is provided regularly by the Department of Health Care Services in the form of All County Welfare Directors Letters.¹⁶ Manuals published by the DHCS include the Medi-Cal Provider Manual, the Eligibility Procedures Manual, and the Manual of Criteria.

The Medi-Cal program, as a governmental entitlement program, is also governed by California's constitutional protections and other state laws. Laws prohibiting discrimination apply, and Medi-Cal beneficiaries in managed care plans have the same protections under the Knox-Keene Health Care Service Plan Act as other HMO members.¹⁷

Finding Information about Medi-Cal

While Medi-Cal eligibility ultimately must follow federal and state law, much of the daily determination of eligibility for Medi-Cal and Medi-Cal covered services derives from manuals and letter to the counties and to managed care plans. Most all of these are now available on the Internet, and advocates would be well-advised to bookmark the Web sites for these resources. The Department of Health Care Services has developed several different manuals offering guidance to providers, eligibility workers and beneficiaries. These include the Medi-Cal Eligibility Procedures Manual¹⁸, the Manual of Criteria¹⁹ and the Medi-Cal Provider Manuals and Bulletins.²⁰ For up-to-date information about eligibility processing, advocates should review All County Welfare Directors Letters and Medi-Cal Eligibility Information Letters (MEBILs).²¹ These are letters provided by the Department of Health Care Services to county public social services agencies regarding new or changed policies and/or procedures used in determining eligibility for Medi-Cal benefits. For information about Medi-Cal managed care, the Medi-Cal Managed Care All-Plan and Policy Letters are an important source of information about what the state is advising private health plans to do.²²

Whom to Contact for Help

When health and consumer advocates need assistance in helping clients to obtain access to quality health care services, there are several state and local government and private

¹⁶ All County Welfare Directors Letters are found at: www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/ACWDLbyyear.aspx.

¹⁷ Cal. Health & Safety Code § 1340 *et seq.* For assistance with finding specific provisions in the Knox-Keene Act, see the Health Consumer Alliance publication, Knox-Keene Protections Quick Reference, at: healthconsumer.org/cs016knoxkeene.pdf.

¹⁸ Available online at: <http://www.dhs.ca.gov/mcs/mcpd/meb/Medi-CalEligibilityProceduresManual/default.htm>.

¹⁹ Available online at: http://www.dhcs.ca.gov/formsandpubs/publications/Documents/Medi-Cal_PDFs/Manual_of_Criteria.pdf.

²⁰ Available online at: <http://www.dhcs.ca.gov/ProvGovPart/Pages/BulletinsManuals.aspx>

²¹ Available online at: www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/ACWDLbyyear.aspx. Under the reorganization of the DHCS Web site, the index to the ACWDLs and MEBILs has been moved to this page: www.dhcs.ca.gov/ProvGovPart/county/Pages/default.aspx.

²² Available online at: www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx.

agencies they can contact. Among the private organizations that can offer help is the Health Consumer Alliance (HCA), which is a statewide collaborative of nine consumer assistance programs and two support centers, National Health Law Program and Western Center on Law and Poverty. HCA's local Health Consumer Centers operate in thirteen counties: Alameda, El Dorado, Fresno, Imperial, Kern, Los Angeles, Orange, Placer, Sacramento, San Diego, San Francisco, San Mateo and Yolo. Its mission is to help low-income people obtain essential health care services.

The HCA has information about each of the Medi-Cal programs as well as other consumer-friendly information on its Web site at www.Healthconsumer.org.
