Briefing Paper

Joint Oversight Hearing
Assembly and Senate Committees on Health
Do Medi-Cal Rates Ensure Access to Care?

Wednesday, March 4, 2015
State Capitol, Room 4202
9:30 a.m. – 12:30 p.m.

Purpose

This oversight hearing of the Senate and Assembly Health Committees will examine whether Medi-Cal rates ensure program beneficiaries have access to health care services. The members of the Committees and the public will hear from the Department of Health Care Services (DHCS), the Legislative Analyst's Office, the Bureau of State Audits, and affected stakeholders regarding the following:

- How DHCS currently sets rates for Medi-Cal managed care plans and fee-for-service;
- DHCS compliance with the annual review and revision requirements in existing law for Medi-Cal physician and dental services;
- How Medi-Cal rates compare with other states' Medicaid programs, Medicare rates and rates paid by third party health plans and insurers;
- The impact of the Medi-Cal managed care plan and provider payment reductions currently in effect;
- Whether Medi-Cal rates are sufficient to ensure access to care for Medi-Cal beneficiaries; and,
- How the state determines and monitors whether Medi-Cal beneficiaries have access to care.

Background

The Medi-Cal program provides health care services to nearly 12 million low-income Californians. Medi-Cal is administered by DHCS, and the federal Centers for Medicare and Medicaid Services (CMS) oversees the program to ensure compliance with federal law.

The number of individuals enrolled in California's Medi-Cal program has almost doubled, increasing from 6.6 million in 2007–08 to 11.9 million in 2014-15. Of the 12.2 million people expected to be enrolled in Medi-Cal in 2015-16, 73 percent will be in Medi-Cal managed care plans (8.9 million people) and 27 percent (3.2 million people) will be in Medi-Cal fee-for-service.

While the number of people receiving health care through Medi-Cal has grown dramatically, beginning in 2008, Medi-Cal payment rates to health plans and providers in the program have been reduced to help address the state budget deficits. In 2011, the Legislature passed and Governor Brown signed AB 97 (Committee on Budget), Chapter 3, Statutes of 2011 into law, which largely replaced prior Medi-Cal rate reductions and which remains in effect. Major provisions of AB 97 include the following:

- Reduced Medi-Cal provider payments by 10 percent for fee-for-service (FFS) benefits for dates of service on and after June 1, 2011;
- Required Medi-Cal managed care plan rates to be reduced by the actuarial equivalent amount of the FFS reduction, effective July 1, 2011;
- Froze rates at the 2008-09 rate year and then applied the 10 percent rate reduction for certain types of facility providers;
- Required the payment reductions to be applied retroactively to June 1, 2011 or on such other date as may be applicable when federal approval is obtained;
- Conditioned the implementation of the payment reductions on the reductions complying with federal Medicaid requirements;
- Granted the director of DHCS the discretion to not implement a particular payment reduction or adjustment, or to adjust the payment as necessary to comply with federal Medicaid requirements, to the extent that the director determines that the payments do not comply with the federal Medicaid requirements or that federal financial participation is not available with respect to any payment that is reduced; and,
- Prohibited implementation of AB 97 until federal approval was obtained.

Federal approval of the AB 97 rate reductions was obtained in October 2011, but a court injunction prevented DHCS from implementing many of these reductions. In June 2013, the injunctions were lifted, giving the state authority to (1) apply the reductions to current and future payments to providers on an ongoing basis; and, (2) retroactively recoup the reductions from past payments that were made to providers during the period in which the injunctions were in effect (this is commonly referred to as a "claw back").

Since the 2013-14 budget was enacted, several types of providers and services have been exempted from the ongoing payment reductions through either administrative decisions by DHCS or through subsequently enacted legislation. DHCS administratively exempted from the AB 97 rate reduction the following providers/services:

- Pediatric health care;
- Audiology rates by a particular type of provider;
- Residential care facilities for the elderly and care coordinator agencies;
- Genetic disease screening program;
- Community-based adult services providers located in San Francisco;

- Non-profit dental pediatric surgery centers that provide at least 99 percent of their services under general anesthesia to children with severe dental disease under age 21;
- For-profit dental pediatric surgery centers that provide services to at least 95 percent of their Medi-Cal beneficiaries under age 21; and,
- Certain prescription drugs (or categories of drugs) that are generally high-cost drugs used to treat extremely serious conditions, such as hemophilia, multiple sclerosis, hepatitis.

Medi-Cal managed care plans were also exempt from the retroactive recoupment.

Providers subject to the retroactive payment recoveries include pharmacies, durable medical equipment/supply providers, clinical laboratories/laboratory services, and radiology service providers. DHCS has indicated these retroactive payment recoveries will not occur until after the prospective 10 percent provider payment reductions are implemented, and DHCS has indicated it will provide at least 60 days advanced notification of scheduled recoveries.

DHCS assumes total fund savings from the AB 97 reductions of $550 million ($275 million GF) in 2015-16.

Medi-Cal Rates and Monitoring Access to Care

Many factors affect whether beneficiaries have access to Medi-Cal services. These factors include beneficiaries' health care needs and characteristics, service delivery models, procedures for enrolling and reimbursing qualified providers, the availability of providers in the community, and Medi-Cal service payment rates to providers.

In 2009, Congress created the federal Medicaid and CHIP Payment and Access Commission (MACPAC) to study and make recommendations on beneficiary access to care in Medicaid and the Children's Health Insurance Program (CHIP). MACPAC reviewed 30 years of research and consulted extensively with key stakeholders to develop a recommendation on how to measure access to care for Medicaid beneficiaries. MACPAC's first report to the Congress, published on March 15, 2011, sets out a three part framework for analyzing access to care: (1) enrollee needs; (2) the availability of care and providers; and (3) utilization of services.

Medi-Cal FFS

Medi-Cal rates and access to care requirements vary by FFS versus managed care, and are governed by a complex mix of state and federal laws and regulations, administrative decisions by DHCS and the federal CMS, and court interpretation of federal Medicaid requirements.

Medicaid is a cooperative federal-state program, and in order to qualify for federal funds, states must submit their Medicaid plan and any amendments to CMS. Before approving a Medicaid State Plan Amendments (SPA), CMS conducts a review to determine whether they comply with federal requirements. For the AB 97 FFS rate reductions, the state submitted several SPAs for federal approval. Relevant federal law (Section 1902(a)(30)(A) of the Social Security Act) for the AB 97 SPAs is as follows (emphasis added):

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist

enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area;

As a condition of approval of the AB 97 FFS rate reductions in California's SPA, CMS required DHCS to monitor health care access. DHCS was required to provide metrics which adequately demonstrated beneficiary access to CMS, and a monitoring plan that would apply to the services where rates were being reduced. DHCS developed a health care access monitoring system to better detect if Medi-Cal beneficiaries are experiencing difficulties accessing health care services in FFS Medi-Cal. CMS indicated DHCS would monitor predetermined metrics on a quarterly or annual basis in order to ensure the beneficiary access is comparable to services available to the general population in the geographic area. DHCS indicates it will report on 23 access measures annually and a subset of four access measures quarterly. The four areas reported quarterly are changes in physician supply, Medi-Cal beneficiary participation, service utilization rates per 1,000 member months, and beneficiary feedback.

The Legislative Analyst's Office (LAO) 2014-15 analysis of the health reviewed DHCS' baseline analysis and quarterly monitoring reports. The LAO came away with numerous concerns about the quality of the DHCS data, the soundness of the methodologies, and the assumptions underlying the administration's findings on FFS access. In the LAO's view, these concerns are sufficient to render the administration's public reporting of very limited value for the purpose of understanding beneficiary access in the FFS system. The LAO specifically cited inflated estimates of available FFS physicians, and a flawed construction and interpretation of enrollee-to-physician ratios that failed to take into account physicians accepting new patients. Regarding Denti-Cal coverage (which is primarily provided through FFS Medi-Cal), the LAO stated that, because dental care will remain primarily a FFS benefit for the foreseeable future, it recommended the Legislature enact legislation that would create meaningful standards for monitoring Denti-Cal access.

Medi-Cal Managed Care

Medi-Cal managed care rates are also set under state and federal requirements. State law requires DHCS to pay capitation rates to health plans participating in the Medi-Cal managed care program using actuarial methods under what is commonly referred to as the "Mercer methodology" (Mercer is DHCS' actuarial consulting firm). Medi-Cal managed care plans must provide DHCS with financial and utilization data to establish rates. DHCS is required to utilize a county- and model-specific rate methodology to develop Medi-Cal managed care capitation rates that includes, but is not limited to, all of the following:

- Health plan-specific encounter and claims data;
- Supplemental utilization and cost data submitted by the health plans;
- FFS data for the underlying county of operation or other appropriate counties as deemed necessary by DHCS;
- DMHC financial statement data specific to Medi-Cal operations; and,
- Other demographic factors, such as age, gender, or diagnostic-based risk adjustments, as DHCS deems appropriate.

Federal regulations for Medicaid managed care plans require all payments under risk contracts (such as to Medi-Cal managed care plans) and all risk-sharing mechanisms in contracts to be

actuarially sound. The requirement for actuarially sound capitation rates means capitation rates that:

- Have been developed in accordance with generally accepted actuarial principles and practices;
- Are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- Have been certified by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

For enrollees of Medi-Cal managed care plans, DHCS has requirements for network adequacy in existing law, regulation, contracts with health plans, and through All Plan Letters issued by DHCS. For example, DHCS contractually requires Medi-Cal managed care plans to abide by the time and distance standards in the Knox-Keene Act. The Knox-Keene Act is the body of law regulating health plans, and it requires a primary care physician to be no more than 15 miles or 30 minutes from the place of residence or work of the member unless the member chooses a different provider; the Medi-Cal standard is 10 miles from a member's residence unless the plan has a DHCS-approved alternative. DHCS indicates it evaluates access and ensures that time and distance standards are met by:

- Conducting readiness reviews prior to implementation of managed care expansions or benefit changes;
- Reviewing quarterly network submissions by managed care plans;
- Monitoring grievances and appeals/state fair hearings (to determine if a spike in access complaints occurs at any time);
- Conducting medical audits to review whether access to care needs are being met; and,
- An interagency agreement with the Department of Managed Health Care (which oversees enforcement of the Knox-Keene Act) for the transition of populations into Medi-Cal managed care. The interagency agreement focuses on financial audits, medical surveys and network adequacy reviews.

In addition, the Knox-Keene Act requires Medi-Cal managed care plans (except for County Organized Health Systems, which are exempt from the Knox-Keene Act) to make all services be readily available at reasonable times to each enrollee consistent with good professional practice. Regulations implementing the Knox-Keene Act require timely access to care by requiring urgent and non-urgent appointments to be provided within specified timeframes. Health plan members have the right to appointments within the following time frames:

Urgent Appointments	**Wait Time**
For services that don't need prior approval	48 hours
For services that do need prior approval	96 hours
Non-Urgent Appointments	**Wait Time**
Primary care appointment	10 business days

Specialist appointment	15 business days
Appointment with a mental health care provider (who is not a physician)	10 business days
Appointment for other services to diagnose or treat a health condition	15 business days

In its 2014-15 health budget write-up, the LAO stated Medi-Cal managed care has overtaken and surpassed FFS as the primary Medi-Cal service delivery system. While the LAO noted that the amount of attention devoted to FFS issues related to AB 97 rate reductions is understandable, it is increasingly important to exercise oversight over access to services in Medi-Cal managed care, given the state's growing reliance on managed care to cover more complex groups of beneficiaries and services as the majority of Medi-Cal beneficiaries are mandatorily enrolled in managed care.

The LAO stated, in concept, that shifting beneficiaries and services from FFS to managed care should also improve the state's monitoring of access to care in the Medi-Cal program as there are no state statutory guidelines for interpreting adequate access in FFS Medi-Cal, other than compliance with the broad equal access provision of federal Medicaid law. The LAO recommended the Legislature focus the majority of its oversight on managed care access, including on-going monitoring of managed care access and the meaningfulness of existing access standards and the Administration's performance in monitoring plans' compliance with those standards.

While Medi-Cal managed care plan rates are subject to the AB 97 rate reduction, the DHCS budget also contains a placeholder increase of 3.57 percent ($581 million total funds/$281 million GF) based on the 2103-14 to 2014-15 overall rate increase. DHCS indicates actual managed care rate adjustments for 2015-16 will be available for the May 2015 budget revision.

Do Medi-Cal Rates Ensure Access to Care?
Despite the state requirement for an annual review of physician and dental rates, the federal requirement for actuarially sound capitation rates, and the federal requirement that payments are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population, multiple studies have found Medi-Cal rates are below those paid by other payors, and access to care for Medi-Cal beneficiaries is not the same as for individuals with employer-sponsored insurance (ESI). Surveys of Californians conducted before coverage expansions enacted under the ACA consistently showed a wide gap between Medi-Cal enrollees and other insured populations with respect to access to care.

- A 2011 survey funded by the California HealthCare Foundation (CHCF) of over 1,500 Medi-Cal beneficiaries identified difficulties in finding health care providers who accept their coverage, as 34 percent of Medi-Cal beneficiaries said it was difficult to find health care providers who accept their insurance, compared to 13 percent for people with other coverage. The survey found a higher percentage of adults with Medi-Cal say they have more difficulty getting appointments with specialists and primary care providers than adults with other health coverage (42 percent v. 24 percent for specialists and 26 percent v. 15 percent for primary

care providers).

- The 2012 California Health Interview Survey asked how access to care in Medi-Cal compares to employer-sponsored insurance (ESI) for adults with similar health care needs. Medi-Cal had worse gaps in potential access to care, including Medi-Cal beneficiaries being less likely to have a usual source of care other than the emergency room as compared to individuals with ESI (21.5 percent v. 8.1 percent), Medi-Cal beneficiaries were more likely to have the emergency room as their usual source of care compared to individuals with ESI (3.7 v. 0.5 percent), and Medi-Cal beneficiaries were sometimes/never able to get a physician appointment within two days of seeking an appointment compared to individuals with ESI (46 percent v. 20.6 percent).

- DHCS' Medi-Cal Managed Care 2013 Consumer Assessment of Healthcare Providers and Systems (CAHPS) provides the results of a member satisfaction survey conducted of adult and child members of Medi-Cal managed care plans during the first half of 2013. DHCS contracted with Health Services Advisory Group, Inc. (HSAG) to conduct the CAHPS surveys to assess the perceptions and experiences of Medi-Cal managed care program beneficiaries and evaluate the quality of the health care services they receive. HSAG administered the surveys to approximately 24,000 adult members and parents or caretakers of child members in 22 Medi-Cal managed care plans.

  In assessing the Medi-Cal managed care plans' strengths and weaknesses across the CAHPS global ratings and composite measures, twenty-eight out of 44 Medi-Cal managed care plans demonstrated poor performance for "Rating of Health Plan," and 32 Medi-Cal managed care plans demonstrated poor performance for the "Getting Care Quickly" measure. For the "Getting Needed Care" CAHPS measure, the survey results showed below-average performance, with the overall Medi-Cal managed care plans rating for the adult population being fair and the overall Medi-Cal managed care plans rating for the child population being poor when compared to national Medicaid data.

In addition to surveys of beneficiaries, surveys of physicians and dentists have found lower participation in Medi-Cal and lower reimbursement rates as compared to Medicare and private insurance.

- A survey of physicians through the Medical Board of California found the percentage of California physicians accepting new patients in 2013 was 62 percent for Medi-Cal, compared to 79 percent for private insurance and 75 percent for Medicare. The percentage of physicians with any Medi-Cal patients in their practice (69 percent) was significantly lower than the percentage with any Medicare patients (77 percent) and much lower than the percentage with any privately insured patients (92 percent).

- A December 2012 publication by the Kaiser Commission on Medicaid and the Uninsured showed how states compare in their 2012 Medicaid fee levels, and how Medicaid fees compared to Medicare fees. In California, Medi-Cal fees for all services were 51 percent of Medicare, primary care physician fees were 43 percent of Medicare, and obstetrical care services were 54 percent of Medicare.

- A December 2014 Bureau of State Audits (BSA) audit of the Denti-Cal program that, while number of active provider statewide appears sufficient to provide services to children, some counties may not have enough providers to meet the dental needs of child beneficiaries. BSA reported five counties may lack active providers, an additional 11 counties had no providers willing to accept new Medi-Cal patients, and 16 other counties appear to have an insufficient number of providers.

  BSA found the utilization rate for Medi‑Cal dental services by child beneficiaries is low relative to national averages and to the rates of other states. BSA's analysis of federal data from federal fiscal year 2013 (October 1, 2012 through September 30, 2013) shows that California had the 12th worst utilization rate for Medicaid children receiving dental services among 49 states and the District of Columbia (data from Missouri was unavailable). According to the data, only 43.9 percent of California's child beneficiaries received dental services in federal fiscal year 2013 while the national average for the 49 states and the District of Columbia was 47.6 percent. Utilization rates for the individual states ranged from a low of 23.7 percent in Ohio to a high of 63.4 percent in Texas. Denti-Cal statewide utilization rates for child beneficiaries for 2013 were 41.4 percent.

  The BSA stated a primary reason for low dental provider participation rates is low reimbursement rates compared to national and regional averages and to the reimbursement rates of other states BSA examined. For example, California's rates for the 10 dental procedures most frequently authorized for payment within the Medi‑Cal program's FFS delivery system in 2012 averaged $21.60, which is only 35 percent of the national average of $61.96 for the same 10 procedures in 2011.

Legislation to Address Medi-Cal Rates and Access to Care

In 2013, AB 900 (Alejo) and SB 646 (Nielsen) would have eliminated scheduled Medi-Cal payment reductions for distinct-part skilled nursing facilities that were part of AB 97, and SB 640 (Lara) would have eliminated the 10 percent Medi-Cal rate reduction required by AB 97. All three measures were held on their respective houses' Appropriations Committee suspense files.

Last year, AB 1805 (Skinner) would have eliminated the 10 percent Medi-Cal rate reduction required by AB 97 for dates of service on and after June 1, 2011. In addition, AB 1759 (Pan and Skinner) would have made permanent the ACA required temporary reimbursement rate increase for specified Medi-Cal primary care providers, beginning January 1, 2015 (the ACA required states to increase Medicaid primary care physician service rates to 100 percent of Medicare rates for services provided from January 1, 2013 through December 31, 2014). Neither bill became law.

To ensure better transparency regarding health plan provider networks, SB 964 (Hernandez), Chapter 573, Statutes of 2013, required health plans to submit to DMHC information regarding network adequacy, including, but not limited to:

- Provider office location;
- Area of specialty;
- Hospitals where providers have admitting privileges;
- Providers with open practices;
- The number of patients assigned to a primary care provider; and,

- Grievances regarding network adequacy and timely access that the health plan received during the preceding calendar year.

For plans that use a different network for its Medi-Cal managed care product line than its other product lines, plans must submit data for its Medi-Cal managed care product line separately from the data submitted for its other product lines. Plans must also submit this information to DHCS.

This year, SB 243 (Hernandez) and AB 366 (Bonta) are two identical companion bills that have been introduced to:

- Repeal implementation of prior year Medi-Cal rate reductions, including the AB 97 10 percent reduction for affected Medi-Cal providers;
- Increase payment rates for specified outpatient health care providers up to Medicare payment levels;
- Increase hospital Medi-Cal rates on a one-time basis and require annual increases thereafter; and,
- Require the Department of Health Care Services (DHCS) to pay Medi-Cal managed care plans at the upper end of their rate range so as to ensure a more robust Medi-Cal provider network in Medi-Cal managed care.

Policy questions for discussion:

1. Should the AB 97 reductions have a sunset date?

2. What criteria did DHCS use to administratively exempt some health care providers but not others from the retroactive recoupment requirement of AB 97?

3. For health care providers providing emergency services (hospital emergency department, emergency room physicians, and ambulance providers) who have to provide services without questioning the ability of a patient to pay, how should access to these providers be determined given that these providers effectively cannot opt out of participation in Medi-Cal?

4. What effect does lack of access to care in Medi-Cal have on Medi-Cal beneficiaries?

5. How do rates in Medi-Cal compare to rates in Medicare and rates paid by other third party payors?

6. What should be the state fund source used to increase Medi-Cal rates?