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Medi-Cal: Overview and Payment Issues

LEGISLATIVE ANALYST'S OFFICE

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Assembly Committee on Public Health and
Developmental Services
Second Extraordinary Session
Hon. Rob Bonta, Chair





Overview of Presentation



Medi-Cal Overview

- Coverage.
- Financing.
- Delivery systems and payment structures.



Medi-Cal Payment Issues

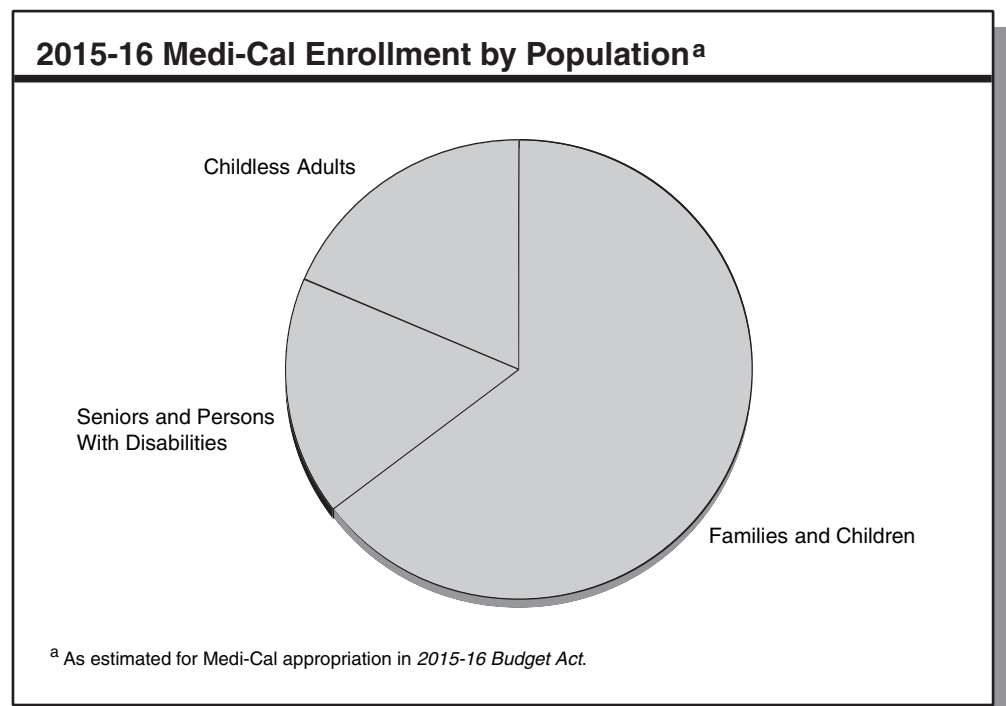
- Budget reductions.
- Select legislative actions to eliminate reductions.
- Legislative proposal to increase rates.



Medi-Cal Overview: Coverage

Medi-Cal is California’s version of the federal-state Medicaid program, which provides health coverage to low-income people. Medi-Cal is by far the state’s largest health program in terms of annual caseload and expenditures. In 2015-16, Medi-Cal is estimated to provide coverage to over 12 million people, at a total fund cost of \$91 billion (\$18 billion General Fund).

☑ **Eligibility and Recent Expansion.** Until recently, Medi-Cal eligibility was mainly restricted to low-income families with children, seniors and persons with disabilities (SPDs), and pregnant women. As part of the Patient Protection and Affordable Care Act (ACA), beginning January 1, 2014, the state expanded Medi-Cal eligibility to include additional low-income populations—primarily childless adults. In 2015-16, over 2 million newly eligible individuals are expected to be enrolled as a result of this expansion.





Medi-Cal Overview: Coverage *(Continued)*



Benefits. Medi-Cal covers a wide range of health-related services, some of which are listed below. (Most Medi-Cal benefits are overseen at the state level by the Department of Health Care Services [DHCS], although some benefits are administered by other state departments.)

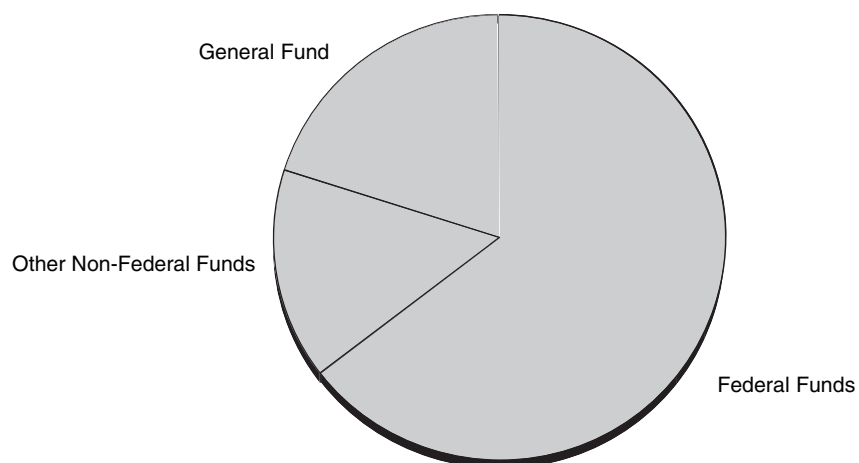
- **Physical Health Care.** Federal law establishes minimum benefit requirements for state Medicaid programs, including physician and hospital services. Medi-Cal also covers services considered optional under federal law, such as prescription drugs.
- **Long-Term Services and Supports (LTSS).** Medi-Cal provides a variety of LTSS, mainly for SPDs. This includes institutional care in skilled nursing facilities (SNFs) and home- and community-based services.
- **Behavioral Health.** Medi-Cal covers an array of mental health and substance use disorder services.



Medi-Cal Overview: Financing

- Medi-Cal Is a Federal Matching Program.** The costs of the Medi-Cal program are generally shared between the state and the federal government. For most families and children, SPDs, and pregnant women, the federal government pays one-half of Medi-Cal costs for providing services to these populations. For a subset of children with higher incomes, the federal government pays 65 percent of the costs. Finally, under the ACA, the federal government currently pays 100 percent of the costs for the newly eligible population. The federal share for this population will phase down to 90 percent by 2020 and thereafter.
- State's Share Financed Through Various Sources.** While the General Fund pays the bulk of the state's share of Medi-Cal costs, federal law also permits the state to finance its remaining share through various non-General Fund sources. These include (1) certain expenditures and transfers by counties and other local governments, and (2) health care-related taxes (described on the next page).

2015-16 Medi-Cal Funding by Source^a



^a As appropriated in 2015-16 Budget Act.



Medi-Cal Overview: Financing *(Continued)*



Health Care-Related Taxes. Federal Medicaid law defines a *health care-related tax* as a licensing fee, assessment, or other mandatory payment that is related to the provision of or payment for health care services or items. In many cases, states collect these payments from health care providers to help finance the nonfederal share of their Medicaid expenditures. Below, we list three of California's major health care-related taxes.

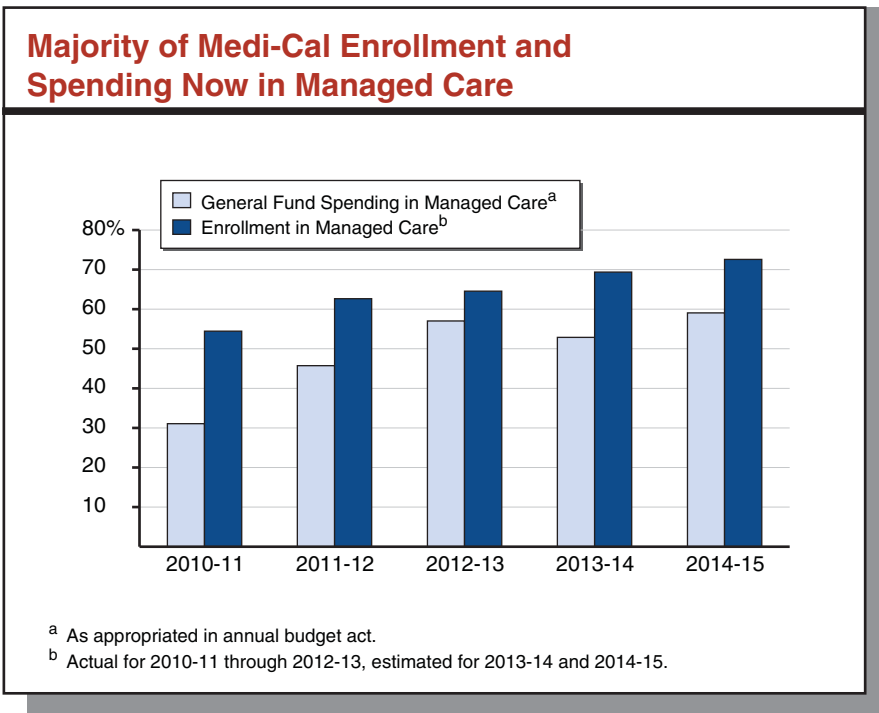
- ***Hospital Quality Assurance Fee.*** The state imposes a quality assurance fee on hospitals, which finances the nonfederal share of supplemental Medi-Cal payments to hospitals. A portion of the proceeds also offsets General Fund costs for providing children's health care (\$815 million in 2015-16).
- ***SNF Quality Assurance Fee.*** The state imposes a quality assurance fee on SNFs, which finances part of the annual Medi-Cal payment increases to these facilities.
- ***Managed Care Organization (MCO) Tax.*** The state collects the MCO tax from health plans that participate in Medi-Cal managed care (described later). The tax is currently matched with enough federal funds to (1) hold the plans financially harmless from paying the tax and (2) offset other General Fund costs (\$1.1 billion in 2015-16).



Medi-Cal Overview: Delivery Systems and Payment Structures

- ☑ **Two Main Delivery Systems.** Medi-Cal provides health care through two main systems:
 - **Fee-for-Service (FFS).** In FFS, health care providers receive an individual payment from the state for each service delivered to a Medi-Cal beneficiary.
 - **Managed Care.** In managed care, the state contracts with health plans, also known as MCOs, to provide health care coverage for Medi-Cal beneficiaries.

- ☑ **Managed Care Is Dominant Delivery System.** Enrollment in managed care is mandatory for most Medi-Cal beneficiaries to receive services. In 2015-16, more than three out of four Medi-Cal beneficiaries will be enrolled in managed care. Moreover, the majority of General Fund spending for Medi-Cal is now in managed care.





Medi-Cal Overview: Delivery Systems and Payment Structures (Continued)

- In FFS, State Establishes and Pays Provider Rates.*** In FFS, provider rates are generally developed by DHCS. The state's methodologies for both setting rates and paying providers vary depending on the category of service.

 - ***Cost-Based Reimbursement.*** Medi-Cal pays some providers—such as long-term care facilities and federally qualified health centers—based on their projected costs for providing services. (In some cases, providers submit annual cost reports for DHCS to use in determining rates.)
 - ***Fee Schedule.*** The state pays for many outpatient tests and procedures based on a predetermined fee schedule. For some providers—such as physicians and dental providers—rates in the fee schedule generally have not increased over the past decade.

- In Managed Care, State Pays Health Plan Rates Developed by Actuaries . . .*** In managed care, the state pays health plans a fixed rate per enrollee, per month regardless of the number of services delivered. This is known as a “capitated rate.” Capitated rates are developed annually by the state’s actuaries and must be “actuarially sound”—meaning they should reflect plans’ reasonable costs of doing business in Medi-Cal. Generally, actuaries use plan-specific historical data on utilization and costs to develop capitated rates, and incorporate assumptions about medical inflation and other cost trends. This rate-setting process generally results in capitated rates that increase by several percentage points annually.



Medi-Cal Overview: Delivery Systems and Payment Structures *(Continued)*



... While Plans Negotiate With and Pay Providers in Their Networks. Each health plan contracts with providers who agree to accept payments from the plan, also known as the plan's "provider network." Through contract negotiations, plans determine payments to their network providers for providing Medi-Cal services. These negotiated payments may differ across plans, and do not necessarily match the level or structure of the state's FFS payments for the same services. (For example, in some counties, plans pay a single capitated rate to physician groups for providing all necessary primary and specialty care services to Medi-Cal enrollees.)



Medi-Cal Payment Issues: Budget Reductions

- ☑ ***2011-12 Budget Authorized Medi-Cal Payment Reductions.*** The 2011-12 budget package authorized the administration to reduce Medi-Cal FFS payments to providers for certain services by up to 10 percent, and to reduce payments to Medi-Cal managed care plans by a related amount. These reductions—commonly referred to as the AB 97 payment reductions—originally applied to a wide range of providers and services.

- ☑ ***Reductions Were Enjoined by Federal Court Until Mid-2013.*** Federal court injunctions prevented the state from implementing many of the reductions until June 2013, when the injunctions were lifted. This gave the state authority to (1) implement the reductions to current and future payments on an *ongoing* basis, and (2) *retroactively* recoup the reductions from past FFS payments that were made to providers during the period in which the injunctions were in place. (There are no retroactive recoupments from managed care payments.)

- ☑ ***Administration Has Foregone Some Reductions and Recoupments.*** The AB 97 legislation gives the administration authority to partly or fully exempt specific providers and services from the reductions, in order to comply with federal Medicaid access requirements. Citing these requirements, the administration has exempted some providers and services from *ongoing* reductions and/or *retroactive* recoupments. For managed care payments, the administration also decided against applying reductions related to pharmacy and specialty physician services.



Medi-Cal Payment Issues: Budget Reductions

(Continued)

2015-16 May Revision Estimate of AB 97 General Fund Savings		
<i>(In Millions)</i>		
	Ongoing Reduction	Retroactive Recoupment
Intermediate care facilities for the developmentally disabled	\$5.2	—
Distinct-part nursing facilities	—	\$13.9
Physicians	24.9	—
Medical transportation	7.2	—
Medical supplies/durable medical equipment	8.7	0.9
Dental	30.0	—
Clinics	9.3	—
Pharmacy	15.4	1.8
Other providers	15.8	—
Managed care	81.5	—
Totals	\$198.1	\$16.7



Medi-Cal Payment Issues: Select Legislative Actions to Eliminate Reductions

- ☑ ***Assembly Budget Proposed Staggered Elimination of AB 97 Reductions.*** The Assembly's version of the 2015-16 budget would have—on a staggered time line—eliminated the ongoing reductions and retroactive recoupments for all providers. The Assembly proposal would have restored 5 percent of the 10 percent payment reduction in April 1, 2017, and the remaining 5 percent on April 1, 2017. The estimated General Fund cost of the proposal was \$25 million in 2015-16, and \$233 million under full implementation (beginning 2017-18).

- ☑ ***2015-16 Budget Restores Medi-Cal Payments for Dental Providers.*** The enacted 2015-16 budget eliminated the ongoing 10 percent payment reduction for dental providers, at a state cost of \$30 million. The remaining reductions are estimated to save the General Fund \$185 million in 2015-16.



Medi-Cal Payment Issues: Legislative Proposal to Increase Rates

Senate Bill 243 (Hernandez)—introduced in the 2015 legislative session—would require certain payment increases in the Medi-Cal program. As noted below, this proposal goes beyond a full repeal of the AB 97 reductions. Below are the categories of proposed increases and their associated annual General Fund costs as estimated by the Senate Appropriations Committee. (These cost estimates were based on information provided by DHCS.)

- Raising FFS Payments for Hospital Inpatient Services.*** Medi-Cal FFS payments for hospital inpatient services would be increased by 16 percent in 2015-16, and subsequently increased at the annual rate of medical inflation. These payment increases, combined with the resulting impact to the hospital quality assurance fee, are estimated to cost \$1 billion General Fund annually.
- Eliminating Remaining AB 97 Payment Reductions.*** Medi-Cal payments for services provided after June 1, 2011 would be determined without application of the current payment reductions, at an estimated cost of \$270 million General Fund annually. (We note that this cost estimate was made prior to the enacted budget action to repeal the ongoing 10 percent payment reduction for dental providers.)
- Raising Medi-Cal Payments to Medicare-Equivalent Levels.*** The proposal would require a variety of Medi-Cal payment increases that would be benchmarked to Medicare payment levels, for a total estimated cost of \$5.3 billion General Fund annually.

 - ***FFS Rates for Medicare-Covered Services.*** Medi-Cal FFS payments for outpatient services, medical transportation, and several other services would be increased to equal the Medicare payment level for those services.



Medi-Cal Payment Issues: Legislative Proposal to Increase Rates *(Continued)*

- ***Proportionate Increase in Dental Payments.*** Payments for dental services would be increased in proportion to the increase in other FFS payments to the Medicare payment level. (Dental services generally are not covered by Medicare.)
- ***Corresponding Increase in Managed Care Payments.*** Medi-Cal managed care payments would be increased by an amount corresponding to FFS payment increases.