Unlocking Medi-Cal’s Managed Care Rates

Medi-Cal is the nation’s largest Medicaid program, providing health coverage to more than 7.5 million Californians including low-income children, their parents, and seniors and persons with disabilities (SPDs). California increasingly relies on health plans to deliver quality care at lower cost through Medi-Cal Managed Care, which currently serves 69% of the Medi-Cal population (more than 5.2 million Californians).

Unlike Medi-Cal fee-for-service — in which the state reimburses doctors for each and every service provided — the state pays Medi-Cal health plans a fixed monthly amount, or capitation payment, for each member enrolled. Thus, the cost of managed care is more predictable.

Adequate Rates: The Key to Medi-Cal’s Long-Term Health

The monthly capitation rate must be sufficient to cover the cost of providing care to the Medi-Cal population. If rates are too low, the state runs the risk that health plans will become financially insolvent — and go out of business — or that they will no longer participate in the Medi-Cal program. Moreover, federal regulations require states to pay rates that are “actuarially sound” — neither too high nor too low; adequate but not excessive.

The state must provide adequate rates to plans and providers to ensure low-income Californians can find doctors who accept Medi-Cal. The process for setting Medi-Cal rates is therefore critical to the long-term health of the Medi-Cal Managed Care program.

The Medi-Cal Rate-Setting Process

California Department of Health Care Services (DHCS) collects data from Medi-Cal health plans and from the fee-for-service system* on:
- Medi-Cal population:
  - Population acuity (health)
  - Population risk factors (age, gender)
  - Utilization (amount of services used)
- Benefits covered (physician visits, hospital stays, prescription drugs)
- Expected cost of services
- Geography (high- vs. low-cost regions)
- Estimated savings of managed care:
  - ability to improve patient health
  - negotiated rates with providers
  - bulk purchasing from medical suppliers and pharmaceutical companies
  - greater emphasis on generic drugs, preventive services, etc.
- Health plan administrative expenses

DHCS finalizes the rates:
Due to budget constraints, the state consistently pays health plans a rate even lower than the lowest end of the approved rate range based on assumptions of unidentified “efficiency factors.”

Actuarial consultant develops & adjusts rates:
- Uses data collected by DHCS and a CMS checklist to develop base rates
- Adjusts rates* for managed-care-specific and plan-specific factors, and by county
- Final rates are ranges of rates.

Actuary certifies rates:
An actuary must certify that the rate ranges are “actuarially sound.”

CMS approves rates:
CMS must review and approve the rate ranges as actuarially sound.

What is Actuarial Soundness?

Centers for Medicare & Medicaid Services (CMS):
- developed in accordance with generally accepted actuarial principles;
- appropriate for the population and benefits covered; and,
- certified by an actuary who meets the qualifications set by the American Academy of Actuaries and follows the standards prescribed the Actuarial Standards Board.

American Academy of Actuaries:
- “provide for all reasonable, appropriate and attainable costs”:
  - the benefits covered;
  - health benefit settlement expenses;
  - Marketing/administrative expenses;
  - state fees and taxes; and,
  - the cost of capital.

Federal regulations specify that the following must be taken into account:
- utilization and cost data;
- the benefits covered;
- health plan administrative expenses;
- factors such as inflationary trends, regional cost differences, and managed care’s cost containment effects.

Actuarial Soundness & the Budget

Per CMS, state budgets are not supposed to influence Medicaid rates. In reality, states have limited resources and often cut rates to insufficient levels.

*DHCS does not make the data used to set rates, the assumptions used by the actuaries to adjust the rates, or the assumptions relating to “efficiency factors” publicly available.
Unlocking Actuarial Soundness
The current rate-setting process fails to produce rates that are in fact actuarially sound because:

- The fees paid in the Medi-Cal fee-for-service system are excessively low and do not reflect the true cost of care. Using these fees as a baseline for managed care distorts the total cost of providing care to the Medi-Cal Managed Care population. As already mentioned, if rates are too low, providers will not accept Medi-Cal patients.
- The process is not transparent. Health plans submit data to DHCS, but the final selection of data from the managed care and fee-for-service systems used to set rates — and the assumptions made by the actuarial consultants to adjust the base rates — are not publicly available.
- Actuarial soundness has no set definition, so different actuaries looking at the same data may come up with different rates.
- Even if the range of rates developed by the actuary and approved by CMS are actuarially sound, the state consistently takes the rate at the lowest end of the range and then reduces it even further based on assumptions of unidentified “efficiency factors.”
- Health plan rates already assume a high level of efficiency. Moreover, they are set prospectively. The state consistently takes a retrospective approach to identify what it assumes to be inappropriate or unnecessary utilization in prior years with no explanation for its assumptions.

Reform Needed Sooner Rather Than Later
Because managed care has shown to deliver better access, higher quality, and more coordinated care at lower cost, the state has been shifting more and more high-needs — and therefore higher-cost — populations into managed care.

In addition, the Affordable Care Act will expand Medi-Cal to 1.4 million uninsured Californians in 2014, many of whom will have pent up demand for health care services because they previously could not afford, or were denied, coverage due to costly preexisting conditions. Providing care for both the high-needs populations and newly insured individuals is going to increase the overall cost of administering the Medi-Cal program.

As Medi-Cal Managed Care continues to grow, health plans and their provider networks must have the capacity to ensure timely access to quality care. Medical groups serving more than half the state’s Medi-Cal population are already struggling to maintain financial solvency because of insufficient reimbursement rates.

Adequate capitation rates are therefore necessary to ensure the long-term health of the Medi-Cal program, the health plans and providers that participate, and ultimately the millions of Californians they serve.

The Solution
Medi-Cal Managed Care rates and the rate-setting process should be reformed to:

- reflect true actuarially sound principles, not state budget constraints;
- be fully transparent;
- reflect the real market cost of services rather than the excessively low rates paid in the fee-for-service system; and,
- account for the needs, health status, and risk of the Medi-Cal population.

For More Information:
42 CFR Ch. IV (10–1–06 Edition) § 438.6 Contract requirements.
California Department of Managed Health Care. Provider Solvency Update. February 2013.

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