ACA 1202
INCREASE PAYMENTS TO PRIMARY CARE PROVIDERS

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ACA Section 1202: Increased Payment to Primary Care Providers

- Section 1202 of the ACA requires Medicaid programs to pay at the Medicare rate for certain primary care services for services provided in CY 2013 and 2014
- 100 percent federal funding available to States for the difference between the Medicare rate in CY 13/14 and the Medicaid rate in CY 2009.
- To date, DHCS has paid providers over $1.6 billion; $431 billion in FFS and $1.2 billion in managed care.
- Approximately $800 million in managed care ACA 1202 related payments are still pending federal approval.
- President Obama's 2015 budget includes a provision to extend the ACA 1202 payments through 2016.
- Absent a federal extension of ACA 1202, continuation of this provision would cost the State an estimated $800 million in GF per year.

How Does DHCS Monitor Access?

Fee-for-Service

As part of implementation of AB 97 payment reductions, DHCS developed an access monitoring plan that was approved by the federal Centers for Medicare and Medicaid Services

- DHCS publishes quarterly and annual access to care reports that target 23 measure that fall under four domains: (1) Beneficiary Access (2) Provider Availability (3) Services Utilization and (4) Access Outcomes
- DHCS also investigates access concerns that are brought to our attention by stakeholders on an ad hoc basis. Data and other information may be used to help in determining access impacts such as Medi-Cal market share, provider participation ratios, and costs.

Managed Care

DHCS shares responsibility with the Department of Managed Health Care for ensuring that managed care plans provide adequate and timely access to care for Medi-Cal beneficiaries. Plans must meet various contractual and statutory requirements for network adequacy, time and distance standards, and other requirements monitored through regular surveys and audits.

Medi-Cal Services and Enrollment are Primarily in Managed Care

- Today, Medi-Cal covers approximately 12 million individuals, nearly 1 in 3 Californians. Medi-Cal enrolled about 3 million new beneficiaries since January 2014.
- Most Medi-Cal services are provided through 22 contracted managed care plans serving over 9 million beneficiaries, or about 80 percent of the Medi-Cal population. About 89 percent of Medi-Cal children are served through managed care.
- Managed care enrollment increased significantly due to:
  - Transition of SPDs into managed care in 2011
  - Expansion into rural counties in 2013 (managed care now in all 58 counties)
  - ACA expansion
- Majority of people and services remaining in FFS today include:
  - Limited/restricted scope populations
  - CCS eligible conditions
  - Certain prescription drugs
  - Dental services

Managed Care Rate Setting

- The primary goals of DHCS' managed care rate setting is to ensure that rates are reasonable and attainable, that it matches payment to risk, and to encourage quality and efficiency in our Medi-Cal health plans.

- In general, DHCS uses actual health plan experience for the specified population in setting rates for the managed care populations and uses a combination of plan-specific and risk-adjusted county average experience for each plan's rates.

- With the exception of the Rural Expansion counties, rates that are developed for Medi-Cal health plans have traditionally been county specific, such that even plans that are in multiple counties have separate rates for each county.

Rates Must Be Actuarially Sound

- Federal and state laws require that managed rates be actuarially sound. This means that rates need to be reasonable and appropriate for the risk and services for which the plans are responsible

- Rates are “risk based”--the plans are responsible for any costs that are above the rates that they paid, but also benefit from the ability to save money from efficiencies in the way they manage their programs

- Because actuarial soundness is the essential element of rate setting, program changes in the fee for service side *may* affect managed care rates.

Health Plan – Provider Payment Relationships Vary

- Health plans contract with various providers to meet their statutory and contractual access requirements.
- Plans may pay contracted providers on a fee-for-service or an at-risk basis such as through capitation.
- Many plans contract with their providers for more than established Medi-Cal FFS rates.

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