Protect Medi-Cal Funding
Access to Providers
Issue Brief #9 in a 12-Part Series

Medi-Cal provides a long-term investment in the health of Californians. Medi-Cal coverage and services are tailored to meet the unique needs of low-income people, but still costs less per beneficiary than employer-based insurance.[1] The Better Care Reconciliation Act (BCRA) under consideration by the Senate, like the American Health Care Act (AHCA), passed by House Republicans in May, would seriously jeopardize the health and financial security of over 13 million Californians—one third of the state's residents—who rely on Medi-Cal each year.[2] California estimates the bill, if passed, would cost the state more than $30 Billion over the next ten years.[3] The recently released federal budget by the current administration further eviscerates funding for Medicaid. This issue brief explains why Medi-Cal is so critical to ensuring that low-income people have access to health care providers, and how they would be harmed by Medicaid funding cuts.

Why Medicaid provider access protections are important:

- **Adequate provider rate protections are designed to ensure access.** No health insurance can provide meaningful access to care if providers are paid so little that they do not participate. Medicaid includes specific rules to promote adequate provider payment rates. States must set payment rates high enough to ensure that access to care in Medicaid is equivalent to access for the general population in the geographic area.[4] In addition, payment rates for Medicaid managed care must be "actuarially sound," meaning that the amount of money the state pays the plan is expected to be sufficient to cover the costs incurred by the plan in providing health care services.[5] While state Medicaid programs are sometimes criticized for paying providers too little, Medicaid is extremely efficient with the dollars allocated to the program, spending less per enrollee than private insurance and maximizing coverage for approximately 97 million of the country's most vulnerable individuals.[6] Recognizing the importance of paying providers adequately, California recently passed a bond measure that will be used to increase reimbursement rates for certain critical provider types, including dentists and psychiatrists.[7] These increases are intended to address access problems in Medi-Cal that the state uncovered in a survey last year.[8]

- **Medi-Cal managed care network adequacy requirements protect low-income people.** The Medicaid population includes a wide range of vulnerable individuals, including older adults, persons with disabilities, pregnant women, women with breast and cervical cancer, and children with behavioral health conditions. A robust network of providers is necessary to effectively cover such a diverse and complex population. Thus, federal regulations ensure that each Medicaid managed care plan maintains a network of providers sufficient in number, mix, and geographic distribution to meet the needs of the enrollees in the service area.[9] In California, the state has enacted significant additional protections to ensure that Medi-Cal managed care enrollees have access to the range of providers they need to see to get care.[10] Additionally, in its current Medi-Cal 1115 Waiver, the state has undertaken a new monitoring program to assess access in Medi-Cal managed care, so the state can address any problems.[11]

- **Medi-Cal ensures that low-income people have access to community health clinic services**. Low-income individuals heavily depend on care from federally qualified health centers (FQHCs) and rural health clinics (RHCs) in their communities.[12] Medicaid requires states to cover FQHC and RHC clinic services, including for the Medicaid expansion population.[13] State managed care plans are also required to include FQHC services.[14] Medicaid law guarantees fair minimum payment rates for these providers, including payments made by managed care plans.[15] California ensures that managed care enrollees have access to full range of services provided by FQHCs and RHCs, including chiropractic care and podiatry services.[16]

How funding caps threaten provider access protections in Medi-Cal:

- **Funding cuts could lead to provider rate cuts.** A per capita cap or other cut to reduce federal Medicaid funding will shift more of the costs onto the state. In California, Medi-Cal could respond to budget gaps by seeking to cut provider rates to save money—something it has done in the past in response to budget pressures.[17] As a result, California's rates are among the lowest in the country.[18] Recently, California has made some efforts to address access issues caused by cuts in prior years.[19] A new round of rate cuts would harm providers and health care infrastructure, reduce provider participation in Medi-Cal, and make it more difficult for Medi-Cal enrollees to access care. Rate cuts and related access problems would likely be felt the most in the rural parts of the state where providers are already scarce.[20]

- **Funding cuts could lead to more restrictive provider networks.** In trying to make up for lost federal funding, California might seek to limit the providers participating in fee-for-service Medi-Cal in an attempt to conserve funds. California

might also cut Medi-Cal managed care payment rates to save money, which is likely to lead the Medi-Cal plans narrowing their networks in response. Either way, with fewer providers participating in the program, enrollees in underserved areas, including rural areas, would be seriously harmed.[21] Enrollees with complex medical conditions, such as many older adults or children with developmental disabilities, could face reduced access to specialists, forcing them to delay or go without needed services.

- **Funding cuts would likely lead to reduced access to providers**. Another strategy California is likely use to save costs once its federal funding is reduced is to create additional barriers to accessing providers. For example, California could increase use of utilization controls such as prior authorization and referral requirements or seek to impose treatment limits to reduce access to medical or mental health providers. California might also try to increase cost sharing such as premiums and copayments, making it difficult for low-income individuals to afford health care services.[22] Policies like these would particularly harm individuals with chronic health conditions or disabilities who need regular medical care to stay healthy.

ENDNOTES

[1] *See* TERESA COUGHLIN ET AL., KAISER COMM'N ON MEDICAID & THE UNINSURED, WHAT DIFFERENCE DOES MEDICAID MAKE? 4, 7 (2013), http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8440-what-difference-does-medicaid-make2.pdf (Nationally, employer-based coverage would cost 28% more than covering the same individual with Medicaid).
[2] CAL. DEP'T HEALTH CARE SERVS., MEDI-CAL MONTHLY ENROLLMENT FAST FACTS 1 (2017) (enrollment as of December, 2016 at 13.5 Million), http://www.dhcs.ca.gov/dataandstats/statistics/Documents/Fast_Facts_December_2016.pdf; *see also, e.g.,* KIM LEWIS, NAT'L HEALTH LAW PROG., TOP 10 CHANGES TO MEDICAID UNDER THE SENATE'S ACA REPEAL BILL: IMPLICATIONS FOR CALIFORNIA (2017), http://www.healthlaw.org/publications/browse-all-publications/10-changes-to-medicaid-under-senate-aca-repeal-bill-implications-for-ca.
[3] Letter from Jennifer Kent, Cal. Dep't Health Care Servs., to Diana Dooley, Cal. Dep't Health & Hum. Servs. (June 27, 2017), http://www.dhcs.ca.gov/formsandpubs/publications/opa/Pages/Better-Care-Reconciliation-Act-(BCRA)-Analysis.aspx.
[4] 42 U.S.C. § 1396a(a)(30)(A); 42 C.F.R. § 447.203 – 204.
[5] 42 U.S.C. § 1396b(m)(2)(A)(iii).
[6] *See* EDWIN PARK & MATT BROADDUS, CENTER ON BUDGET AND POLICY PRIORITIES, CORRECTING SEVEN MYTHS ABOUT MEDICAID (2014), http://www.cbpp.org/cms/?fa=view&id=4023.
[7] *See* Cal. Dept. Health Care Servs., Proposed State Plan Amendments, http://www.dhcs.ca.gov/formsandpubs/laws/Pages/Pro_SPA.aspx (last visited July 11, 2017).
[8] *See* CAL. DEPT. HEALTH CARE SERVS., CALIFORNIA'S FEE-FOR-SERVICE MEDI-CAL PROGRAM HEALTH CARE ACCESS MONITORING PLAN (2016), http://www.dhcs.ca.gov/formsandpubs/laws/Documents/2016AccessMonitoringPlan.pdf.
[9] 42 C.F.R. § 438.207(b)(2).
[10] *See* ABBI COURSOLLE, NAT'L HEALTH LAW PROG., NETWORK ADEQUACY LAWS IN MEDI-CAL MANAGED CARE PLANS (2014), http://www.healthlaw.org/publications/search-publications/network-adequacy-laws-in-medi-cal-managed-care-plans.
[11] *See* HEALTH SERVS. ADV. GROUP, MANAGED CARE QUALITY AND MONITORING DIVISION (2017), http://www.dhcs.ca.gov/Documents/Access_Assess_Design_DRAFT.pdf.
[12] Health centers provide services to one in three people living in poverty, and 72% of all health center patients are living in poverty. *See* NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, A SKETCH OF COMMUNITY HEALTH CENTERS (2014), http://www.nachc.com/client//Chartbook_2014.pdf.
[13] 42 U.S.C. §§ 1396d(a)(2)(B) and (C), 1396u-7(b)(4).
[14] *Id*. § 1396n(b).
[15] *Id.* §§ 1396a(bb), 1396b(m)(2)(A)(ix).
[16] Letter from Sarah C. Brooks, Cal. Dep't Health Care Servs., to Medi-Cal Managed Care Health Plans (Jan. 26, 2015) (APL 15-003), http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2015/APL15-003.pdf.
[17] *See, e.g., Douglas v. Indep. Living Ctr. of S. California, Inc*., 565 U.S. 606, 611 (2012) (describing a series of cuts California made during the great recession).
[18] *See, e.g.,* Kaiser Family Found., Medicaid Physician Fee Index: 2016, http://www.kff.org/medicaid/state-indicator/medicaid-fee-index (last visited July 13, 2017) (last year, California ranked 48th among states in terms of its Medicaid reimbursement rates). A recently filed lawsuit has challenged California's rates, noting that they have stagnated over time. *See* Soumya Karlamangla, *Medi-Cal Patients Sue State, Claiming Widespread Discrimination*, L.A. TIMES, July 12, 2017, http://www.latimes.com/local/california/la-me-ln-medi-cal-lawsuit-20170711-story.html.
[19] *See* CAL. DEPT. HEALTH CARE SERVS., MEDI-CAL FEE-FOR-SERVICE ACCESS TO CARE QUARTERLY MONITORING REPORT #10 - 2014 QUARTER 1 (2015), http://www.dhcs.ca.gov/dataandstats/statistics/Documents/ADA_Final_ExecSummary_2014Q1.pdf.
[20] *See, e.g.,* Hannah Esqueda, In California's Rural Central Valley, Access to Care is a Growing Challenge, CTR. HEALTH JOURNALISM FELLOW. BLOG (Mar. 2, 2016), https://www.centerforhealthjournalism.org/2016/02/29/california%E2%80%99s-rural-central-valley-access-care-growing-challenge.
[21] *See id.*

[22] *See* ABBI COURSOLLE, NAT'L HEALTH LAW PROG., PROTECT MEDI-CAL FUNDING SERIES, MEDI-CAL AFFORDABILITY (2017), http://www.healthlaw.org/about/staff/abbi-coursolle/all-publications/protect-medi-cal-funding-medi-cal-affordability.