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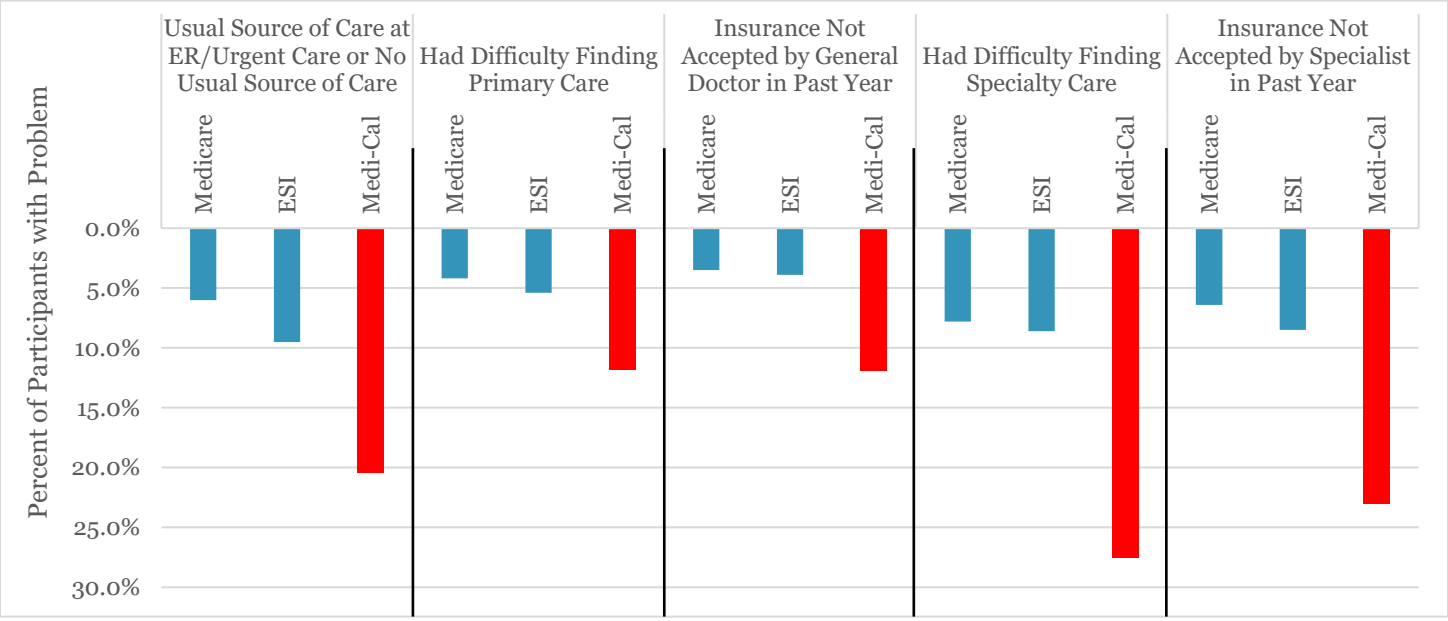
MEDI-CAL CIVIL RIGHTS VIOLATIONS: THE DATA

MEDI-CAL PARTICIPANTS' SIGNIFICANTLY INFERIOR ACCESS TO CARE

In 2015, the latest year of available data, Medi-Cal participants had significantly inferior access to care than those with Medicare or employer-sponsored insurance (ESI).[i]



LOW REIMBURSEMENT RATES DRIVE THESE ACCESS DISPARITIES

California ranks near the bottom among states in terms of reimbursement to physicians participating in Medicaid for both Fee-for-Service (FFS) and Medicaid Managed Care (MMC).

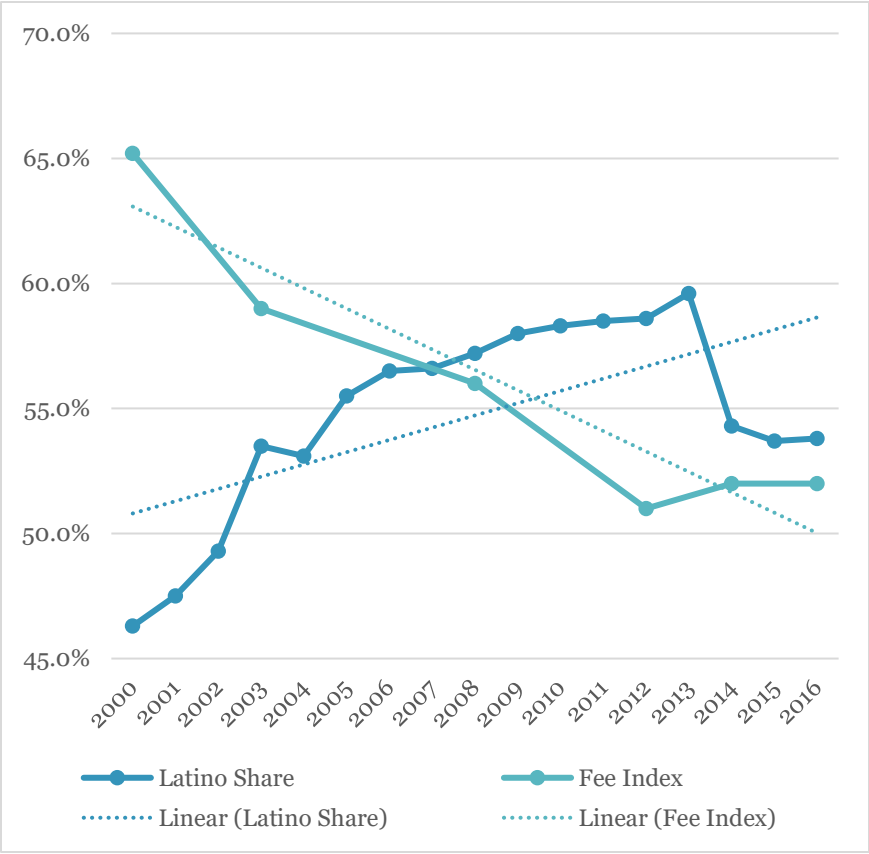
Fee-for-Service	Managed Care
• The California Department of Health Care Services (DHCS) sets per-service reimbursement for care. • For primary care, Medi-Cal's reimbursement in 2016 was just 41% of Medicare's, ranking 49th out of 50 measured Medicaid programs.[ii] • For all measured services (including primary and specialty care), Medi-Cal's reimbursement was just 52% of Medicare's, ranking 48th out of 50 measured programs.	• DHCS sets capitation payments (i.e., lump payment to MMC plans for each patient served). • In doing so, DHCS has relied on too-low FFS rates as a component, incorporated unidentified "efficiency factors," relied on data that does not take access into account, and improperly relied on rate ranges.[iii] • As a result, capitation rates are lower than the actuarially equivalent rates for Medicare or ESI would be and MMC payments to physicians are generally at or below FFS rates, at 10% below FFS for office visits and 5% below FFS for all services.[iv]

- In 2015, only 60% of California physicians were accepting new Medi-Cal patients, 17% fewer than those accepting new Medicare patients and 25% fewer than those accepting new commercially insured patients.[v] Certain specialties are particularly unlikely to accept Medi-Cal patients. For example, mental health diagnoses are among the most common reasons for hospitalization among Medicaid patients around the country, but psychiatrists had the lowest rate of Medi-Cal participation of any major specialty (37%).
- Physicians' acceptance of Medicaid patients increases as Medicaid payment rates increase.[vi]

LACK OF MONITORING AND ENFORCEMENT COMPOUNDS THE PROBLEM

DHCS has failed to meet or enforce standards requiring ready access to care for Medi-Cal patients.

- MMC plans regulated by DHCS are required to meet certain minimum standards, such as having at least one primary care provider for every 2,000 participants; primary care providers less than 30 minutes or 10 miles from participants' residences; and maximum wait times of 48 hours for urgent care appointments, 10 business days for routine primary care visits, and 15 business days for specialty care.
- A 2015 report by the State Auditor found these standards were not enforced.[vii] For example, DHCS did not verify health plan data on network adequacy and access. The State admits it is unable to verify MMC compliance with these standards.



DISPARATE IMPACT ON LATINOS

The access disparities have an adverse, disparate impact on Latinos, a racial group that is disproportionately represented among Medi-Cal participants.

- Medi-Cal reimbursement rates relative to Medicare have fallen as Medi-Cal has become increasingly Latino.
- Latinos are now heavily overrepresented among the Medi-Cal population – in 2016, they comprised about 54% of Medi-Cal enrollees, while only comprising approximately 39% of California's population. Disinvestment in Medi-Cal has therefore disproportionately impacted Latinos and their ability to receive adequate healthcare.

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[i] UCLA Center for Health Policy Research, CHIS, http://healthpolicy.ucla.edu/chis/data/pages/GetCHISData.aspx.
[ii] *See* Stephen Zuckerman et al., The Urban Institute, Medicaid Physician Fees after the ACA Primary Care Fee Bump 5 tbl.1 (Mar. 2017).
[iii] California Association of Health Plans, Issue Brief: Unlocking Medi-Cal's Managed Care Rates (April 2013).
[iv] U.S. Gov't Accountability Office, GAO-14-533, Medicaid Payment: Comparisons of Selected Services under Fee-for-Service, Managed Care, and Private Insurance 22 tbl.4 (2014) (analyzing 26 evaluation and management services).
[v] Janet M. Coffman, Physician Participation in Medi-Cal: Is Supply Meeting Demand? 13 (California HealthCare Foundation June 2017).
[vi] Sandra L. Decker, In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, but Rising Fees May Help, 31:8 Health Affairs 1673, 1678 ex.1 (Aug. 2012).
[vii] Cal. State Auditor, Report 2014-134, Improved Monitoring of Medi-Cal Managed Care Health Plans is Necessary to Better Ensure Access to Care (June 2015); *see also* Legislative Analyst's Office, Access to Care in Medi-Cal: Focusing Oversight on Managed Care (Mar. 4, 2015).