Capitation Rates in the Medi-Cal Managed Care Program

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Introduction

Medicaid programs across the country have adopted managed care delivery systems as a means of stabilizing the cost of serving Medicaid enrollees and improving access to services. Health plans agreeing to participate in managed care programs are paid a capitation rate by the state to cover all costs of a defined population group. The capitation rates are calculated based on methods that are determined in part by the Health Care Financing Administration, which oversees the state/federal program. Federal funds cover 50% to 76% of the cost of Medicaid programs, and states must comply with federal guidelines to obtain federal financial participation. In California, 51.67% of Medicaid costs are paid by federal funds.

California operates several forms of managed care programs for Medicaid enrollees, most of which are paid through capitated systems. The basic rate setting process for all models paid through capitation is the same, with some slight variation depending on the specific delivery model.

The purpose of this paper is to:

1. Provide an overview of the Medi-Cal managed care program and describe the functions of various agencies in determining payment rates.
2. Discuss generally accepted rate setting methods, including constraints on payment rates that derive from federal rules.
3. Describe the methods used by the State of California to determine payment rates for the Medicaid (Medi-Cal) population, and discuss variations in rate setting approaches that are used in other states.
4. Provide a comparison of Medi-Cal fee-for-service and managed care payment levels to those of other payers.

In the first section of the paper we describe the various Medi-Cal managed care delivery models to set the context for discussing the methods for developing the payment rates. The following section describes generally accepted methods for rate-setting. This section also provides a discussion of constraints on rate setting options. The third section describes the methods used in California for setting payment rates. The final section provides a comparison of Medi-Cal payment levels to those in other states and to premium rates paid by other health care purchasers in California, as well as comparing provider payment rates under Medi-Cal and Healthy Families, California's Title XXI program.

I. Description of Medi-Cal Managed Care

California operates six general forms of managed care, with three of the delivery models requiring mandatory enrollment. Two of the delivery models are available on a voluntary basis and have very limited enrollment. Finally, a number of special projects serve very specific population groups. This paper focuses primarily on the three managed care delivery systems with mandatory enrollment, with brief descriptions of the other models.

Models of Medicaid managed care delivery in California

County Organized Health Systems

County Organized Health Systems (COHS) operate in six counties. They are single-plan models operated by counties that accept full risk for a broad scope of services; the counties operate with special approval under federal law. The first County Organized Health Systems were authorized in the early 1980s in Santa Barbara, San Mateo and Monterey Counties. Of these three, Santa Barbara's and San Mateo's programs remain in operation. Three additional County Organized Health Systems became operational in the 1990s, with programs in Solano, Santa Cruz and Orange Counties. The Solano program expanded into neighboring Napa County in 1998.

Two-Plan Model

The Two-Plan Model is the largest of the Medicaid managed care programs in California. Under this model, which operates in twelve counties, the State contracts with two health plans. One is intended to be a "Local Initiative" plan, while the other is termed a "mainstream" or "commercial" plan. The Local Initiative plan is developed by public providers and local stakeholders such as community health advocates, while the commercial plan is selected

through a competitive process based on quality and access criteria. The Local Initiatives are organized similarly in concept and design to County Organized Health Systems and have independent governing boards established by the county boards of supervisors. The Two-Plan Model covers the most populous areas of the state, including Alameda, Contra Costa, Fresno, Kern, Los Angeles, Riverside, San Bernardino, San Francisco, San Joaquin, Santa Clara, Stanislaus, and Tulare Counties. These counties currently have over 1.7 million Medi-Cal recipients enrolled in managed care, or 72% of total Medi-Cal managed care enrollees.

Geographic Managed Care

Geographic Managed Care (GMC) is a multi-plan competitive model. This model is most similar to the Medicaid managed care programs used in the majority of other states, with most of the commercial health plans in a geographic area participating in the Medicaid managed care program. Plans negotiate with the State to establish final payment rates. This program currently operates in two counties, Sacramento and San Diego.

Prepaid Health Plans and Primary Care Case Management

The Prepaid Health Plan and Primary Care Case Management models operate on a voluntary enrollment basis. Prepaid Health Plan and Primary Care Case Management plans will remain in place in counties that are not part of the mandatory managed care program. These options are available largely in areas that do not have sufficient concentrations of population to warrant full-scale use of managed care, and for population groups that are excluded from mandatory managed care enrollment.

Special Projects

California operates several small managed care programs that serve a total of approximately 2,000 enrollees. These programs primarily enroll elderly individuals and provide comprehensive acute and long-term care services, including enhanced in-home and social support.

Covered populations

Each model of Medi-Cal managed care specifies the eligibility groups that are required to enroll, and some groups are specifically excluded from enrollment in managed care under state law or as a result of the Balanced Budget Act of 1997. Most individuals in eligibility groups that are not required to enroll in the Medi-Cal managed care program operating in their county may enroll on a voluntary basis.

The County Organized Health System model enrolls all Medi-Cal managed care enrollees in a county, with some minor exceptions. There have been some exclusions for those who are eligible under Medically Needy Share-of-Cost (for a limited scope of services), the prenatal care Percent of Poverty aid categories, or those who have special needs or medical conditions. Approximately 95% of Medi-Cal recipients are enrolled in managed care in the counties operating County Organized Health Systems.

In the other mandatory managed care programs, Geographic Managed Care and Two-Plan Model counties, mandatory enrollment is more limited. Both programs require enrollment by individuals covered by Public Assistance – Family, Medically Needy No Share of Cost – Family, and Medically Indigent Children eligibles. Other family-related population groups, known more broadly as the Temporary Aid to Needy Families (TANF) population, are required to enroll in Two-Plan Model counties, but not in Geographic Managed Care counties. Neither program extends mandatory enrollment to individuals covered by the Aged, Blind and Disabled programs. Approximately 67% of Medi-Cal eligibles in Two-Plan Model and GMC counties are required to enroll in managed care. Another 23% have the option to enroll on a voluntary basis, and approximately 10% are in eligibility categories that are not permitted to enroll in managed care.

Table 1 shows the eligibility groups enrolled in each of the mandatory enrollment delivery systems.

Table 1
Medi-Cal Managed Care Models

Model	Counties	Mandatory Eligibility Categories	Enrollment (as of 1/99)
County Organized Health Systems	Napa (w/Solano) Orange San Mateo Santa Barbara Santa Cruz Solano	All Major Aid Categories	355,728
Geographic Managed Care	Sacramento San Diego	• Public Assistance – Family • Medically Needy No Share of Cost – Family • Medically Indigent – Child	307,491
Two-Plan Model	Alameda Contra Costa Fresno Kern Los Angeles Riverside San Bernadino San Francisco San Joaquin Santa Clara Stanislaus Tulare	• Public Assistance – Family • Medically Needy No Share of Cost – Family • Medically Indigent – Child • Refugee	1,718,738

Services included in managed care contracts

Medicaid programs cover a broad scope of services, with coverage that is more extensive than most private health plans. California covers all of the federally required services as well as most of the optional services. Available services include traditional hospital, physician and ambulatory care, prescription and some over-the-counter drugs, dental, vision, long-term care, mental health, rehabilitation, and home health services. Additional coverage includes non-emergency transportation, podiatry, chiropractic, and other special programs. Included among special programs are school-based health services, direct observed therapy tuberculosis treatment, and lead poisoning case management. This paper focuses on the medical component of acute care services, the core of most Medicaid managed care programs.

California's managed care contracts vary in the scope of services covered. State agencies, either the California Department of Health Services (DHS) or the California Medical Assistance Commission (CMAC), contract with each plan for "physical care" and establish rates for a set of services generally including most primary and acute care services. Services not included in the physical care plan rates include mental health and substance abuse treatment, dental services, vision, and long-term care.

Responsibility for payment rates in the Medi-Cal program

Health plan payment rates are determined based on actions taken by the executive and legislative branches of state government, as well as directives resulting from the judicial branch. Rules governing the program are created by the federal government.

- The federal government sets rules for operating Medicaid programs in general and Medicaid managed care in particular. Federal guidelines establish minimum standards for payments to providers, which are linked to access to services in most cases and covering provider costs in some circumstances. Health Care Financing Administration (HCFA) regional offices play an important role in assessing compliance with standards. In addition, provider groups may sue states in federal court, challenging the state's compliance with these standards. Each state files a Medicaid State Plan with HCFA, which governs the operations of that state's Medicaid program. Changes in the general structure of a state's Medicaid program require that the State Plan be amended, with review and approval by HCFA.
- The Governor's office recommends the Medi-Cal budget to the California Legislature, including changes in payment levels from year to year. These recommendations, as well as other policy initiatives, may be general to cover broad aspects of the Medi-Cal program, or highly specific to target certain types of services or population groups. The Governor's office may also recommend significant policy initiatives that change the structure of the Medi-Cal program.

- The Legislature sets the Medi-Cal budget and stipulates general payment rates. The methods used for determining payments to certain providers are often established in law, and the Legislature may target certain services or population groups for changes in payments. The Legislature must approve any significant deviations from established policy, including implementation of new managed care programs.
- The California Department of Health Services within the Health and Welfare Agency has primary responsibility for administering the Medi-Cal program. DHS develops policy initiatives for approval by the Governor and Legislature and implements policy, as well as having responsibility for the day-to-day operations of the program. Actuaries in DHS' rate development branch calculate the payment rates for Medi-Cal managed care programs based on federal guidelines, state policy, and available funding.
- The California Medical Assistance Commission reports to the Governor's office and negotiates payment rates for plans participating in the Geographic Managed Care and County Organized Health System programs (with the exception of Santa Barbara) within the limits established by DHS. The Santa Barbara COHS negotiates rates with DHS based on the same criteria. CMAC also has responsibility for negotiating Medi-Cal inpatient hospital payment rates.

II. Rate Setting Methods Permitted by HCFA

Capitation rates in Medicaid managed care programs are constrained by the HCFA "Upper Payment Limit (UPL)," which is described as the fee-for-service equivalent cost of providing services to an actuarially equivalent population. In other words, the capitation rates can be no higher than what would have been paid had the state paid for all services on a fee-for-service basis. The only exception to this guideline is among some states with Section 1115 waivers, where different rate setting methods have been negotiated.[1] In these states, the state and federal governments agree to a method for establishing budget neutrality that is generally based on a per capita cost and an estimated number of participants. The rate setting methods described in the remainder of this paper relate to programs that operate under more standard federal guidelines in states that do not have Section 1115 waivers.

Because capitation rates are linked to the fee-for-service equivalent cost (FFSE), a state's Medicaid fee-for-service payment level in large part determines the approximate level of capitation rates. States with generally high Medicaid payment levels will have the opportunity to pay capitation rates that are relatively high, while states with low fee-for-service payment levels will have capitation rates that are also low. The utilization rate of medical services is the other significant component that determines differences in capitation rates.

Level of flexibility in determining the Upper Payment Limit

While standard methods have been developed nationally for calculating the Upper Payment Limit, there remains some flexibility in fine-tuning the calculation and in determining the final payments made to health plans. The flexibility relates to the following factors:

[1] Section 1115 waivers are for "demonstration projects." Under these waivers, states commit to studying the effects of broad changes in Medicaid rules. States negotiate a budget with HCFA that is considered to be no higher than the total budget for the standard Medicaid program for the state. Under many of the demonstration projects in operation, significant changes are made in the population covered and the funding sources used.

- The data sources that are chosen as the starting point for the calculations.
- The rate payment categories that are used to pay health plans, including payments based on health status.
- Adjustments made to the data in order to project to the upcoming contract period, including:
  - — the choice of trend rates that are applied;
  - — population and service changes to reflect the population that will be covered by managed care;
  - — prescription drug rebates;
  - — other adjustments to reflect legislative or policy changes occurring since the data period; and
  - — administrative costs.
- Adjustments to the Upper Payment Limit to reflect expected managed care savings and arrive at the capitation rates made to health plans.

Selection of data and rate payment categories

A first step in developing capitation rates is determining the data that will be used for the analysis and the rate categories that will be used for making payments. Varying rate categories are used to identify population groups with expected differences in average costs. These rate categories are important to assure that the population enrolled in managed care is similar to the population that was used to develop the capitation rates, or to make appropriate adjustments.

The general approach for calculating capitation rates and Upper Payment Limits involves summarizing relevant historical Medicaid fee-for-service data by service type for each rate category. Typically, two years of data are used for the analysis, with appropriate adjustments to reflect program changes.

When state Medicaid programs enroll a large percentage of eligible members into managed care plans, the population remaining in fee-for-service is no longer representative of the average Medicaid enrollee. As a result, the historical fee-for-service data available to the state in determining the Upper Payment Limit is not representative of actual program costs. States such as California and Oregon are turning to health plan reported encounter data in their managed care rate-setting calculations to address this problem.

States use different numbers of rate categories for making payments to plans. The number of rate setting categories determines the level of precision in paying health plans. Programs with mandatory enrollment often use fewer rate payment categories, while those with voluntary enrollment may use a larger number. When enrollment is voluntary, more information is needed to determine whether those individuals who enroll in the program use health care services at average levels. With mandatory enrollment, rate payment categories are used for two purposes:

(1) to assure that any differences between the population that comprises the base for the rate development and the group that enrolls in the program are taken into account, and (2) to allow for varying payment rates to individual health plans based on each plan's enrollment mix.

Some HCFA regional offices are concerned that the rates clearly reflect the historical payment levels for each geographic area covered by managed care, while others have allowed statewide payment rates. A critical concern among states in setting capitation rates is proving that the total payments do not exceed the HCFA Upper Payment Limit. Any payments in excess of this limit would not receive federal matching payments and would have to be fully state-funded.

Adjustments to the data

The data available for developing capitation rates always require some level of adjustments. In programs that are new to managed care, the adjustments may be relatively minor, while those that have contracted with managed care plans for some time or where there are significant changes in the rules governing the program often require more complex adjustments. These adjustments are required to approximate the FFSE cost for the geographic area covered by the managed care program. Over time, fee-for-service data from the area become unreliable as a large percentage of the population enrolls in managed care. The portion that remains in the fee-for-service system cannot be expected to reflect the true average cost of the population that participates in managed care, and substitute methods of calculation must be developed.

Part of the process of selecting the data for developing capitation rates involves defining the eligibility rules for the program. Experience shows that individuals just entering Medicaid programs often have higher health care costs than the average Medicaid recipient. If health plans are responsible for covering health care costs from the date an individual enrolls in Medicaid, the entire fee-for-service data base would appropriately be used for rate development. If instead health plans take responsibility for costs some time after the initial date of eligibility, adjustments must be made to the data to exclude costs and eligibility information that occur before the normal date of enrollment in a managed care plan. Many states that use Medicaid managed care programs also include an eligibility guarantee, extending the period of eligibility for managed care enrollees. When these types of eligibility rule changes are put into place, adjustments to the base data must be made.

In all cases, the data that are available must be updated to reflect the time period of the contract, as well as any changes in program rules. Typical adjustments include the following:

- Trend and Completion of Data. Since the historical data used for rate setting is usually a year old or more, trend adjustments must be applied to project the claims forward into the contract period. Trend adjustments refer to changes in both the unit cost of services and the utilization rate. Normal levels of technology change are also included in trend adjustments.

Trend rates are often calculated separately for several broad service groupings, such as: inpatient, outpatient, professional, pharmacy, and miscellaneous. Trend rates can also be calculated separately for members with and without Medicare coverage due to the differing nature of claims covered by Medicaid for the two population groups. The calculated trend rates are compared to other state information regarding program changes during the data period to evaluate any anomalies. In some cases, significant changes in service use occur between the data reporting period and the contract period, and the data need to be "rebased." For example, when a new technology is introduced, there may be a jump in costs. While the change in costs should be taken into account, the rate of change cannot be expected to continue in the future. This situation has occurred recently in the area of behavioral health drugs, where technology changes have resulted in large increases in use of services. The new rates of usage can be considered the "base" for projecting forward, but the pace of changes is expected to slow.

Adjustments to complete the claims data are applied to reflect total estimated costs during the historical data period. Health care providers generally take some time to submit all claims, and the Medicaid agency requires some additional time to review and pay the claims. As a result, the claims that are shown in the database may not reflect all services that were provided.

- Covered Services. In many cases changes in Medicaid service coverage occur between the base data period and the proposed contract period. These changes can result from program expansions, such as new vaccinations or transplant protocols. They can also result from legislative mandates to expand coverage. Adjustments to the base data must also be made if managed care plans are not responsible for the full scope of services that are available under the fee-for-service program.
- Drug Rebates. Drug manufacturers are required to provide Medicaid programs favorable rates similar to those available to their best customers. However, since Medicaid fee-for-service claims are paid on an individual basis to community-based pharmacies, the discounted rates are not available directly. As a substitute, the manufacturers make rebates to Medicaid programs that reflect the total amount of drugs from each manufacturer purchased for Medicaid recipients. These rebates are not reflected in the claims database, since they do not apply to individual claims. A reduction must be made to the claims data base to reflect the net cost of prescription drugs after rebates.
- Other Adjustments. In developing capitation rates it is also important that other changes in the fee-for-service Medicaid program be taken into account. When the legislature changes coverage—for example, with a 48-hour

minimum maternity stay—these changes often result in new costs. Other important changes that have occurred recently include the expansion of Early and Periodic Screening, Diagnosis, and Testing (EPSDT). These legislative and policy changes can significantly affect the fee-for-service Upper Payment Limit and the capitation rates.

- Administrative Costs. Federal guidelines permit states to include in their calculation of the Upper Payment Limit the net administrative savings of the managed care program. To the extent that the use of managed care decreases the state's administrative costs, for example, because of reduced claims administration, the state may include these savings in the health plan's capitation payment. Separate payments to account for expected health plan administrative costs cannot be added to the HCFA Upper Payment Limit.

Expected savings from managed care

The above process results in average capitation rates that are equal to the HCFA Upper Payment Limit, also known as the fee-for-service equivalent cost for a mandatory enrollment program. Many states also opt to apply managed care savings adjustments to set capitation rates at a level below the UPL. Managed care savings adjustments can be applied at an aggregate level (e.g., 95%) or can be estimated by service category to reflect expected managed care shifts from institutional to ambulatory settings.

Risk sharing

Many states offer health plans risk sharing arrangements to minimize the potential losses that may occur if a health plan has a few individuals with extraordinarily high levels of cost. Risk sharing is done through three basic approaches.

- Individual stop loss. Individual stop loss provides coverage for the high costs of individual Medicaid recipients. Typically states will offer stop loss coverage during the early years of managed care implementation to gain participation of health plans. Particularly for small plans and plans that are organized around traditional safety net providers, stop loss coverage provides a critical level of protection. Many larger health plans and those with a commercial book of business will choose to purchase stop loss through private insurers. Smaller plans and those that are organized specifically to cover Medicaid recipients may not have ready access to private coverage.

  States generally offer stop loss that covers a percentage of claims above a given threshold for an individual. The threshold may vary based on the size of the plan. A common stop loss level is $50,000, with a 10% risk sharing provision. Under this arrangement, the health plan would cover the first $50,000 in

claims costs for an individual and 10% of all remaining costs. Costs are usually calculated based on Medicaid fee-for-service payment levels, although some states may negotiate a different payment level that recognizes a health plan's actual expenditures.

When states provide stop loss insurance, the base capitation rates are reduced to recognize the reduced financial responsibility of the health plans. This reduction is similar to the premium a plan would pay for private stop loss insurance.

- Aggregate stop loss. Aggregate risk sharing is less common. Under this approach, a health plan will negotiate with the Medicaid agency for an expected level of total expenditures, generally linked to the capitation rates and numbers of eligibles. If expenditures exceed payments by an agreed-upon percentage, the state will cover a portion of the excess cost. Similarly, if total expenditures are less than the capitation payments, the state will recoup a portion of the savings. These types of arrangements are generally used only when a state is introducing a new population group to the managed care program and health plans are reluctant to participate.
- Carve-outs for special populations. Many states exclude specific population groups from managed care. In addition, certain high cost services may be excluded from managed care. Typical population exclusions include individuals who are dually eligible for Medicare and Medicaid, groups with special health care needs, or with extraordinarily high costs. Behavioral health services are often carved out or are separately contracted.

Health status risk adjustment

More complex rate setting methods involve the use of diagnostic, or health status, risk assessment tools. These tools are designed to measure the expected level of health care service need for groups of individuals based on their medical history. Several states, including Colorado, Oregon, Utah and Maryland, have begun using risk adjusted payment methods. The methods used by each state vary in the specific tools that are used for measuring differences in risk, but the basic goals of the programs are the same: to target Medicaid spending to the health plans that enroll individuals with high levels of health care need.

Disability Payment System

Two of the states, Oregon and Colorado, make use of the Disability Payment System (DPS) developed by Dr. Richard Kronick and colleagues at the University of California, San Diego. This system was initially developed for disabled populations in order to recognize important differences in health care needs for individuals with disabilities and to assure that health plans

are paid adequately to provide care for them. The DPS tool has since been expanded to include applications for the Temporary Assistance to Needy Families and related aid categories.

The DPS makes use of detailed encounter data that reports on all health care service use to measure the diagnostic mix of enrollees in health plans. A relative risk score is then calculated that is used to determine payment rates. The risk assessment score is most often applied to the average capitation rate after determining the fee-for-service Upper Payment Limit. For example, the risk assessment score for a plan may be 1.05, indicating that the health plan's measured risk and expected costs are 5% above average. If the average capitation rate for all plans is $100, the payment to the high risk plan would be $105. Similarly, a plan with a risk assessment score of 0.95, indicating that the risk is 5% below average, would receive a payment of $95. The risk assessment score may also be used to estimate the difference in expected cost between the fee-for-service population included in the data base and managed care enrollees.

In Colorado, the Medicaid fee-for-service risk mix is compared to the Medicaid managed care plans' risk mix to determine the average payment level. That process results in the average payments to health plans being slightly higher than they would have been without risk adjustment due to the structure of the managed care program that was in place before risk adjustment was introduced. In Oregon, the risk mix is measured among health plans. In that state different methods are used to determine the correct average payment amount.[2]

Marker Diagnosis method

Utah is currently using a Marker Diagnosis method that relies on inpatient hospital data only, as detailed encounter data are not yet available from health plans. The Marker Diagnosis method uses a specific list of inpatient conditions from which to measure health status. Utah intends to convert to a more comprehensive tool, most likely the DPS, when better data are available from health plans. This state sought a tool that could measure differences in risk among plans.

Ambulatory Care Group method

Maryland uses the Ambulatory Care Group (ACG) method developed by Dr. Jonathan Weiner and colleagues at Johns Hopkins University. Similar to the DPS, the ACG method uses comprehensive encounter data and considers all health care services used by an individual in developing a relative risk profile. Maryland pays a risk adjusted amount for each individual rather than an average amount for the health plan.

[2] The Oregon Health Plan Medicaid Demonstration operates under an 1115 waiver with very different methods for setting average payment rates. Colorado operates a more standard managed care program.

Diagnostic Cost Group method

A fourth tool for measuring differences in risk is the Diagnostic Cost Group (DCG) method developed by Arlene Ash, Randall Ellis, and colleagues at Boston University. A version of this method that uses hospital inpatient data only will be used starting in 2000 to set payment rates for health plans participating in the Medicare program. It is not currently used in any state Medicaid managed care programs, although a model has been developed for use in Medicaid programs.

These risk assessment tools are designed to more precisely estimate the expected cost of a population, similar in concept to the existing methods of paying plans based on the demographic characteristics of their enrollees. Several other states are investigating using risk assessment techniques to fine-tune their rate setting methods. At this time, California does not use risk assessment tools in setting payment rates for health plans.

III. Medi-Cal's Rate Setting Method

California develops capitation rates for managed care plans based on methods that have been approved by the Health Care Financing Administration and comply with generally accepted standards. Specifically, historical fee-for-service data are used to estimate the fee-for-service equivalent cost and appropriate adjustments are then applied to project costs into the contract period. A unique characteristic of California's rate setting method is the use of managed care data as one component of the rate development process. Data from the Santa Barbara County Organized Health System is used to estimate costs for managed care plans. In this section we provide a general overview of the rate setting methods used in California.

Data sources

A critical first step in calculating capitation rates for Medicaid managed care plans is determining the correct data source and obtaining accurate data. In California, managed care has been in place for many years, although the geographic area covered by managed care plans has been relatively limited until the implementation of the Two-Plan Model. When managed care enrollment represents a relatively low percentage of total Medi-Cal enrollment, fee-for-service data give an accurate estimate of the true fee-for-service cost of services. As managed care enrollment increases, the fee-for-service data tend to be less reliable, as the groups that remain covered by fee-for-service are not representative of the total population.

Due to large Medi-Cal managed care enrollment, California has reached the point of requiring additional data for calculating capitation rates and the Upper Payment Limit and has addressed this concern through the use of data from the Santa Barbara County Organized Health System. This data source was chosen for two reasons: (1) the Santa Barbara system is considered reasonably representative of utilization rates under managed care, and (2) detailed encounter data are available from Santa Barbara.

The methods for calculating the Upper Payment Limit are largely the same for the three mandatory Medi-Cal managed care programs, with slight variations in terms of the data that are used for the starting point. For Two-Plan Model counties, fee-for-service data for the twelve counties covered by that program is used as the primary source. For County Organized Health Systems and the Geographic Managed Care program, statewide fee-for-service data are used. All of the data sources are for the period prior to the significant expansions of Medi-Cal managed care.

The basic steps for calculating capitation rates for Two-Plan Model plans are as follows:

- Step 1: Combined fee-for-service data for the Two-Plan Model counties are segregated into rate cells by eligibility category and special adjustments are made for population groups and services that are not included in the capitation rates. Data are distributed to eight broad service categories including physician, pharmacy, hospital inpatient, hospital outpatient, long-term care, Federally Qualified Health Center fee-for-service equivalent cost, Federally Qualified Health Center incremental cost, and other.
  - — Adjustments are made specifically to reflect health plan responsibility for long-term care and for testing requirements for AIDS.
  - — Specific procedures are excluded from health plan contracts, and the costs for these services are removed from the database in the form of percentage adjustments to the base data. These adjustments are described in detail in the following section titled “Medi-Cal populations and services requiring special attention.”
  - — Mental and behavioral health services are also excluded from health plans’ contracts.
- Step 2: Adjustments are calculated to reflect several differences in expected costs during the contract period:
  - — An age/sex adjustment is calculated to reflect the demographic mix of enrollees in managed care.
  - — An eligibility mix adjustment is made to reflect differences in cost among different groups of eligibles.
  - — An adjustment is made to reflect the fact that not all claims for services provided during the historical data period have been processed through the state’s claims payment system.
  - — A series of trend adjustments are made to reflect changes in utilization rates and fee levels during the contract period.
  - — An interest offset is applied to reflect the earlier payment of capitation

amounts compared to fee-for-service claims. Under managed care, health plans are paid prospectively, while fee-for-service payments are made after services are obtained.

— Adjustments are made to reflect legislative changes in benefits and payment levels that are scheduled to take effect before or during the contract period.

— An adjustment is made to reflect net administrative cost savings due to reduced claims processing requirements, and balanced by any new state administrative costs for administering the managed care program.

- Step 3: From these adjusted data, a statewide cost per person, or per capita cost, is calculated, which is then used to calculate total expected expenditures under the Two-Plan Model. This amount represents the federal Upper Payment Limit.
- Step 4: Separately, data from the Santa Barbara County Organized Health System are used to calculate per capita costs under a managed care plan. Adjustments are made to the Santa Barbara data to reflect county-specific costs per unit of service for hospital claims and the Medicare area adjustment factor for physician services. The total expected cost for services based on these data is calculated similar to the calculation in Step 3.
- Step 5: The total costs estimated through the fee-for-service data (Step 3) are compared to the total costs calculated with managed care data (Step 4), and the managed care data are adjusted as needed to remain within the state's budget guidelines and the federal Upper Payment Limit.
- Step 6: Plan-specific capitation rates are calculated based on the per capita cost for the program as a whole (from Step 5), and each plan's enrollment mix. Plans also have the opportunity to request an adjustment to their rates if they believe their maternity experience is higher than average.
- Step 7: Plans are offered the option of purchasing individual stop loss insurance from the State. Plans that choose this option have their capitation payments reduced by the value of the stop loss insurance. A range of claim thresholds from $25,000 to $150,000 is available.

For County Organized Health Systems and Geographic Managed Care, the methods used to develop the rates are largely the same. The important differences relate to the data used for developing the rates and the range of covered services and population groups. County Organized Health Systems cover nearly all Medi-Cal beneficiaries in the county. Consequently, data for the appropriate range of eligibility categories is used in developing the Upper Payment Limit. Similarly, that system covers a broader range of services, so many of the service exclusion adjustments (carve-outs) made for the Two-Plan Model rates are not appropriate. The range of

population and services covered by the Geographic Managed Care program is more similar to that of the Two-Plan Model.

Medi-Cal populations and services requiring special consideration

Certain high cost population groups are treated differently under the various Medi-Cal managed care programs. In addition, certain types of services are sometimes excluded from capitation rates because of their high cost or because different agencies have responsibility for the service. Some exclusions are accomplished by excluding the group from managed care entirely, while others are accommodated by properly adjusting capitation rates to accurately reflect expected costs of the group.

- California Children Services:[3] Children covered by California Children Services (CCS) enroll in managed care plans for primary care services under the Two-Plan Model. However, services related to the medical condition that qualifies them for CCS are obtained on a fee-for-service basis. Children with a CCS-eligible medical condition have significantly higher costs than other children in the Family category. The state is undertaking a managed care pilot project for CCS children who are also eligible for Medi-Cal. The older County Organized Health Systems include CCS children in their programs; newer COHS programs exclude these children. CCS children are not included in GMC plans.
- Disabled: Disabled individuals may enroll in the Two-Plan Model and GMC on a voluntary basis. These individuals are enrolled in COHS plans on a mandatory basis. Rate setting for disabled individuals requires consideration of the health care conditions of the enrollees. More so than for Family rate categories, diagnostic risk adjustment may be appropriate for this population in developing payment rates when multiple plans provide services. This is particularly true in a voluntary enrollment situation, where the individuals who choose to enroll in managed care may have significantly different health care needs than the average disabled member. With voluntary enrollment, the state runs the risk of either under- or over-paying for services.
- HIV/AIDS: California pays a separate capitation rate for individuals with AIDS and HIV. This separate payment rate is designed to assure that health plans are paid adequately for these high cost individuals. In addition to paying a separate capitation rate, costs for certain drugs related to treatment of AIDS and HIV are paid on a fee-for-service basis. This payment approach reduces the risk to health plans as new technologies are developed.

[3] California Children Services provides coverage for high cost medical conditions based on medical status. Approximately 60% of the children covered by the program are also eligible for Medi-Cal, with the remainder eligible for CCS only. CCS is a joint state/county operated program.

- Behavioral health: Mental and behavioral health services are excluded from capitated contracts for Two-Plan Model and GMC plans. Similar to CCS, older COHS plans cover these services, while newer plans do not as a result of state law. These services are the responsibility of the California Department of Mental Health and will be contracted directly with county mental health departments. Each county delivers mental and behavioral health services to all of its Medi-Cal beneficiaries via separate managed care organizations; these behavioral health organizations are not capitated.
- Other services: California carves out several other specific services from the capitation arrangement. These include dental, certain organ transplants, vision services, and chiropractic services. Coverage of these specific services varies widely among the Medi-Cal managed care programs.

Comparison of Medi-Cal rate setting to methods used in other states

The methods used by California to develop maximum allowable capitation rates are similar to those used in nearly all states. As in all states, the primary drivers in determining capitation rates are the underlying fee-for-service payment schedule and utilization rates.

The greatest variation in methods used for determining payment amounts is whether the state establishes the rate or whether health plans participate in the rate setting process. Some states solicit bids from plans as part of the rate setting process. Others negotiate with plans regarding payment levels, covered services, and operational requirements. In all cases, states operating within standard Medicaid rules must comply with the federal Upper Payment Limit in developing their capitation rates.[4]

There are three basic options for determining final payment amounts:

- Administrative rate setting;
- Competitive bidding; and
- Negotiation.

It is important to note that in all of these methods states first establish the Upper Payment Limit, and the negotiations or bidding revolves around the percentage of the Upper Payment Limit that will be paid to each health plan. Many states choose a method for determining final payment amounts based on the perceived level of interest among health plans in obtaining a contract as well as the administrative requirements of the various approaches.

Administrative rate setting

California uses an administrative approach for determining rates for the Two-Plan Model.

[4] States with Section 1115 waivers are sometimes permitted to deviate from this standard provided their total expenditures are shown to be revenue neutral to the federal government.

This method results in a payment amount that meets HCFA guidelines, and does not include negotiation between the state and health plans. In California, plans compete to earn the right to be offered as the commercial plan in each Two-Plan Model county, with the competition scored based on quality and access criteria; price is not part of the evaluation criteria. Fixed rates are calculated based on a combination of fee-for-service and managed care data, with adjustments as described above. Data from the twelve counties covered by the Two-Plan Model are combined to develop estimated utilization rates. County-specific data are used to modify portions of the calculations. Different payments are made to the Local Initiative plans compared to the commercial plans to recognize the added costs to Local Initiative plans of contracting with traditional and safety net providers. Approximately half the states with Medicaid managed care programs use this method, including Colorado, Florida, Maryland, Oregon, and New Jersey.

Competitive bidding

Fourteen states use a competitive bidding approach that requests bids from plans and allows competition based on both price and other criteria. States that use this method include Arizona, New York, Michigan, and Washington. Under competitive bidding, maximum and minimum payment rates are generally established in advance and plans bid to receive a contract. Some states offer incentives in the form of increased enrollment for lower bids.

Generally states develop a maximum bid price based on the federal Upper Payment Limit less expected savings from managed care. Competitive bid processes will typically request large amounts of information from bidding health plans that describe the process used for developing the bid including estimated utilization rates, unit payment amounts and administrative expenses. Some states impose limits on administrative costs as part of the bid process. The final bid price cannot exceed the FFSE. California does not currently use a competitive bidding process in determining final payments to health plans.

Negotiation

A hybrid of the rate setting and competitive bidding approaches is negotiated rates, used by six states. Again, the state must first establish the maximum acceptable capitation rate based on the Upper Payment Limit and any expected savings from managed care. States and health plans then negotiate the final payment amount. This method is used in California for Geographic Managed Care plans and County Organized Health Systems, as well as in the Medicaid programs in Kentucky, Massachusetts, Minnesota, and New Hampshire. Health plan utilization data may be used to inform the negotiation process.

In both competitive bidding and negotiation, adjustments to average capitation rates may be used to fine-tune the analysis of bid prices. Some states are beginning to use health-status risk assessment techniques to adjust the bids received from health plans.

IV. Medi-Cal Managed Care Rates in Perspective

California's payments for managed care plans are bounded by the federal Upper Payment Limit; payments to plans in the current contract year are set at 94% of the FFSE. This 94% level was developed based on state budget limits and to reflect amounts that DHS rate setting staff believed to be reasonable annual rate increases. While states have the latitude to pay up to 100% of the FFSE, significant changes in overall capitation rates can be achieved only through redefining the Upper Payment Limit or increasing fee-for-service payment levels.

It may be possible to work with the Health Care Financing Administration to redefine the Upper Payment Limit to include additional costs. For example, to the extent that access to care may be improved through increased participation of providers, it may be possible to increase the payment limit. This argument typically is successful only for limited service areas and for defined sets of services. One example is access to dental services, where in many states it is often difficult to identify a provider willing to accept Medicaid recipients. If managed care plans significantly improve access to services it is sometimes possible to allow a higher capitation amount. Similarly, in rural areas that may be under-served in the fee-for-service system access to additional providers may result in higher expected costs.

Capitation rates generally see a significant increase only when a corresponding increase in fee-for-service expenditures is expected. Changes in payment rates result in an increase in the FFSE. Similarly, initiatives to increase the use of particular types of services result in an increase in the FFSE. Examples include initiatives to improve compliance with vaccination schedules and increased use of EPSDT services.

Payments to plans

In assessing the appropriateness of the Medi-Cal payment level in California, it may be useful to compare Medi-Cal's payment rates to those paid by other California purchasers for other

population groups. It may also be useful to compare rates for the Medi-Cal TANF category to similar population groups in other states. A critical component of the capitation rate development is the underlying fee-for-service fee schedule for different payers and for other Medicaid programs.

The findings from a May 1999 study by the Urban Institute's Assessing the New Federalism Project, "Medicaid Managed Care Payment Methods and Capitation Rates: Results of a National Survey"[5] indicate that California's payment rates are relatively low compared to other states. This result is striking in comparison to payments to Medicare managed care plans, where California receives some of the highest payment amounts. An important corollary to the Urban Institute's analysis is a comparison to payment levels for other payers, including Medicare and commercial health plans. In making these comparisons it is important to note that significant differences in population and benefit packages can cause differences in payment levels.

In this section we discuss payment levels for health plans and providers within California and in other states. This comparison is provided as a basis for discussion of rate levels within Medi-Cal managed care.

Comparisons to other payers

To assess the level of payment rates for Medi-Cal enrollees in managed care plans, we developed a number of comparisons:

- Fee-for-service payments: Medi-Cal payment levels versus other state Medicaid programs for high volume services;
- Fee-for-service payments: Medi-Cal payment levels versus other payers in California for high volume services;
- Capitation rates: Medi-Cal managed care versus other Medicaid managed care programs;
- Capitation rates: Medi-Cal managed care versus other payers in California, with adjustments for varying population groups and benefit designs; and
- Commercial premiums: Commercial premiums in California versus other states, based on premium rates for the Federal Employees Health Benefits Plan.

Finally, while detailed fee schedules are not available, we discuss some of the payment arrangements being used under California's Healthy Families Program, the Title XXI program that covers children in families with income under 200% of the federal poverty level who are not eligible for Medi-Cal. That program contracts with managed care plans on a competitive bid

[5] Holahan J., S. Rangarajan and M. Schirmer. *Medicaid Managed Care Payment Methods and Capitation Rates: Results of a National Survey*. The Urban Institute: Assessing the New Federalism. Occasional Paper 26. May 1999.

basis to provide services that are similar to those available under Medi-Cal, with some important differences. Healthy Families participants have cost sharing requirements, while Medi-Cal recipients do not. The Healthy Families population is most similar to the children covered under the current Medi-Cal managed care program in Two-Plan Model and GMC counties.

Fee-for-service payments: Medi-Cal versus other state Medicaid programs

Medi-Cal payment levels for high volume services are generally lower than those paid in other states. We surveyed six states and requested information on their payment levels for a specific list of high volume services. Note that information was requested related to physician services only, as California's contracts with hospitals are confidential. Identifying consistent services for other types of providers is more difficult. Table 2a shows a comparison of fee levels for specific services in California Medicaid and other state Medicaid programs. This table shows that Medi-Cal's fee-for-service payment rates are generally lower than the rates paid by other states for comparable services, although there is some variation for specific services.

Table 2a
Comparison of Fee-For-Service Medicaid Payments

Procedure Description	CPT Code	Medi-Cal	Florida	Illinois	New York	Oregon	Texas	Virginia
Well-child visit	99392	$29.04	N/A	N/A	$29.00	$32.96	$47.20	$68.13
Office visit: Mild to moderate	99213	$18.18	$25.00	$30.00	$6.50	$24.46	$22.84	$30.63
Office visit: Moderate to severe	99214	$30.30	$37.74	$45.00	$6.50	$49.90	$34.72	$46.21
History/exam: Newborn	99431	$45.45	$48.39	$41.00	$6.50	$39.44	$52.79	$67.07
IP visit 1st day: Moderate	99222	$64.64	$64.32	$34.00	$6.50	$74.86	$69.22	$88.20
Subsequent day IP visit	99232	$33.33	$30.49	$20.15	$5.00	$35.23	$33.12	$41.72
Simple repair of wound	12001	$13.48	$45.63	$34.00	$8.00	$57.22	$54.83	$62.32
Hernia surgery	49505	$303.21	$234.86	$369.00	$140.00	$291.26	$247.15	$320.05
1st hour of critical care	99291	$107.26	$108.97	$33.05	$25.00	$130.63	$43.88	$148.93
Insert emergency air tube	31500	$47.17	$71.01	$50.25	$20.00	$90.57	$86.80	$97.18

By dividing each Medi-Cal fee-for-service payment by the corresponding rate paid in other states, relative payment levels of California are calculated as shown in Table 2b. For example, for a well-child visit the following table shows that Medi-Cal's payment of $29.04 is 88.1% of the payment that would be made by the Oregon Medicaid program. An important note with regards to New York is that while the per-visit payments for services such as office visits are extremely low ($6.50 for most office visits), the overall amount paid by the New York Medicaid program per member is high, indicating that physicians in that state bill for a larger number of services than in California and other states.

Table 2b
Medi-Cal Fee-For-Service Payments as a Percentage of Other State Payments

Procedure Description	CPT Code	Florida	Illinois	New York	Oregon	Texas	Virginia
Well-child visit	99392	N/A	N/A	100.1%	88.1%	61.5%	42.6%
Office visit: Mild to moderate	99213	72.7%	60.6%	279.7%	74.3%	79.6%	59.4%
Office visit: Moderate to severe	99214	80.3%	67.3%	466.2%	60.7%	87.3%	65.6%
History/exam: Newborn	99431	93.9%	110.9%	699.2%	115.2%	86.1%	67.8%
IP visit 1st day: Moderate	99222	100.5%	190.1%	994.5%	86.3%	93.4%	73.3%
Subsequent day IP visit	99232	109.3%	165.4%	666.6%	94.6%	100.6%	79.9%
Simple repair of wound	12001	29.5%	39.6%	168.5%	23.6%	24.6%	21.6%
Hernia surgery	49505	129.1%	82.2%	216.6%	104.1%	122.7%	94.7%
1st hour of critical care	99291	98.4%	324.5%	429.0%	82.1%	244.4%	72.0%
Insert emergency air tube	31500	66.4%	93.9%	235.9%	52.1%	54.3%	48.5%

Fee-for-service payments: Medi-Cal versus other payers in California

We also obtained information on fee-for-service payment levels for other payers in California. Specifically, we obtained payment information for two large Preferred Provider Organizations (PPOs) in California, as well as information on Medicare payment amounts and the fee schedule for one of the large HMOs participating in the Medi-Cal managed care program. We did not obtain data on payment levels for other HMO enrollees, as these plans often pay providers on a capitated basis and payment amounts for individual services are not readily available. Data for the Medicare and PPO rates are shown both for the San Francisco and Los Angeles areas to show representative data from the two most populous areas of the state. (Medi-Cal pays the same fee-for-service rate for all areas of the state.)

Table 3a shows a comparison of fee levels in Medi-Cal to those for other payers in California. Medi-Cal's fee schedule is consistently lower than the fee schedules used by these other payers, as is common for Medicaid programs. The Medi-Cal managed care plan shown here pays rates to physicians that are 5% above Medi-Cal's payment rates in order to encourage provider participation.

Similar to Table 2b, these Medi-Cal fee-for-service rates can also be expressed as a percentage of the rates of the other California payers to show relative payment levels. (See Table 3b.)

Table 3a
Medi-Cal Fee-For-Service Payments versus Other California Payers

Procedure Description	CPT Code	Medi-Cal	Medi-Cal HMO	San Francisco			Los Angeles		
				Medicare	PPO #1	PPO #2	Medicare	PPO #1	PPO #2
Well-child visit	99392	$29.04	$30.54	N/A	$115.00	$47.86	N/A	$110.00	$47.67
Office visit: Mild to moderate	99213	$18.18	$19.13	$48.30	$47.33	$43.91	$46.38	$45.41	$43.73
Office visit: Moderate to severe	99214	$30.30	$31.88	$73.04	$70.67	$55.85	$70.34	$68.02	$55.63
History/exam: Newborn	99431	$45.45	$47.82	$95.73	$106.36	$99.17	$91.69	$101.21	$98.77
IP visit 1st day: Moderate	99222	$64.64	$68.01	$129.65	$134.32	$123.38	$125.44	$129.55	$123.37
Subsequent day IP visit	99232	$33.33	$35.07	$61.18	$63.15	$60.25	$59.29	$61.04	$60.01
Simple repair of wound	12001	$13.48	$14.15	$107.69	$93.33	$87.11	$103.86	$90.50	$88.56
Hernia surgery	49505	$303.21	$318.37	$462.03	$491.46	$639.90	$448.19	$475.45	$650.48
1st hour of critical care	99291	$107.26	$112.96	$218.90	$223.87	$220.41	$212.51	$216.78	$219.51
Insert emergency air tube	31500	$47.17	$49.53	$138.52	$147.64	$139.38	$134.41	$142.68	$141.69

Table 3b
Medi-Cal Payments as a Percentage of Other California Payers

Procedure Description	CPT Code	Medi-Cal HMO	San Francisco			Los Angeles		
			Medicare	PPO #1	PPO #2	Medicare	PPO #1	PPO #2
Well-child visit	99392	95.1%	N/A	25.3%	60.7%	N/A	26.4%	60.9%
Office visit: Mild to moderate	99213	95.0%	37.6%	38.4%	41.4%	39.2%	40.0%	41.6%
Office visit: Moderate to severe	99214	95.0%	41.5%	42.9%	54.3%	43.1%	44.5%	54.5%
History/exam: Newborn	99431	95.0%	47.5%	42.7%	45.8%	49.6%	44.9%	46.0%
IP visit 1st day: Moderate	99222	95.0%	49.9%	48.1%	52.4%	51.5%	49.9%	52.4%
Subsequent day IP visit	99232	95.0%	54.5%	52.8%	55.3%	56.2%	54.6%	55.5%
Simple repair of wound	12001	95.3%	12.5%	14.4%	15.5%	13.0%	14.9%	15.2%
Hernia surgery	49505	95.2%	65.6%	61.7%	47.4%	67.7%	63.8%	46.6%
1st hour of critical care	99291	95.0%	49.0%	47.9%	48.7%	50.5%	49.5%	48.9%
Insert emergency air tube	31500	95.2%	34.1%	31.9%	33.8%	35.1%	33.1%	33.3%

Capitation rates: Medi-Cal managed care versus other Medicaid managed care programs

The Urban Institute's Assessing the New Federalism Project has completed an extensive study of managed care payment rates in nearly all states for similar populations. The results of this analysis suggest that Medi-Cal rates are among the lowest in the country.[6]

Capitation rates: Medi-Cal versus other California payers

Medi-Cal's capitation payments are lower on average than those for other payers in California after adjusting for differences in covered benefits and health status. These low Medi-Cal payment levels correspond in part to the low fee schedule that underlies the capitation rates. However, the capitation rates are closer to the average than the fee-for-service payment rates. This result suggests that utilization rates in the Medi-Cal fee-for-service system are higher than in other programs.

To develop a comparison of per capita payments for other California payers we started with premium rates for small-group commercial populations using data from the Health Insurance Plan of California (HIPC). The starting HIPC rates used were for the "Employee + one or more child(ren)" category. The following adjustments were then made:

- We adjusted for differences in the benefit design and the health status of the TANF/CalWORKs population. In particular, we adjusted for the cost sharing requirements of commercial plans and the difference in expected maternity prevalence between Medi-Cal and the small group plans.
- The HIPC premiums are age rated; premiums for this study were chosen to most closely compare to the average age mix of the TANF/CalWORKs population.
- The HIPC premiums were adjusted to reflect the difference in average family size between that small-group population and the Medi-Cal TANF/CalWORKs population.
- We also adjusted for average differences in administrative expenses; small group premiums include costs associated with marketing, which are not a health plan responsibility under Medi-Cal.

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[6] Holahan J., S. Rangarajan and M. Schirmer. *Medicaid Managed Care Payment Methods and Capitation Rates: Results of a National Survey.* The Urban Institute: Assessing the New Federalism. Occasional Paper 26. May 1999.

Table 4 shows a comparison of per capita payment rates for Medi-Cal and these adjusted HIPC small group premiums. The HIPC plans included in this study are among the largest participating in that program. An average of rates for Los Angeles and San Francisco is used for the comparison.

Table 4
Medi-Cal Capitation versus Adjusted HIPC Premiums

Plan	Capitation	Ratio of Medi-Cal to HIPC Plans
Medi-Cal	$82.75	1.00
HIPC Plan 1	$130.65	0.63
HIPC Plan 2	$105.17	0.79
HIPC Plan 3	$120.84	0.68
HIPC Plan 4	$99.07	0.84
HIPC Plan 5	$122.44	0.68

Commercial premiums: California versus other states

To provide a consistent measure for comparison, we also calculated the ratio of commercial premium rates in California to other areas around the country. For this comparison we used premium rates paid under the Federal Employees Health Benefits Plan (FEHBP); this plan was chosen because the benefits offered to enrollees are relatively constant across the country, allowing for a direct comparison of premiums.

FEHBP is a large purchaser of health care in major metropolitan areas around the country, and covers federal employees, retirees, and their dependents. The package of covered services is fairly representative of employer-purchased health care, including 100% coverage of hospital services, $5 or $10 co-pays for physician office visits and prescription drugs. Dental and vision services are excluded from the plans analyzed. We chose to compare the employee-only rate because this rate category has the least variation in family size.

Table 5
FEHBP Rates

Area	1999 FEHBP Monthly Single Rate	Ratio to California Average
California Average	$170.26	1.00
New York City Average	$203.97	0.83
Houston Average	$169.62	1.00
Dallas Average	$172.74	0.99
Chicago Average	$227.89	0.75
Oregon Average	$189.60	0.90
Miami Average	$166.05	1.03
Washington, D.C. Average	$177.82	0.96

Table 5 shows FEHBP rates in California and other major metropolitan areas around the country. This table shows that premiums in California are towards the low end of premiums in other states for a similar scope of benefits, with New York and Chicago having

significantly higher premiums and other areas having premiums approximately the same as those in California.

These results indicate that overall health care costs in California are relatively similar to those in other major cities for this program. On the other hand, Tables 2a and 2b shows that fee-for-service payment levels for Medi-Cal are low compared to other Medicaid programs. In addition, the Urban Institute's study of Medicaid capitation rates across the country indicate that Medi-Cal's managed care rates are also relatively very low.[7]

Provider payments: Medi-Cal versus Healthy Families

Provider payments under the Healthy Families Program vary based on the type of plan that is contracting for services. Many of the Medi-Cal Local Initiative and County Organized Health System programs provide services to Healthy Families members. In addition, Healthy Families contracts with a number of the commercial health plans that hold Medi-Cal contracts, as well as some plans that do not contract with Medi-Cal. We surveyed several of the plans to determine their provider payment arrangements for Healthy Families participants and Medi-Cal participants. Of those plans that responded, all reported paying providers Healthy Families rates that are higher than the Medi-Cal fee-for-service payment level. Table 6 provides a summary of the provider payment arrangements used in the Healthy Families Program, and where available, a comparison to the payment arrangements for the same plans for Medi-Cal members.

[7] Holahan J., S. Rangarajan and M. Schirmer. *Medicaid Managed Care Payment Methods and Capitation Rates: Results of a National Survey*. The Urban Institute: Assessing the New Federalism. Occasional Paper 26. May 1999.

Table 6
Comparison of Medi-Cal and Healthy Families Payment Arrangements

Plan	Type	Medi-Cal Provider Payment Arrangements	Healthy Families Provider Payment Arrangements
1	Commercial	Pays approximately 5% above Medi-Cal fee-for-service (FFS) payment level.	For HMO, uses Plan Medi-Cal payment levels+20%; for Exclusive Provider Organization, uses commercial payment rates, which are significantly above Medi-Cal FFS.
2	Commercial	Not applicable – no Medi-Cal contract.	Uses commercial payment arrangements.
3	Commercial	Mix of capitation and FFS. Capitation is based on state's payment rates. Provider payments are typically higher than Medi-Cal FFS payment rates.	Uses commercial payment rates, which are higher than Medi-Cal.
4	Commercial	Primarily capitation; provider payments are derived based on amount of funds available from State, but there is not a direct relationship between the Medi-Cal FFS payment rates and the plan's capitation payments.	Pay FFS at rates that are higher than the Medi-Cal FFS payment schedule.
5	Local Initiative	Total payments, including return of withhold, results in rates that are currently approximately 25% above the Medi-Cal FFS payment levels. Expecting to increase this payment level by an additional 10% in the next year.	Payments are comparable to those for Medi-Cal, which are currently approximately 25% above Medi-Cal FFS payment levels.
6	Local Initiative	Varies by provider group. Some are paid FFS and some are capitated. Some groups are receiving total payments that are significantly above the Medi-Cal FFS payment level, while others are being paid approximately at the FFS payment level. Risk is transferred to providers in the form of capitated payments.	Payments are approximately 25% above the plan's Medi-Cal payment levels.
7	County Organized Health System	Payments are not based on Medi-Cal fee schedule in any way. Primary care services are capitated. Could not say what the relationship is between plan payments to providers and Medi-Cal FFS payment levels.	Payments for all professional services are approximately 25% higher than the plan's Medi-Cal payment levels and are made on a FFS basis.

Conclusions

Medi-Cal's payments to managed care plans reflect relatively low fee-for-service payment levels. The methods used by the state's actuaries are consistent with the methods required under federal regulations. Although some minor adjustments may be made to the capitation rates, significant changes in average rates can occur only if there is a change in the underlying fee-for-service system or if the guidelines for developing the rates change. State budget limits also affect capitation rates. Federal guidelines would allow the state to pay up to 100% of the fee-for-service Upper Payment Limit; health plans participating in Two-Plan Model counties are paid at 94% of that amount for the current contract year.

At the same time, fine-tuning of payments to health plans may more accurately reflect the expected costs of enrollees in particular health plans. Methods such as diagnostic risk assessment may yield more accurate results for specific population groups. To date, few of the most costly individuals have been enrolled in managed care, other than in County Organized Health Systems. If the State decides to expand managed care enrollment to additional population groups, it will be important to consider more complex rate setting methods to assure funds are appropriately directed to providers based on the relative health care needs of enrollees.

Many of the managed care plans appear to be able to pay providers at rates that are higher than Medi-Cal fee-for-service payment levels. A more thorough analysis of plan and provider relationships could yield important information regarding issues of providers and access to quality health care.