An LAO Report

A More Rational Approach to Setting Medi-Cal Physician Rates

Background

In California, the federal Medicaid Program is administered by the state Department of Health Services (DHS) as the California Medical Assistance Program (Medi-Cal). Its costs are shared by the state and the federal governments.

LAO Findings

Our analysis indicates that the rates paid to physicians for services provided under the Medi-Cal Program are relatively low compared to the rates paid by the federal Medicare Program and other health care purchasers. Despite state and federal requirements, DHS has not conducted annual rate reviews or made periodic adjustments to Medi-Cal rates to ensure reasonable access to health care services. Rate adjustments have generally been adopted on an ad hoc basis, and not upon an assessment of the access of Medi-Cal beneficiaries to quality health care.

Thus, there is not a rational basis for Medi-Cal rates. In comparison, Medicare uses a comprehensive, annually updated, rate-setting system.

LAO Recommendations

We recommend that the Legislature establish a more rational process for periodically reviewing and adjusting Medi-Cal rates.

- In the short term, if the Legislature wishes to continue to narrow the significant gap between Medi-Cal physician rates and the rates paid under other health programs, Medicare rates should be used as a benchmark.
- In the long term, the Legislature should direct DHS to perform a comprehensive analysis of access to physician services and the quality of care provided to Medi-Cal beneficiaries, and offer proposals commencing in 2002-03 for periodic future adjustments to physician rates based upon that analysis.

This approach would benefit the state by potentially improving the quality of health care and ensuring that the Medi-Cal Program complies with state and federal requirements to provide reasonable access to health care for Medi-Cal beneficiaries. It could also lead to more efficient use of medical services, provide more fairness to medical providers by basing rates upon objective measures, and simplify the calculation of rates.

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February 1, 2001

INTRODUCTION

Background

State-Federal Health Care Program. In California, the federal Medicaid Program is administered by the state as the California Medical Assistance (Medi-Cal) Program. This program provides health care services to more than 5 million welfare recipients and other qualified low-income persons (primarily families with children and the aged, blind, or disabled). The Department of Health Services (DHS) administers the program. The federal Health Care Financing Administration (HCFA) oversees the program to ensure compliance with federal law. The state and the federal government share the cost of most Medi-Cal benefits on a roughly equal basis.

Expenditures for Physician Services. For 2000-01, the Medi-Cal Program will spend an estimated $1.2 billion ($600 million General Fund) for physician services in the traditional "fee-for-service" portion of the program in which providers are paid for each examination, procedure, or other service that they furnish. In addition, a significant portion of the estimated $3.8 billion ($1.9 billion General Fund) in premiums that Medi-Cal provides to health plans for beneficiaries in managed care indirectly pays for physician services.

About half of the persons eligible for Medi-Cal are enrolled in managed care organizations while the remainder receive services under the fee-for-service portion of the program. Although we believe a review is warranted of the managed care plan rate system, this analysis focuses primarily upon the mechanism for establishing physician rates for fee-for-service Medi-Cal services. Our key findings, which we discuss below, are summarized in Figure 1.

THE CURRENT RATE-SETTING SYSTEM

Medi-Cal Physician Rates Relatively Low

Budget Problems Held Down Rates. Studies show that the rates that Medi-Cal pays for physician services are relatively low compared to rates paid by other major purchasers of health care. For example, a May 1999 study conducted by Pricewaterhouse Coopers LLP for the Medi-Cal Policy Institute found that Medi-Cal physician rates for some common procedures were substantially less than those paid by the federal Medicare Program, which provides health care benefits for the elderly and some disabled persons, or by private health plans. Medi-Cal rates for certain medical services were often less than half the rates paid by other health care purchasers.

A national study of physician rates in state Medicaid Programs by the Urban Institute found that these states, on average, paid physicians at rates equal to about 64 percent of Medicare rates. However, the study found that California's Medi-

Cal rates were comparatively lower, amounting to an average of 47 percent of the Medicare rates in 1998.

These low rates resulted in part from the state's budget problems during the recession of the early 1990s. Most Medi-Cal physician rates were frozen and some rates were actually reduced to hold down state costs. As the state economy and state budget situation improved, rates were increased in the 1998-99 and 1999-00 state budgets for specific services, such as primary care and emergency room services. But no general increase affecting Medi-Cal physician rates across the board had been implemented since 1985-86 until the enactment of the *2000-01 Budget Act.*

Figure 1

Current Physician Rate-Setting System

Key Findings

- Medi-Cal rates are low compared to Medicare and other health care purchasers.
- The Medi-Cal Program has not met state and federal requirements for setting rates ensuring reasonable access to health care.
- Research indicates physician rates can affect access to care and health care quality.
- Medi-Cal physician rates are not based upon an assessment of relative access of Medi-Cal beneficiaries to quality health care or any measure of the actual costs of providing medical services.
- Medicare has a rational, comprehensive rate-setting system that adjusts physician rates annually.
- Medi-Cal physician rates now average about 60 percent of Medicare rates.

Figure 2

Physician Rate Increases for Medi-Cal and Related Health Programs—General Fund

2000-01
(Dollars in Millions)

	Amount	Percent Increase
Child Health and Disability Prevention Program—health screening exams	$19.2	20.0%
California Children's Services	9.2	20.0
Emergency room and on-call physicians	10.5	40.0
Neonatal intensive care	5.4	30.0
Comprehensive perinatal services	2.6	11.0
Other physician services	84.9	15.6
Total	**$132.9**	

As shown in Figure 2, the 2000-01 budget provided about $133 million from the General Fund (plus matching federal funds) for (1) targeted rate increases and (2) a general physician rate increase (identified as "other physician services").

The recent rate increases, however, do not put into place any ongoing process for evaluating physician rates or for periodically adjusting them when appropriate.

Requirements of State And Federal Law

Periodic Rate Revisions Mandated. State law estab-

lishes the following two general criteria for Medi-Cal physician rates:

- Rates must be sufficient to provide Medi-Cal recipients with reasonable access to medical care services and especially to primary and maternity care services.
- Rates must apply statewide, except that higher rates may be paid if necessary to provide access to care in specific areas.

The state provision for reasonable access to care is consistent with the requirement of federal Medicaid law that rates be sufficient to enlist enough providers so that care and services are available to Medicaid participants to at least the same extent that they are available to the general population in the geographic area.

State law also requires the DHS to annually review and periodically revise Medi-Cal physician and dental rates "to ensure the reasonable access of Medi-Cal beneficiaries to physician and dental services." The annual review of physician rates must take into account the following factors:

- Annual cost increases for physicians as reflected in the Consumer Price Index.
- Physician reimbursement levels of Medicare, Blue Shield, and other third-party payers.
- Prevailing customary physician charges within the state and in various geographical areas.
- Changes in the list of approved medical procedures.
- Characteristics of the current population of Medi-Cal beneficiaries and the medical services needed.

Requirements for Regular Rate Reviews Have Not Been Met. Despite these statutory provisions, DHS has not performed the required annual rate reviews or proposed revisions to physician rates for many years. The rate increase included in the 2000-01 budget was not based upon any objective analysis of the adequacy of physician rates.

The Legislature approved a bill in 1999 (AB 461, Hertzberg) to require DHS to conduct a rate review by April 1, 2000, including a comparison of Medi-Cal physician rates with those of Medicaid Programs in five comparable states. The Governor vetoed this legislation, stating that DHS lacked the administrative resources to conduct such a rate review.

Do Rates Make a Difference?

The Relationship Between Rates and Health Care. Based upon a recent survey of Medi-Cal beneficiaries, the Medi-Cal Policy Institute reported that 80 percent of program participants believe that they are receiving high quality medical services. However, 56 percent reported difficulty finding doctors who would provide them treatment, and 78 percent said it is very important that more doctors participate in the program.

Would higher physician rates result in better access to care and better quality of care for Medi-Cal beneficiaries? Clearly, rates must at least be above some minimal level in order for health care providers to participate. Given that about 35,000 physicians and 8,400 physician groups currently

are active Medi-Cal providers, Medi-Cal rates meet this minimum level. Given this level of provider participation, the more complex question is whether increasing rates above this level results in a corresponding increase in patient access to health care and the quality of that care. There is some research evidence that higher physician fees can improve access to care and quality of care.

A recent national analysis of Medicaid physician rates by the Urban Institute concluded that "physician fee levels affect both access and outcomes for Medicaid patients." One study cited by the Urban Institute report found that higher rates were "associated with a small, but significant, decline in the infant mortality rate." Another study found that children enrolled in Medicaid Programs that paid relatively higher physician fees were more likely to obtain care at a doctor's office.

Unfortunately, while state policy requires that Medi-Cal pay adequate physician rates, there is no simple formula that relates rate levels to health care access and quality.

For example, a one-time 5 percent increase in pediatric rates might not result in a measurable improvement in either access to care or the quality of such care for children. The evidence does suggest, however, that the failure to consider any rate adjustments for years at a time—as has sometimes been the state's practice—increases the risk that Medi-Cal rates will be insufficient to ensure reasonable access to care and quality of care.

There are established methods available to adjust Medi-Cal physician rates for these purposes. Such objective factors as the waiting period for a typical beneficiary to obtain certain medical services or the proportion of Medi-Cal beneficiaries receiving certain preventative care procedures could be evaluated. Measures of these objective factors for Medi-Cal could be compared to measures of the same factors for the California health care marketplace. Rate changes could then be proposed when these measurements indicate that problems exist in access to health care or in the quality of that care.

How Does Medi-Cal Determine Physician Rates?

Three-Step Process. There are three basic steps in the methodology for calculating most Medi-Cal physician rates. First, physician procedures are classified according to a *coding structure*. Second, each procedure is assigned a *relative unit value*. Third, the payment amount is determined by multiplying the relative unit value by a *dollar conversion factor*. (We explain each of these steps in more detail below.) This is the same general approach to calculating physician rates used by the Medicare Program and by many other insurers and health plans, although the specific factors each employs can and do vary.

Coding Structure. The American Medical Association (AMA) publishes the national standard coding system for defining and classifying physician procedures—the Current Procedural Terminology (CPT™). The initial CPT coding system was developed in 1966, and the AMA issues annual updates to recognize new procedures and technology, as well as practice changes. The CPT

coding system is quite detailed—the *Year 2000 CPT* update includes 7,755 individual procedure codes and their descriptions. Individual types of procedures sometimes have multiple codes that can reflect the intensity of the procedure or the setting in which it is delivered. For example, there are ten procedure codes for a regular office visit reflecting whether the visit is with a new or an established patient and five levels for each type of visit relating to the intensity levels of the visit.

The CPT procedure codes are one component of a more comprehensive Health Care Financing Administration Common Procedure Coding System (HCPCS). The HCPCS is the uniform national coding structure mandated by the federal HCFA for processing federal payments of Medicare and Medicaid (Medi-Cal in California) claims. The HCPCS structure also includes codes for laboratory tests, medical supplies and appliances, and services provided by nonphysician health professionals. The HCPCS also includes a number of special "local" codes for components of the Medi-Cal Program, such as children's health screening examinations provided through the Child Health and Disability Prevention Program.

Relative Unit Values. A relative unit value system is simply a way of weighing various medical procedures for rate-setting purposes. For example, such a system could weight medical procedures according to the amount of resources needed to provide each service. Under such a system, a low value would mean that relatively little clinician time and other resources would be needed to provide such a medical service, and a high value would mean greater resources would be needed to carry out a medical procedure.

Until August 2000, the relative values used to establish Medi-Cal physician rates were based upon a 1969 document, *Relative Value Studies*, containing a relative unit value system developed by the California Medical Association (CMA). The system has become outdated. We note that the CMA established the system to serve as a billing guide for physicians, thus its relative values reflected the fees that physicians customarily charged at that time for the different medical procedures, not necessarily the relative cost of providing those services.

Effective August 1, 2000, DHS revised the relative values for Medi-Cal physician rates as part of its implementation of the rate increases provided in the 2000-01 budget. The DHS revision was intended to reduce the disparity between Medi-Cal physician rates and the rates used by the federal Medicare Program. We discuss this revision in more detail later in this report.

Dollar Conversion Factors. Dollar conversion factors are applied to translate the relative unit value of a procedure into an actual payment amount. For example, an office consultation with a relative value of 9 and a conversion factor of $10 per unit of relative value would result in compensation by Medi-Cal at a rate of $90 (9 x $10) per office visit. In effect, conversion factors represent a judgment about how much the state is willing to pay for particular classes of medical procedures or services. Medi-Cal uses approxi-

mately 20 different types of conversion factors to determine payments for physician services. For example, the conversion factor for primary care is $10 per unit of relative value, while the general surgery conversion factor is about $37.

Rate Structure Very Complex. Medi-Cal rates also are subject to a variety of additional adjustments. For example, the conversion factor for primary care procedures increases by up to 24 percent if the care is provided to a child, or in a clinic or emergency room. The rate for an assistant surgeon is one-fifth the rate paid for a primary surgeon. When a surgery is performed, the rate of payment for additional procedures is reduced by 50 percent.

Figure 3 shows how the rate of payment for a specific procedure—in this example, a visit by a new patient to a doctor—depends upon its relative unit value, its dollar conversion factor, and other rate modifications. In our example, the payment for the identical medical procedure can range from $22.90 to $31.12. The thousands of possible procedure codes, relative unit values, conversion factors, and other rate modifications result in an extremely complex rate structure.

No Rational Basis for Rate System. As we have noted earlier in this report, DHS has no regular process in place for the periodic evaluation of the adequacy of physician rates or for periodically adjusting them. Physician rates are no longer tied to the 1969 relative unit value system developed by CMA.

Thus, the rate adjustments approved in recent years in the budget process have generally been adopted on an ad hoc basis, usually in response to complaints about limited access to specific services and to provider requests for rate increases. The rate increases included in the 2000-01 budget, for example, were based upon general legislative concerns about the adequacy of rates and overall budget priorities; they were not based on any specific objective measures of the adequacy of those rates in ensuring patient access to care or quality of care.

Figure 3

Example of a Medi-Cal Physician Rate Calculation Office Visit for a New Patient[a]

	Adult Patient		Child Patient	
	Doctor's Office	Community Clinic	Doctor's Office	Community Clinic
Unit value	2.29	2.29	2.29	2.29
Conversion factor (per unit)	$10.00	$12.38	$10.91	$13.59
Rate	$22.90	$28.35	$24.98	$31.12

[a] Procedure code CPT 99201—least intensive office visit.

While DHS has used additional funding received through the budget to adjust Medi-Cal physician rates to reduce some of the disparities with Medicare, large differences still exist for some medical procedures.

Ramifications of the Problem. The lack of a rational system for physician

rate-setting has significant potential ramifications for the provision of health care for Medi-Cal beneficiaries and the administration of the program.

- The state will not ensure reasonable access to quality health care services.
- Physician services will be used less efficiently, with overpayments for some medical procedures and underpayments for others, providing an incentive for the overuse of some services and the underuse of others. Some medical providers may not be fairly compensated for certain medical procedures.
- The Medi-Cal rate system will remain complex and difficult to administer for DHS and participating physicians, making it more difficult to accurately determine what providers should be paid for a medical procedure and more difficult for physicians to accurately bill the state for their services.

Medicare's Approach to Setting Physician Rates

Key Differences With Medi-Cal. Medicare is the largest purchaser of physician services in the nation. In 1998, physicians charged $14.9 billion to Medicare for patient care. Like Medi-Cal, Medicare uses CPT codes to designate specific physician services, assigns a relative value to each service, and then multiplies the relative value by a dollar conversion factor to yield a rate. The Medicare rate-setting method, however, differs substantially from the method used for setting Medi-Cal rates. Key features of the Medicare approach and how they differ from the Medi-Cal approach are described below.

Resource-Based Relative Value System (RBRVS). The relative unit values assigned to physician procedures by Medicare are based on detailed national surveys of the costs of work performed by physicians, the cost of their medical practices, and malpractice costs associated with each type of service. Medicare establishes these values for each of almost 100 geographic areas, including nine separate regions in California.

The federal government annually updates the relative unit values it assigns to medical procedures. Consequently, the relative unit values change each year to reflect evolving technology and medical practices. Prior to August 2000, Medi-Cal's relative values generally had not been updated other than to add new procedures to the system over time.

Single Conversion Factor. In contrast with the Medi-Cal Program, which uses many different dollar conversion factors to compute physician reimbursement rates, the Medicare Program relies upon one standard conversion factor. That single Medicare dollar conversion factor is based upon changes in medical inflation and the national economy and is used to adjust rates once each year to establish a targeted rate of growth for program spending. The conversion factor is increased if actual spending for Medicare has been below an established growth-rate target. The conversion factor is adjusted downward if actual

spending growth has been faster than the target growth rate. Medi-Cal does not make similar adjustments to its conversion factors.

A Comprehensive Approach. The Medicare RBRVS system administered by HCFA is the most comprehensive, annually updated, rate system in the nation, and it is publicly available for use by anyone, including other public agencies such as the Medi-Cal Program. Many purchasers of health care, including both private health plans and about 19 state Medicaid Programs, use the RBRVS system when adjusting physician rates. Some purchasers simply adopt the Medicare rates, while others modify the RBRVS system to better meet their needs. One simple modification is to set payments for health services at a percentage of the Medicare rate. Rates can be added for unique services or to provide special incentives to meet the needs of a specific population.

Rate Gap With Medicare Has Narrowed

Medi-Cal Rates Now 60 Percent of Medicare. The 2000-01 budget included about $85 million from the General Fund (plus an equivalent amount of federal matching funds) for a general increase in physician rates averaging 15.6 percent. Because the intent of the budget action was to reduce disparities with Medicare, larger rate increases were provided for some procedures than for others. State payments to managed care health plans will also be increased proportionally to allow those plans to provide higher compensation for physicians.

Based upon data provided by DHS, we estimate that the overall level of Medi-Cal physician payments has increased to roughly 60 percent of the Medicare rates allowed for nonhospital settings as a result of the recent physician rate increases. We estimate that Medi-Cal physician payments averaged about 50 percent of the Medicare rates before the recent rate increases were implemented.

RECOMMENDATIONS FOR REFORMING THE WAY PHYSICIAN RATES ARE SET

We recommend that the Legislature establish a more rational process for setting and then periodically reviewing and adjusting physician rates for the Medi-Cal Program. Our specific recommendations are summarized in Figure 4 (see page 10) and are discussed below.

Interim Step—Base Medi-Cal Rates Upon the Medicare Program.

Proposal. Due to the lack of objective data at this time about health care access or quality of care for Medi-Cal beneficiaries, we have no basis for recommending any further change now in Medi-Cal physician rates. However, as we have

Figure 4

LAO Recommendations for Setting Medi-Cal Physician Rates

Establish a More Rational Process

- ***Interim Rate Adjustments.*** We have no basis at this time for recommending Medi-Cal physician rate increases. If the Legislature wishes to increase rates, we recommend that those rate increases be made in a way that narrows the gap but does not exceed 80 percent of Medicare rates.
- ***Reporting of Rate Comparisons.*** We recommend that the Department of Health Services (DHS) report each year to the Legislature regarding how Medi-Cal rates compare to Medicare rates and the cost of keeping those rates in alignment with Medicare and other major purchasers of health care.
- ***Future Rate Adjustments.*** We recommend that DHS perform a comprehensive analysis of access to physician services and quality of care provided to Medi-Cal beneficiaries and the actual cost of providing medical services. Thereafter, DHS should base future rate adjustments upon that analysis. All rates would thereafter be reviewed at least once every five years.

noted in this report, Medi-Cal rates in many cases are well below the rates paid by other health care purchasers, including Medicare.

Accordingly, we recommend that any rate adjustments the Legislature does choose to provide in the interim for the Medi-Cal Program in the state budget process be made in a way that further narrows the program's differences with Medicare rates. For reasons we discuss below, we recommend that any specific rate increases generally be limited to 80 percent of the Medicare level, with the first priority being to provide increases in Medi-Cal rates for the specific procedures with relatively low rates compared to Medicare.

Under our approach, the state would use Medicare rates as a benchmark for implementation of any further Medi-Cal physician rate increases. In so doing, the state would cease making ad hoc rate changes in physician rates.

Our analysis indicates that Medicare provides the state with a useful benchmark for rate-setting, for several reasons. Because the relative values and conversion factor the Medicare rate system assigns to medical procedures are updated regularly, Medicare rates fairly accurately reflect the current costs of providing physician services. Using Medicare rates as the basis for Medi-Cal rate-setting would allow DHS to avoid the expensive and unnecessary process of developing its own separate physician rate structure. This approach also should not be difficult for health care providers to accept, given that four out of five California physicians participate in Medicare.

Copayments for "Dual Eligibles." Our recommendation that interim rate changes be limited to 80 percent of Medicare rates is due to the way Medicare and Medi-Cal provide coverage to persons eligible for both programs. Most of the elderly (age 65 and older) and some of the disabled persons enrolled in Medi-Cal also qualify for Medicare benefits. The Medi-Cal Program pays the Medicare premiums and deductibles and any

required copayments for medical services on behalf of these persons. Currently, there are about 825,000 Medi-Cal enrollees known as dual eligibles also enrolled in Medicare.

Participating physicians generally agree to accept the Medicare rates for services to Medicare beneficiaries. However, the Medicare *payment* is only 80 percent of the Medicare *rate*—with copayments by beneficiaries making up the remaining 20 percent of the payment due to the physician. For example, if the rate for a service is $100, then Medicare pays $80 and the patient is responsible for a copayment of $20. In addition, Medicare has an annual deductible of $100 for physician and other outpatient services, so that the Medicare beneficiary is responsible for the first $100 of costs each year (plus monthly premiums).

Federal law allows state Medicaid Programs to limit the amount they pay for Medicare copayments on behalf of dual eligibles, and California has chosen to exercise this option under state law. If the Medicare payment is greater than the Medi-Cal rate, then Medi-Cal pays nothing, and the provider receives only the Medicare payment. If the Medi-Cal rate is greater than the Medicare payment, then Medi-Cal pays the difference between the higher Medi-Cal rate and the lower Medicare payment.

For most procedures and services, the Medi-Cal rate is less than the Medicare payment amount. As a result, the state avoids substantial medical costs. Because of this Medicare/Medi-Cal interaction, we recommend that Medi-Cal rates generally be limited to 80 percent of the Medicare rate.

Potential Fiscal Impact. Our recommendation that Medi-Cal physician rates generally not be increased beyond 80 percent of the allowable Medicare rates is intended to ensure that the Medi-Cal Program does not incur a disproportionate increase in state costs.

Our estimates of the additional General Fund costs for modifying Medi-Cal rates are summarized in Figure 5. It shows that if Medi-Cal rates were generally increased to the maximum recommended level of 80 percent of Medicare rates, the annual General Fund cost would be roughly $237 million. (In keeping with past state practice, our fiscal estimates assume that state payments to Medi-Cal managed care health plans would be increased to provide sufficient funding for an

Figure 5

Annual General Fund Cost of Bringing Medi-Cal Physician Rates Closer to Medicare Levels

(In Millions)

	Medi-Cal Rate Compared to Medicare Rate	
	80 Percent	100 Percent
Fee-for-service physician cost	$175	$326
Managed care allocation	62	114
Medicare copayments for "dual eligibles"	—	100
Totals	**$237**	**$540**

equivalent increase in reimbursements for physician services provided through these health plans.)

If the interim 80 percent limit we propose for Medi-Cal rates is exceeded so that Medi-Cal and Medicare physician rates were equal, we estimate that annual General Fund costs would increase much more—about $540 million—for the reasons we have discussed above.

Long-Term—Base Rates on Comprehensive Review

Proposal. We recommend the enactment of legislation directing DHS to perform a comprehensive analysis of the access to physician services and quality of care provided to Medi-Cal beneficiaries. The DHS would recommend periodic adjustments to physician rates based upon the results of that analysis. The Legislature would then determine whether to appropriate funding for such rate adjustments.

This analysis would involve regular measurement and evaluation of both patient access to health care and the quality of that care. While the department now contracts for such reviews for Medi-Cal managed care plans, it does not comprehensively or regularly do so for fee-for-service Medi-Cal services.

Fortunately, a foundation for developing a system of regular measurement and evaluation of access to and quality of care already is being developed. During the summer of 2000, DHS completed the implementation of the new Medi-Cal Management Information System/Decision Support System (MIS/DSS). This system compiles detailed information on the usage of Medi-Cal services by beneficiaries, provider participation and payments, and measures of health care quality. The MIS/DSS has a modern database architecture with the flexibility necessary to address a wide variety of access and quality of care issues.

The California Health Interview Survey, overseen by the University of California, Los Angeles (UCLA) Center for Health Policy Research, will also provide new information on health care access and quality. The survey will provide a basis for comparing health care needs and usage by Medi-Cal beneficiaries with that for other segments of the California population.

Using MIS/DSS data and UCLA survey results, DHS could perform a comprehensive analysis of access to physician services and the quality of care for Medi-Cal beneficiaries and relate them to similar measures for the rest of the state's population. Accordingly, we recommend enactment of legislation requiring DHS to perform a baseline evaluation of access to physician services and quality of care that can serve as a basis for adjusting physician rates commencing with the 2002-03 budget. The legislation would also direct DHS to prepare and submit to the Legislature by March 2002 a plan that would ensure that all Medi-Cal physician rates would be reviewed periodically—in our view, at least once every five years—to ensure that they are adjusted to further appropriate access to health care and quality of care.

While DHS would require some additional funding for personnel and contracts to implement this new process, at least some of the costs might be offset by simplification of the present, highly complex, rate-setting approach.

The long-term fiscal impact of the proposed new rate-setting mechanism is uncertain and would largely depend upon the extent to which the Legislature appropriated funding for the periodic rate increases recommended by DHS.

Benefits of the LAO Approach

We believe our proposal to establish a rational process for setting Medi-Cal rates, and for periodically reviewing and adjusting those rates, offers some significant potential benefits.

Compliance With State and Federal Law. Our approach would ensure that the Medi-Cal Program remains in compliance with state and federal statutory requirements for (1) the payment of rates sufficient to ensure the participation of medical providers and (2) regular review and adjustment of physician rates.

Improved Health Access and Quality of Care. We believe the adoption of our rate-setting approach is likely in the long term to foster reasonable access to health care for Medi-Cal beneficiaries and a better quality of care. This is because our proposal would ensure that rates are reviewed and adjusted with these factors in mind.

More Efficient Use of Physician Services. Physician services are likely to be used more efficiently under our proposal since rates will be more in line with current costs, thus avoiding overuse of some medical procedures and underuse of others. Our plan would also ensure that providers are treated more equally by basing future Medi-Cal rate decisions upon objective measures.

Simplified Administration. Our proposal would also simplify administration of the Medi-Cal Program by doing away with an extremely complex rate structure. For example, the 20 different dollar conversion factors used to determine payments for physician services would be consolidated into one such factor, and many special modifications of rates would no longer have to be calculated.

Keeps Pace With Medical Innovation. Finally, our proposal would ensure that Medi-Cal rates keep pace with changes in medical practices and technology. Such medical innovations have the potential either to significantly reduce or to increase the cost of patient care, as well as to significantly change the effectiveness of patient treatment. Because the revised rate-setting procedures we propose are based upon extensive and ongoing collection of medical cost data, they would ensure that Medi-Cal rates are kept more in line with the actual costs of innovative medical practices.

Acknowledgments

This report was prepared by Daniel P. Rabovsky, under the supervision of Daniel C. Carson. The Legislative Analyst's Office (LAO) is a nonpartisan office which provides fiscal and policy information and advice to the Legislature.

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