December 22, 1975

Letter Report 255.1

Honorable Mike Cullen
Chairman, and Members of the
Joint Legislative Audit Committee
925 L Street, Suite 750
Sacramento, California 95814

Dear Mr. Chairman and Members:

During a study of the Medi-Cal program requested by the Joint Legislative Audit Committee, we found a recent trend of Medi-Cal providers billing for increasingly complex and costly services. This information may interest the Senate and Assembly Health Committees.

The Medi-Cal fee-for-service reimbursement system has not been significantly updated since 1968. To receive higher rates of reimbursement, providers have billed the Medi-Cal program for higher levels of service to Medi-Cal patients. This has been possible because definitions of basic medical procedures developed by the California Medical Association and used by Medi-Cal are ambiguous and do not clearly define the services provided. We estimate that this trend toward higher billings has increased Medi-Cal fee-for-service program costs about four percent a year, or $9 million each year from 1970 to 1973.

In addition, the program's method of calculating fee-for-service reimbursements is unnecessarily complex and creates inequitable reimbursements among various providers and various geographical areas.

The Department of Health has recently proposed reformed methods to calculate reimbursements, and an updated fee-for-service rate structure which would minimize providers' incentive to bill Medi-Cal for increasingly complex services. We recommend that the Department of Health implement these proposals as soon as practicable, and continue to update the rate structure for actual increases in providers' overhead costs.

The following sections describe these situations in more detail.

Billing for Services by Providers

Medi-Cal fee-for-service providers submit reimbursement claims to the program's fiscal intermediaries. Providers bill the program according to procedural code numbers and definitions from the 1969 Relative Value Study (RVS) developed by the California Medical Association. Most of the procedures are very specifically defined. However, some of the most frequently billed procedures, such as those for basic office and hospital visits, are ambiguously defined. For example, the following are used to describe office visits by established patients:

1969 RVS Procedure Number	1969 RVS Definition	Average Medi-Cal Reimbursement July-December 1974
90030	Minimal service, e.g., injection, immunization, or minimal dressing. (Service not necessarily requiring the presence of a physician.)	$ 3.90
90040	Brief examination, evaluation and/or treatment. (A relatively simple procedure requiring a short period of time.)	5.06
90050	Limited examination, evaluation and/or treatment. (A brief or interval history, examination, discussion of findings and/or a rendering of service.)	7.14
90060	Intermediate examination, evaluation, and/or treatment. (A complete history and physical examination of one or more organ systems, but not requiring a comprehensive evaluation of the patient as a whole.)	9.39

90070	Expanded examination or evaluation. (Service requiring an unusual amount of care, skill, or judgment, but not necessitating a complete examination or reexamination of the patient as a whole.)	13.46
90080	Comprehensive examination or evaluation, adult. (A complete evaluation of the patient.)	17.10

The judgmental nature of assigning one of these procedures to services actually rendered has created the opportunity for provider abuse of Medi-Cal's reimbursement system.

Providers Bill Medi-Cal for Increasingly Complex Procedures

We estimate that providers' billings for more complex and costly procedures for basic medical services (including office and hospital visits, emergency services, consultations, and basic psychiatry) have escalated at about four percent a year. This escalation, or procedural inflation, increased Medi-Cal costs an estimated $9 million each year from 1970 to 1973. This estimate is based on an analysis of data maintained by Medi-Cal Intermediary Operations (MIO), the central fiscal intermediary for the fee-for-service program.

Representatives of the California Medical Association stated that the significant factor responsible for this procedural inflation was providers' discontent with Medi-Cal's reimbursement rates, which have been increased only two and one-half percent since 1968.

Complex and Inequitable Medi-Cal Reimbursement System

The methods for calculating Medi-Cal fee-for-service reimbursements are complex and inequitable. Reimbursements are based on the lower of the actual amount billed by the provider or one of three rates developed from statistical profiles of all physician billings processed by Blue Shield between July and December 1968. Department of Health officials report that Medi-Cal physician providers have complained about the confusing nature of this system.

In addition to its complexity, this profile system creates inequitable reimbursements among providers of the same service. One inequity is programmed into two of the three types of profiles, which are based on regional differences in physician charges in 1968. Therefore, the profile system tends to grant higher reimbursements to providers from areas which charged higher rates in 1968.

Other inequities of the profile system derive from the lack of profiles for physicians who became providers after 1968. Such providers are likely to receive lower reimbursements for the same service because reimbursements to providers for whom individual profiles are available are calculated without consideration for the generally lowest-paying of the three profile types. Reimbursements to the newer providers include consideration of the generally lowest paying profile type.

Proposed Policy and Rate Changes
by the Department of Health

Officials at the Department of Health have informed us of their intention to change the basis for Medi-Cal fee-for-service reimbursements. The department proposes to eliminate its use of Blue Shield's profile system for calculating Medi-Cal fee-for-service reimbursements, and to substitute uniform maximum rates for each procedure, similar to the schedule of maximum allowances already employed for all other Department of Health programs. The proposed policy would also increase average payments by 20 percent for basic medical services, such as office visits, and by 9-1/2 percent for more specialized services, such as surgery. The 9-1/2 percent increase is intended to cover actual increases in provider overhead since 1972. The additional 10-1/2 percent increase for basic Medi-Cal services is intended to promote routine preventative care, which the department believes Medi-Cal patients have had difficulty acquiring. The 1975-76 Budget Act provides $57 million for the State's share of such rate increases. However, the department estimates that late implementation of the increases will result in an actual state cost of only $12 million in fiscal year 1975-76.

We believe that these proposals would provide reasonable solutions to the problems of procedural inflation and of unnecessarily complex and inequitable methods for calculating fee-for-service reimbursements. The department's proposed use of uniform maximum reimbursement rates for each medical procedure should provide an easily understood and equitable fee structure for all Medi-Cal services.

The impact of the department's proposed general rate increases on the problem of procedural inflation would be less clear. The most which could be expected would be a reduction in the incentive for providers to increase the complexity of services billed to Medi-Cal. In our judgment, commonly suggested alternative approaches which would attempt to directly control procedural inflation are not feasible because of the judgmental nature of defining medical services.

Recommendations

We recommend that the Department of Health implement its proposed uniform maximum allowances for Medi-Cal fee-for-service reimbursements and its proposed increased reimbursement rates. We also recommend that the department regularly update the rate structure to compensate for actual inceases in provider overhead.

Consideration for Legislative Action

The Senate and Assembly Health Committees may wish to consider statutory provisions for an automatic cost-of-living escalator in Medi-Cal's fee-for-service rate structure. This would permit the Department of Health to budget into the Medi-Cal program annual increases (or decreases) in average provider overhead.

Respectfully submitted,

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