Department of Health Care Services
Proposed Trailer Bill Legislation

Aligning Rate Review with the Access Monitoring Review Plan

FACT SHEET

Issue Title: Aligning Annual Rate Reviews with the Access Monitoring Review Plan. This proposal would eliminate obsolete requirements when DHCS performs rate reviews for physician and dental reimbursable services to more closely align with federal access-to-care requirements.

Background: Existing law requires the Department of Health Care Services (DHCS) to annually review the reimbursement levels for physician and dental services under the Medi-Cal program, and to revise periodically the reimbursement rates to physicians and dentists to ensure reasonable access for Medi-Cal beneficiaries to these services. The annual review of physician services rates requires the inclusion of the following factors:

- Annual cost increases for physicians as reflected by the Consumer Price Index.
- Physician reimbursement levels of Medicare, Blue Shield, and other third-party payors.
- Prevailing customary physician charges within the state and in various geographical areas.
- Procedures reflected by the current Relative Value Studies (RVS).
- Characteristics of the current population of Medi-Cal beneficiaries and the medical services needed.

The annual reviews have become difficult for DHCS to comply with as it is no longer possible to gather the required information. Welfare and Institutions (W&I) Code Section 14079(d), requires the annual reviews to take into account procedures reflected by the current RVS. Since the Budget Act of 2000, physician fee schedules are no longer determined using the 1969 California RVS. Medi-Cal currently determines its own unit values for physician services, excluding pathology and anesthesia. The RVS was found to violate federal provisions against price fixing in 1979 and although once utilized before 1979, the requirement is now obsolete. In addition, W&I Code 14079(b) requires DHCS to include reimbursement rates of Blue Shield and other third-party payors in its annual reviews. However, state law does not require third-party payors to submit this data to DHCS, and DHCS is often unable to obtain this information, even when providers have been compelled to do so through a subpoena. In the rare instance when third-party payors do submit data, it is often unreliable or incomplete.

Additionally, there is an existing federal process for rate reviews with which DHCS must comply. The federal Centers for Medicare and Medicaid Services (CMS) enforces compliance with the access-to-care requirements, including access to physician services, via review and approval of California's Medicaid State Plan and State Plan Amendments, and the ongoing oversight of DHCS' administration of California's Medicaid State Plan. CMS also enforces compliance with the access-to-care requirements via the access monitoring review standards set forth in 42 Code of Federal Regulations Section 447 Subpart B. To meet these requirements, California must, among other things, conduct baseline reviews of core services through its access monitoring review plan and continue to monitor access data to promote ongoing access to care. DHCS has been monitoring access in its fee-for-service (FFS) delivery

system, in part, by maintaining a CMS-approved framework referred to as the Access Monitoring Review Plan (AMRP) since 2011, the most recent of which is entitled the California FFS Medi-Cal Program Health Care Access Monitoring Plan and was published in September 2016 and updated in 2017. The AMRP is a comprehensive report that contains information and data related to the needs of enrollees, availability of providers, changes in beneficiary utilization of covered services, characteristics of the Medi-Cal beneficiary population, and service payment information, among other things. The proposed revision of W&I Code Section 14079 will update the factors utilized in the rate review to reflect available data to comply with the federally-approved framework.

Justification for the Change: This proposal would eliminate irrelevant, obsolete and inaccessible requirements while updating the statute to more closely align with CMS' current access-to-care requirements.

Specifically, this proposal would:

- Require DHCS Director to periodically, rather than annually, review reimbursement levels for physician and dental services to align with federal requirements, which require reviews every three years.
- Clarify that the review of rates pertain to the Medi-Cal Fee-For-Service delivery system since the existing statute predates the managed care delivery system.
- Require DHCS to revise reimbursement rates to the extent the Director deems necessary to comply with applicable federal Medicaid requirements.
- Specify that when DHCS performs its review of the rate, it is to the extent consistent with DHCS' federally approved access monitoring plan, or any successor methodology for monitoring reasonable access to Medi-Cal covered services.
- Remove Blue Shield and other third-party payors' physician reimbursement levels from factors to be considered since data is often unreliable and DHCS is often unable to obtain this information.
- Remove procedures reflected by the current RVS from factors to be considered since physician fee schedules are no longer determined using the 1969 California RVS.

Summary of Arguments in Support:

- Allows DHCS to more fully comply with the section's intent by removing and revising those requirements that are dependent upon sources that are obsolete or inaccessible.
- Removes obsolete and inaccessible data elements.
- Aligns the intent with current federally-mandated access-to-care requirements and more accurately reflect current practices.