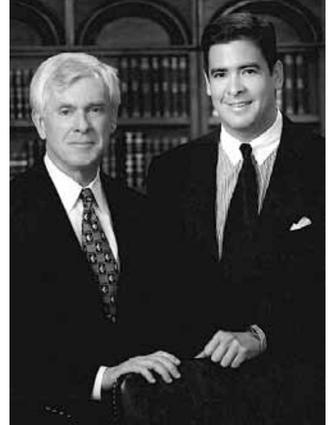
On Your Behalf …
Legislative and Practice Affairs Division

Medi-Cal Payments to Physicians—A Dismal History and Uncertain Future



By William E. Barnaby, Esq., and
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The dreadfully low Medi-Cal payment rates, particularly for physician anesthesia services, have long been a source of frustration for California anesthesiologists. While the Medi-Cal program has grown in expenditures and caseload, payment rates have fallen further and further behind the inflationary increases in business costs of all caregivers—especially physicians. To make matters worse, Medi-Cal provider payment rates have been targeted for cutbacks whenever the state budget faces a deficit, or virtually every year of late.

The funding of Medi-Cal has followed a roller-coaster track parallel to the California economy. Downturns in the state's economy have led to state budget deficits that, in turn, have prompted serious Medi-Cal spending cuts and reforms. It is not surprising that Medi-Cal comes in for close scrutiny whenever the budget needs to find large savings, because it is one of the state's highest-cost programs.

For the 2011–12 fiscal year, Medi-Cal expenditures are expected to be $42.5 billion, to serve 7.7 million beneficiaries. That amount includes a $1.7 billion program reduction already enacted, including a 10 percent across-the-board provider-rate cut that may or may not withstand legal challenges. California ranks dead last in the amount spent per beneficiary, some 60 percent of the national average. Our state is also at the bottom in terms of rates paid to providers.

Medi-Cal began shortly after Congress passed the Medicaid Act in 1965. For the first several years, provider payments pretty much followed usual, customary and reasonable rates. Cost-of-living increases in Medi-Cal rates generally kept pace with inflation. In some years, the cost-of-living boosts were built into budget proposals of the administration in office.

In the early 1980s, California's economy faltered. One of the first programs to feel the pinch was Medi-Cal. In 1982 a 10 percent rate cut was imposed on most Medi-Cal providers, including physicians. As the economy improved and state revenues picked up, Medi-Cal physician rates were raised 7.7 percent in 1984 and 5.3 percent in 1985. Thereafter, Medi-Cal rates remained stagnant for more than 15 years.

In 1992, economic troubles caused the biggest state budget deficit up to that time. Gov. Pete Wilson's solution consisted of a combination of program reductions and a major tax increase. Medi-Cal followed the lead of Medicare in reducing by 9.5 percent payment rates for hospital-based physicians—anesthesiologists, radiologists, pathologists and emergency physicians. These reductions were restored in 1999 by a 10.5 percent hike for the same physician categories. **Additionally in 1999, obstetrical anesthesia was granted a 21.8 percent increase as a result of a concerted campaign by the CSA.**

With the dot-com boom in 2000, state coffers were flush. An across-the-board increase for Medi-Cal providers resulted in a 16.7 percent increase for all physician categories. There has been no upward adjustment of Medi-Cal rates since.

Instead there have several attempts to cut rates. In 2003, a 5 percent rate cut was partially blocked by a federal court injunction, and so it was only in effect for a few months. In 2008, a 10 percent reduction was part of the state budget deficit "fix." It was blocked by a federal court injunction, which led to a number of appeals that continue to date. Three Medi-Cal rate reduction cases have been consolidated on appeal and are before the U.S. Supreme Court. They are expected to be reviewed by the high court in October.

In the past, it was possible for some providers to "cost-shift" to make up Medi-Cal payment shortfalls with reimbursements from private insurers. With the heavy penetration of managed care and stronger resistance from private insurers, the potential for cost shifting has lessened markedly. Some physicians may refuse to treat Medi-Cal patients, but that is not feasible for most anesthesiologists, the majority of whom work in hospitals that accept Medi-Cal patients.

As Medi-Cal rates lag farther behind, the cost of getting them up to more reasonable levels becomes greater. Medi-Cal physician payments are derived from a 50/50 combination of the state's General Fund and federal matching dollars. The federal matching share is determined by a formula established many years ago, based on the average per capita income of a state's residents.

Average income for Californians is among the highest of any state, so California's Federal Medical Assistance Percentage (FMAP) ordinarily is 50 percent. The FMAP for some other states ranges upwards of 75 percent, so less state funding is required to improve payment rates. In those states, every state dollar spent on Medicaid rates brings back two or three federal matching dollars.

The state's economic problems not only led to the underfunding of Medi-Cal, they also impacted the delivery of health care services in the private sector. As part of the 1982 budget cut and reform package, Medi-Cal was allowed to contract with acute care hospitals at a discounted rate. As the package was moving through the Legislature, private health insurers were successful in gaining the same authority. The power of this encouragement for the private sector to negotiate discounted rates may have taken a few years to be realized, but the penetration of managed care in California spiked upwards a few years later. A "reform" initiated for Medi-Cal had a huge and unanticipated effect on the entire health care system.

Until the California economy perks up and the chronic state budget structural imbalance is resolved, more equitable Medi-Cal payments are not likely. That it may take a while makes it all the more essential to fight against additional cuts that would further shred the tattered health care "safety net." Before the recently approved 10 percent rate cut can take effect, it must be approved by the Centers for Medicare and Medicaid Services (CMS). The CSA is an active participant in the CMA-led coalition (Alliance for Patient Care) of more than 60 Medi-Cal provider and patient advocacy organizations. A strong effort is under way by the APC to convince CMS to deny the cuts as failing to meet federal standards for patient access and quality of care. Beyond CMS, more court challenges may yet occur.

Looking further ahead, the federal Patient Protection and Affordable Care Act could ultimately add as many as 2 million beneficiaries to the Medi-Cal rolls beginning in 2014, according to the nonpartisan Legislative Analyst's Office. Who will render care for these additional persons and how the state General Fund will afford its share are two basic issues that make the financial future of Medi-Cal very uncertain.

Report from the Legislative and Practice Affairs Division (LPAD)

By Paul Yost, M.D., LPAD Chair

At the California state level, there is a host of hot current issues, including former Gov. Arnold Schwarzenegger's (GAS) decision to "opt California out" of supervision requirements for nurse anesthetists, attacks on MICRA, and the woes of the state budget.

The Opt-out The CSA, in partnership with the CMA and the ASA, has appealed a lower court's ruling upholding GAS's opt-out. We have a new and talented legal team whose goal is to protect patients by requiring nurses to be supervised by physicians.

MICRA The Consumer Attorneys of California have decided to alter MICRA's limitation of pain and suffering payments to $250,000. Even with MICRA, the average award for damages for malpractice in California has risen much faster than the rate of inflation. Altering MICRA will have many deleterious effects on medical care, including making it harder to find a physician or clinic and raising the cost of health care. According to a 2008 report, repealing MICRA will increase the cost of health care in California by at least $9.5 billion annually, which translates into more than $1,000 per family of four. For more information, see www.micra.org.

The State Budget The state continues to be mired in a budget crisis. With our rejuvenated Gov. Jerry Brown at the helm, we have embarked on another interesting adventure trying to find resources meet our state's obligations. Once again, the state and governor have proposed a 10 percent cut to Medi-Cal rates. The last time the state attempted this tactic, the courts reversed the cut because of evidence that reducing California's already sub-market rate payments would harm access to care. The state of California has appealed the decision to the U.S. Supreme Court; however, a decision is not expected in the immediate future. Medi-Cal payment rates for physicians are among the lowest in the nation for Medicaid, and to decrease them further would force more physicians to leave the program and reduce access to care for millions of poor and unemployed Californians. Regardless of the impact, the state likely will approve these provider cuts, in order to pass a budget. Francisco Silva, CMA's general counsel, said, "We are confident that the Supreme Court will get it right and affirm the 9th U.S. Circuit Court of Appeals' ruling, which concluded that California's move to lower Medi-Cal rates violated federal law." Stay tuned.

LPAD Retreat On January 7, 2011, an LPAD retreat was held. The goal was to identify ways to hone our message and to push our specialty and profession forward for the benefit of our patients and ourselves. Attendees were divided into groups to discuss the following: foundational issues for anesthesiology and medicine; common bonds among physicians in general and anesthesiologists in particular; issues that distract us from our mission; ways to encourage and enhance participation of anesthesiologists.

The overall concept of the retreat was to enhance and celebrate the anesthesiologist as a physician. Indeed, as a well-educated and dedicated professional standing as a crucial cog within the field of medicine, the anesthesiologist is an ideal choice to contribute to the debate on health care issues. Moreover, we can enhance the perception of our specialty and profession by becoming more involved in our community, and also by taking a more active role in the politics of federal, state, and of course, local government. Ultimately, all politics are local.

We actively encourage all CSA members to become involved. Some easy first steps are:

- Join the ASA grass roots campaign on the ASA Web site.
- Check the CSA Web site under "Advocacy" and follow the action alerts.
- Make an appointment and get to know your legislators (to find your legislators, use the easy link on the CSA front page). The best time to develop a relationship with your legislator is when you do not have to ask for something.

If you do make contact with your state or federal legislator, please let our CEO, Barbara Baldwin, know: bbaldwin@csahq.org. If you make contact with your federal legislator, be sure to send an e-mail to our ASA lobbyist, Manuel Bonilla: m.bonilla@asawash.org.

If you would like to attend a campaign fund-raising event for a candidate, please let us know. The ASAPAC or GASPAC may be able to support the candidate.

There are many ways to get involved through the CMA and local medical societies as well. Often, positions on local health care-related boards and commissions are appointed with input from the local medical society.

Our best weapon in the court of public opinion and in the arena of public policy is you. Please get involved and use your intelligence, experience and professionalism to impact those around you.