2003 REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

REVIEW OF MEDICAID REIMBURSEMENT OF PHYSICIANS

(SJR 38/HJR 42)

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Preface

HJR 42 and SJR 38 requested that the Joint Legislative Audit and Review Commission (JLARC) study Medicaid reimbursement of physicians. However, both resolutions were carried over in their respective Committees on Rules. The Joint Commission on Health Care (JCHC) subsequently added the study to its workplan.

In Virginia, the Medicaid system has both a fee-for-service payment system as well as a managed care program. This study focused on the fee-for-service component of Medicaid physician reimbursement.

Virginia's methodology for reimbursing physician services was developed based on Medicare's methodology which uses a resource-based relative value scale (RBRVS) system. An RBRVS system is based on the use of relative value units (RVUs). RVUs are essentially measures of resource utilization and are assigned to services billed under national coding systems.

Under the Medicare RBRVS system the amount paid for services is the product of:

- a nationally uniform relative value for each service,
- a geographic adjustment factor (GAF) for each area,
- and a nationally uniform conversion factor.

There are RVUs assigned for physician work, practice expense and malpractice expense.

Virginia's current system for physician reimbursement is essentially based on the Medicare methodology with the addition of a budget neutrality factor and the deletion of the use of geographic adjustment factors. The budget neutrality factor is approximately the percentage of Medicare that Virginia can afford to pay based on the funding that is available (currently this is 70.72% of Medicare). This methodology is used for all specialties except OB/GYN.

An Urban Institute study of 43 state Medicaid programs concluded that physician reimbursement actually declined between 1993 and 1998 as compared with the rate of inflation during that time period. Physician fees

in Virginia declined for all services by 22.2 percent (without taking into account inflation). Decreases were also observed for obstetric care fees and other service fees while primary care fees increased. State Medicaid reimbursement of physician services was also lower when compared to changes in Medicare reimbursement.

JCHC staff conducted a survey of other states to determine the extent to which these states used an RBRVS system for Medicaid physician reimbursement and what their current Medicaid payments are as a percentage of Medicare. The states surveyed included Alabama, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee and West Virginia. The majority of surveyed states use some form of an RBRVS methodology for calculating Medicaid physician reimbursement. When comparing 2002 Medicaid rates for physician reimbursement to those reported by the Urban Institute study in 1998, you find that: four states (including Virginia) experienced a decrease, four states experienced an increase, and four states did not have data available for one or both years.

JCHC staff discussed Medicaid physician reimbursement with provider groups and their representatives. These groups expressed concerns about reimbursement that included the following: rates are too low, low rates will eventually lead to access issues for specialists, providers who see a large percentage of Medicaid patients are at a disadvantage, and specialties in general do not fare well under an RBRVS system in comparison to preventive services.

Actions Taken by JCHC

JCHC staff developed seven policy options to address concerns about Medicaid reimbursement of physician services. The policy options that increase reimbursement rates would have substantial costs. The policy options are listed on pages 25-26. A summary of public comments received regarding the proposed options are included in Appendix B.

JCHC took the following action with regard to the policy Options:

- JCHC voted to accept Option V, to include further study and analysis of issues related to Medicaid physician reimbursement in the Joint Commission's 2003 workplan.

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I.
Authority for the Study/Organization of Report

Provisions included in two identical resolutions (House Joint Resolution 42 and Senate Joint Resolution 38) during the 2002 General Assembly Session directed the Joint Legislative Audit and Review Commission (JLARC) to study Medicaid reimbursement of physicians.

Although the resolutions were continued until 2003 in the House and Senate Committees on Rules, the Chairman of the Joint Commission on Health Care (JCHC) included the study as part of the Commission's 2002 Workplan. The provisions included within the resolutions directed JLARC to conduct its study with assistance provided by all agencies of the Commonwealth as requested by JLARC. Specifically, the resolutions directed JLARC to analyze:

> (i) the appropriateness of current reimbursement levels and methods of payment for the various physician specialties;
> (ii) how physician reimbursement in Virginia compares to that in other states;
> (iii) whether changes in the amount and method of reimbursement are needed to compensate physicians adequately for their services; and
> (iv) the estimated cost, if any, of any recommended changes in the amount of physician reimbursement.

Copies of both HJR 42 and SJR 38 are attached in Appendix A.

Organization of Report

This report is presented in four major sections. This section discussed the authority for the study. Section II discusses background information concerning the Virginia Medicaid program. Section III provides an examination of the reimbursement of physicians under the Virginia Medicaid program, an examination of practices in other states, and a discussion of some potential proposals to increase reimbursement of physicians under the Medicaid program. Lastly, Section IV provides a series of policy options the Joint Commission on Health Care may wish to consider in addressing the issues raised in this study.

II.
Background

The Medicaid program provides medical and medically-related services for the poor through dual financing from state and federal governments. The Medicaid program was enacted in 1965 as Title XIX and "makes federal matching funds available to states for the costs they incur in paying for health and long-term care services for eligible individuals." According to the United States Department of Health and Human Services, "The Medicaid program is the third largest source of health insurance in the United States – after employer-based coverage and Medicare." Essentially the program covers some low-income women, children, elderly, and individuals with disabilities. However, the program does not cover single adults or couples that do not have children unless they are aged, blind, or disabled. Figure 1 provides a specific list of those individuals covered under Virginia's Medicaid program.

In Virginia, the Medicaid system has both a fee-for-service payment system as well as a managed-care program. This study specifically examines the fee-for-service component of Medicaid physician reimbursement. Payments to managed-care plans are part of a capitated payment system, making it difficult to determine payments for specific services. The following sections will provide an overview of Medicaid expenditures, trends, and providers.

Division of Expenditures Under Medicaid Physician Services

Due to the categories of eligibility mentioned above, the division of expenditures for physician services under the Medicaid program is divided by the Department of Medical Assistance Services (DMAS) between the following groups: aged, blind and disabled, AFDC (Aid to Families with Dependent Children) child, AFDC adult, AFDC unemployed/child, AFDC unemployed/adult, and foster care child. Figure 2 provides a representation of this division of expenditures between these groups of recipients.

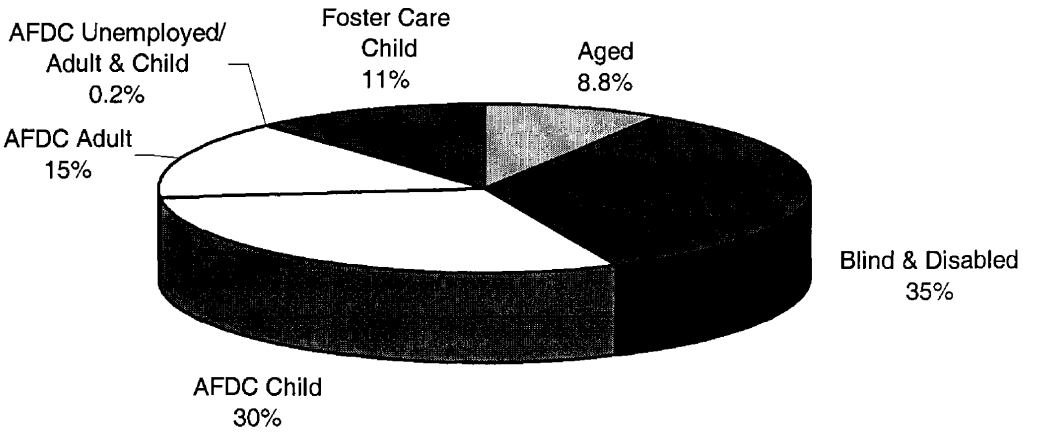
Figure 1

Virginia Medicaid Covered Groups

- Pregnant women (single or married) whose family income is at or below 133% of the Federal Poverty Income Guidelines;
- Children younger than age 6 whose family income is at or below 133% of the Federal Poverty Income Guidelines;
- Low Income Families with Children (LIFC);
- Children ages 6 to 19, whose family income is at or below 133% of the Federal Poverty Income Guidelines;
- Children under age 21 who are in foster care or subsidized adoptions;
- Infants born to Medicaid-eligible women;
- Supplemental Security Income (SSI) recipients who are aged (65 or older), blind, or disabled (unable to work due to severe medical conditions) and meet Medicaid resource limit;
- Individuals age 65 or older, blind or disabled, receiving long-term care services, who have income that does not exceed 300% of the SSI individual payment limit or who meet a monthly spenddown amount;
- Auxiliary Grant (AG) recipients;
- Certain people who are terminally ill and have elected to receive hospice care;
- Individuals age 65 or older, blind or disabled who have income that does not exceed 80% of the Federal Poverty Income Guidelines;
- Women screened by the Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program who have been diagnosed and need treatment for breast or cervical cancer, with incomes below 200% of the Federal Poverty Income Guidelines; and
- Certain refugees for a limited time period.

Source: *Virginia Medicaid Handbook,* Department of Medical Assistance Services, March 2002.

Figure 2
Expenditures for Physcian Services by Category of Eligibility, 2001



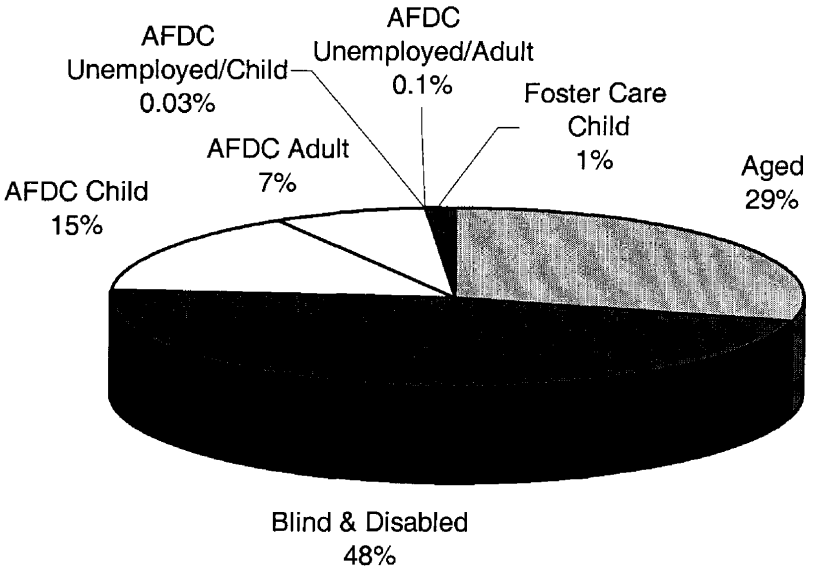
Source: *The Statistical Record of the Virginia Medicaid Program and Other Indigent Healthcare Programs*, State Fiscal Year 2001.

It is apparent from Figure 2 that the blind and disabled account for the largest percentage (35%) of expenditures for physician services. However, in comparing expenditures with the number of unduplicated recipients for physician services in 2001, the blind and disabled category accounts for the second highest (23.1%) percentage of unduplicated recipients behind the category AFDC child (43.4%). This data is based on information contained in the DMAS publication *The Statistical Record of the Virginia Medicaid Program and Other Indigent Healthcare Programs,* FY 2001. In addition, the category of foster care child also accounts for a disproportionate share of Medicaid physician services expenditures (11.5%) while only accounting for slightly over one percent of the unduplicated recipients. Lastly, in accounting for all categories of adult recipients, it is apparent that they account for almost 59 percent of all expenditures related to Medicaid physician services and that children account for approximately 41 percent of the expenditures.

These trends are slightly different than the trends seen in total Medicaid expenditures for all services. Figure 3 provides total Medicaid expenditures by category of eligibility. Children account for approximately 16 percent of all Medicaid expenditures and adults account for the remaining 84 percent. In addition, Figure 4 provides the average

expenditures per recipient for all Medicaid expenditures and for physician services expenditures. In conclusion, children account for a larger percentage of physician services expenditures (41%) in comparison to total Medicaid expenditures (16%).

Figure 3
Total Medicaid Expenditures by Category of Eligibility, 2001



Source: JCHC staff analysis of *The Statistical Record of the Virginia Medicaid Program and Other Indigent Healthcare Programs*, State Fiscal Year 2001.

Figure 4
Average Expenditures per Recipient by Category of Eligibility, 2001

Category of Eligibility	Physician Services Expenditures	Total Medicaid Expenditures
Aged	287	9,141
Blind & Disabled	827	10,102
AFDC Child	382	1,279
AFDC Adult	549	2,097
AFDC Unemployed/Child	247	1,039
AFDC Unemployed/Adult	512	2,455
Foster Care Child	5,534	7,353

Source: JCHC staff analysis of *The Statistical Record of the Virginia Medicaid Program and Other Indigent Healthcare Programs*, State Fiscal Year 2001.

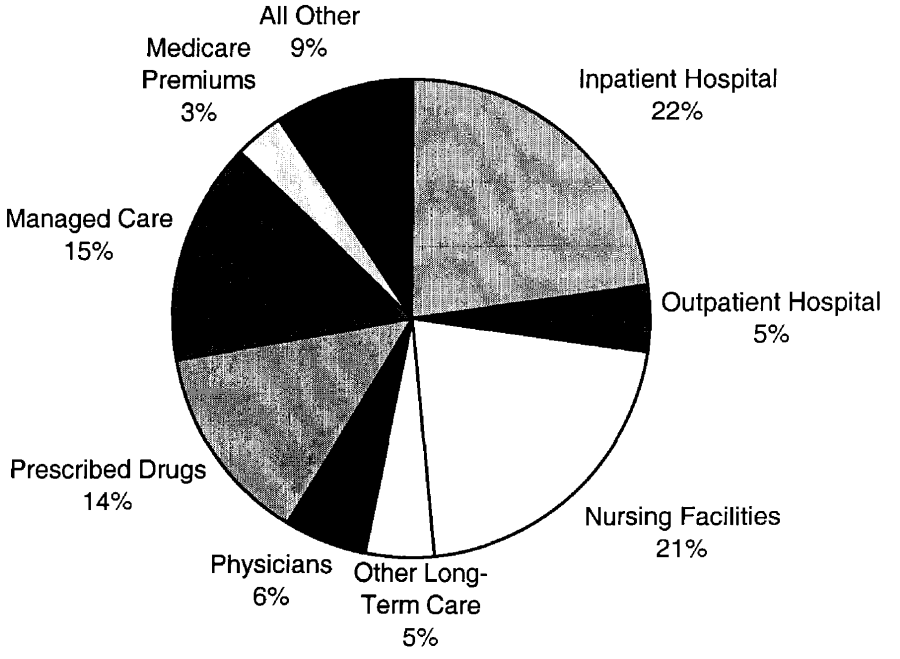
Trends in Medicaid Expenditures and Recipients for Physician Services

Several trends can be observed from evaluating data provided by DMAS in *The Statistical Record of the Virginia Medicaid Program and Other Indigent Healthcare Programs*, FY 2001. This examination leads to the assessment that total Medicaid expenditures for physician services under the fee-for-service program have been declining annually. In addition, physician services as a major category of expenditures has been decreasing as a percentage of total Medicaid expenditures. Thus, physician services is the only major category of expenditure that has consistently experienced a decline in Medicaid expenditures in every year between 1995 and 2001. In addition, the number of unduplicated recipients for physician services has been declining under the fee-for-service program.

Medicaid Expenditures for Physician Services Has Been Declining as a Percentage of Medicaid Budget. Medicaid reimbursement to physicians under the fee-for-service program has been declining since the peak in 1995 at $217.5 million. In 2001, expenditures for physician's services were $138.5 million. Currently, under the category of General Medicaid, physician services as a percentage of total General Medicaid expenditures has been declining (note "General Medicaid" excludes mental health services, Mental Health and Mental Retardation (MHMR) facilities, and MHMR community services). For instance, in 1999, physician services accounted for eight percent of all General Medicaid expenditures. However, in 2001, physician expenditures accounted for six percent of General Medicaid expenditures. Figure 5 shows the breakdown of General Medicaid expenditures by major category in 2001.

Medicaid Physician Expenditures Only Major Category to Decline Every Year. A review of the annual Medicaid expenditures as reported in *The Statistical Record of the Virginia Medicaid Program and Other Indigent Healthcare Programs* (FY 2001) allows for an examination of physician reimbursement expenditures in comparison to expenditures in other major categories. Physician reimbursement as a major category of expenditures was the only category to decrease as a percent of all Medicaid expenditures in every year since 1996. In fact, physician reimbursement showed the largest one year decrease when comparing expenditures from 1995 to 1996 (a 16.1 percent decrease).

Figure 5
Medicaid Expenditures by Major Category, 2001



Source: *The Statistical Record of the Virginia Medicaid Program and Other Indigent Healthcare Programs,* State Fiscal Year 2001. Percentages are based on General Medicaid expenditures (excludes metal illness services, MHMR facilities, and MHMR community).

It should be noted that some of the decreases would be expected given the methodology change that was phased-in beginning in 1995. Prior to 1995, physicians were reimbursed based on a percentage of usual and customary fees in reference to a base year. Beginning in 1995, the use of a resource based relative value system (RBRVS) in calculating physician reimbursements rates began to be phased in. Virginia's current methodology for calculating physician reimbursement will be discussed in more detail in the following chapter.

The Number of Unduplicated Recipients of Physician Services Has Been Declining. Between 1995 and 2001, the number of unduplicated recipients within the fee-for-service program under physician services has been declining. The number of unduplicated recipients provided medical services under the category of physician services in 1995 was 605,211. By 2001, this number had decreased to 372,635, a percent decrease of 38.4

percent. At this same time, the number of participants in some managed care programs increased.

Trends Associated with Providers and Claims

Several trends can be observed from data collected by DMAS concerning physician reimbursement. First, there has been an increase in the number of providers that receive payments for physician services. Second, in general, the number of original claims submitted by physicians decreased between 1995 and 2001. However, the number of original claims fluctuated in the years between 1995 and 2001.

The Number of Providers Receiving Payments from DMAS Has Increased. Data contained in *The Statistical Record* (FY 2001) shows the number of providers receiving payments from DMAS by physician specialty. Figure 6 provides a detailed review of these numbers for 1995 through 2000. Overall, most of theses specialties have experienced an increase in the number of providers receiving payments between 1995 and 2000. The total percent increase in the number of providers receiving payments from DMAS from 1995 until 2000 has been 15 percent. However, there was a decrease of over one percent in the number of providers receiving payments between 1999 and 2000. It is unclear whether this trend continued in 2001 since the needed data is not yet available.

Additionally, the percentage of providers in each specialty has remained fairly constant between 1995 and 2000. For example, Internal Medicine was the only specialty to change by more than one percent. The number of internal medicine providers increased from 29 percent of all providers to 31 percent of all providers during that time period. All other specialties remained at the same percentage in comparison to the total number of providers or increased/decreased by one percent or less.

The Number of Original Claims for Physician Services Has Fluctuated. DMAS data contained in *The Statistical Record* (FY 2001) allows for an analysis of trends associated with the number of original claims for physician services. The total number of original claims in 1995 was 1,063,409 and by 2001 had decreased to 508,405. This is an overall percentage decrease of 52 percent. However, the number of claims fluctuated during this period. Figure 7 provides for an examination of these fluctuations.

Figure 6
Number of Providers Receiving Payments from DMAS

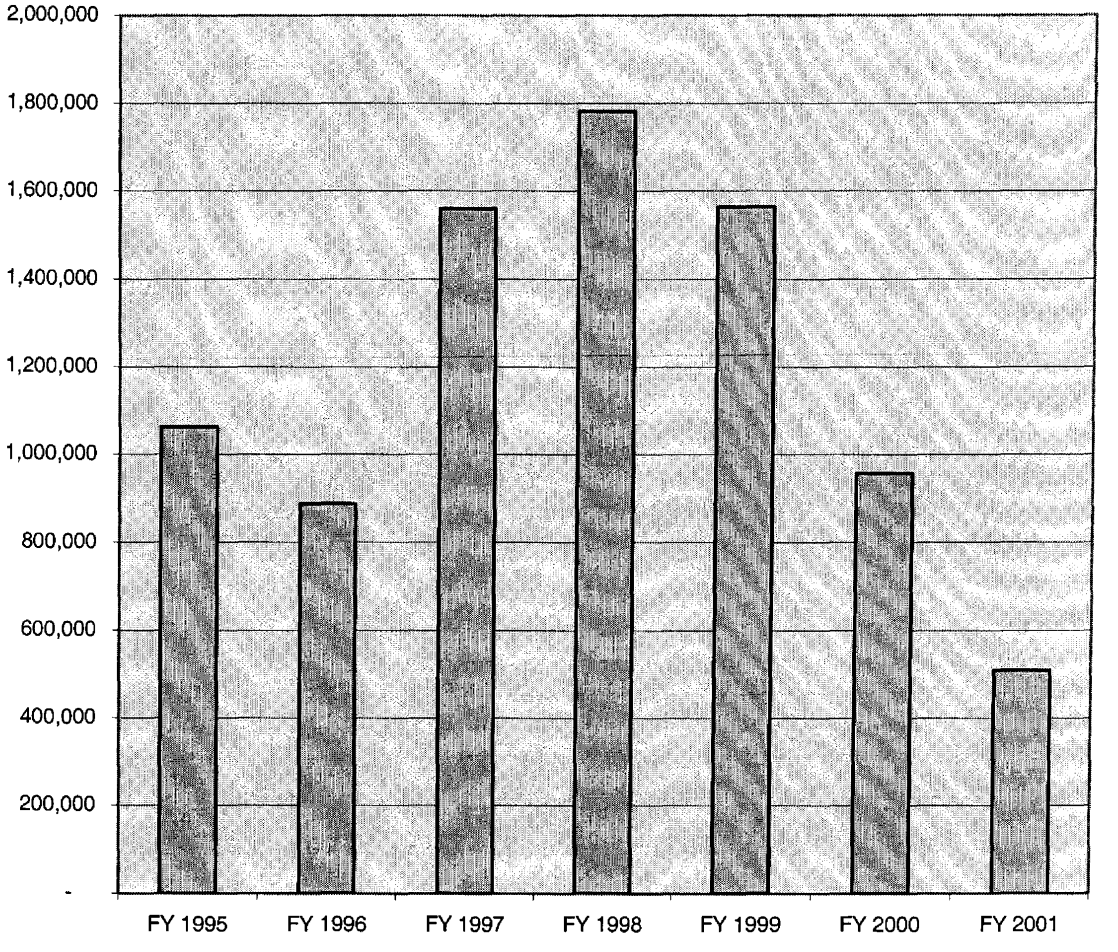
Physicians by Specialty	2000	1999	1998	1997	1996	1995
Anesthesiology	1,086	1,024	1,025	1,039	991	956
Case Management	-	1	1	1	1	1
Colon & Rectal Surgery	15	10	10	10	12	19
Dermatology	168	188	184	177	172	159
Durable Medical Equipment/Supplies	1	1	2	2	2	4
General Practice	2,296	2,302	2,296	2,303	2,224	2,156
General Surgery	777	773	792	809	777	732
Internal Medicine	5,504	5,809	5,210	5,084	4,924	4,499
Neurological Surgery	380	453	521	524	524	490
OB/GYN	1,023	1,034	1,035	1,088	1,059	998
Ophthalmology	621	626	590	602	599	563
Orthopedic Surgery	639	827	659	640	638	623
Otolaryngology	280	270	264	269	280	250
Pathology	354	347	332	327	330	304
Pediatrics	1,747	1,718	1,707	1,502	1,439	1,337
Physical Medicine & Rehabilitation	137	124	122	113	108	96
Plastic Surgery	149	138	148	139	137	127
Preventive Medicine	1	1	9	-	-	-
Psychiatry & Neurological	842	775	763	746	729	683
Psychologist	57	31	6	6	4	6
Radiology	1,377	1,318	1,292	1,290	1,197	1,129
Thoracic Surgery	91	100	103	106	105	93
Urology	318	288	320	321	285	279
Other	90	60	42	49	60	69
Total	**17,953**	**18,218**	**17,433**	**17,147**	**16,597**	**15,573**

Source: JCHC staff analysis of *The Statistical Record of the Virginia Medicaid Program and Other Indigent Healthcare Programs*, State Fiscal Year 2001.

JCHC Staff Completed an Analysis of Providers Participating in the Virginia Medicaid Program

JCHC staff conducted an analysis of data collected by the Board of Medicine (BOM) to look at the total number of providers in the state, the number of providers participating in the Medicaid program, the number of providers participating in the Medicare program, and the number of providers per region of the state. Physicians self-report information to BOM concerning their practices, specialties, whether they accept Medicaid or Medicare patients, and other information.

Figure 7
Number of Original Claims for Physician Services



Source: JCHC staff analysis of *The Statistical Record of the Virginia Medicaid Program and Other Indigent Healthcare Programs*, State Fiscal Year 2001.

The most recent update (2002) of this information showed that there are 29,095 physicians that have a "current active" license status. Of these 29,095 licensed providers, 13,285 stated that they participate in the Medicaid program, and 12,079 are accepting new Medicaid patients. The number of physicians participating in the Medicare program is higher at 16,144. This could potentially mean that raising Medicaid reimbursement rates to the level of Medicare could provide for greater physician participation in the Medicaid program. It should be noted that these numbers include physicians that reside outside of Virginia.

In addition, an examination of physicians by region was conducted for those physicians with a Virginia address. For this group, the number of physicians participating in Medicaid or accepting new Medicaid patients is 11,869. Figure 8 provides the number of currently licensed physicians participating in Medicaid or accepting new Medicaid patients by region of the state. Not surprisingly, urban regions have a larger number of physicians who participate in Virginia's Medicaid program. A true analysis of the adequacy of the number of physicians who participate in the Medicaid program was not within the scope of this study. However, DMAS staff report that they currently do not have access issues with any specialties under the managed care or fee-for-service Medicaid programs.

Figure 8

Licensed Physicians Reporting Participation in the Medicaid Program

Regional Assignments	Providers in Region
Central Virginia	2,709
North Central	1,045
Northern Virginia	2,789
Shenandoah	772
Southside	78
Southwest Virginia	1,726
Tidewater	2,750
Total	**11,869**

Source: JCHC staff analysis of Board of Medicine physician database, 2002.

III.
Review of Physician Reimbursement

Currently, physician reimbursement for Medicaid services in Virginia's fee-for-service program is based on a resource-based relative value scale (RBRVS) system of payment. An RBRVS system is one based on the use of relative value units (RVUs). RVUs are essentially measures of resource utilization and are assigned to services billed under national standard coding systems. Therefore, all services provided by physicians are assigned a relative value under this system. For example, an office visit will have a different value than a tonsillectomy based on the relative amount of work, etc. that is required for each task. Virginia's methodology for reimbursing for physician services was developed based on Medicare's methodology which uses an RBRVS payment system for physician services. Thus, an examination of the Medicare methodology is necessary in reviewing Virginia's physician reimbursement system.

Physician Reimbursement Under the Federal Medicare Program

The Medicare program was established in 1965 under Title XVIII, and is a program that provides health insurance to mainly those 65 and older. The program is managed by the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA). Prior to 1992, physician services were paid on a reasonable charge concept. "This amount was originally defined as the lowest of (1) the physician's actual charge; (2) the physician's customary charge; or (3) the prevailing charge for similar services in that locality." In 1992, HCFA began to base physician payment on either the lesser of the submitted charge or the "amount determined by a fee schedule based on a relative value scale (RVS)." Basing the physician payment system on a resource-based relative value scale (RBRVS) was required under the Omnibus Budget Reconciliation Act of 1989 (OBRA 1989).

Figure 9 provides an explanation of the formula used under the relative-value system for reimbursement of physicians under the Medicare program. The amount paid under the Medicare physician fee schedule "is the product of three factors: (1) a nationally uniform relative value for the service; (2) a geographic adjustment factor (GAF) for each physician fee

schedule area; and (3) a nationally uniform conversion factor (CF) for the service."

Determining the Uniform Relative Value for the Service. Within the formula shown in Figure 9, the relative value units (RVUs) are measures of resource utilization that are assigned to services billed under national standard coding systems. These coding systems include the Common Procedure Terminology (CPT) system and the Health Care Financing Administration Common Procedure Coding System (HCPCS). Hence, each service provided by a physician has a relative value assigned to it in terms of the resources used in furnishing the service. There are RVUs assigned for physician work, practice expense, and malpractice expense.

Applying a Geographic Adjustment Factor. Next, the three "RVUs are adjusted for geographic differences in cost with geographic practice cost indexes" or GPCIs. This essentially means multiplying the three RVU factors by the corresponding GPCI which together account for the geographic adjustment factor (GAF) for a given locality.

Figure 9

Medicare Methodology for Physician Reimbursement

$$CF \times [(RVU_W \times GPCI_W) + (RVU_P \times GPCI_P) + (RVU_M \times GPCI_M)]$$

CF = Conversion Factor
RVU = Relative Value Units
GPCI = Geographic Practice Cost Index
W = RVU for physician work
P = RVU for practice expense
M = RVU for malpractice

Source: *RBRVS History, Calculations, and Development,* RBRVS.com and *Federal Register.*

Adding the Uniform Conversion Factor. Lastly, the conversion factor (CF) is the adjustment that allows for the calculation of the payment for service. The CF translates the relative values into actual payment amounts. Also, the CF is updated annually as required by OBRA 1989 under the sustainable growth rate system provision. "That system allows for updates that reflect medical inflation, changes in Medicare enrollment, changes in the economy, and changes in spending caused by the introduction of new laws and/or regulations." Essentially, this provision allows for lowering on increasing the conversion factor depending on whether expenditures exceed or are below projected rates of growth.

Virginia's Current Medicaid Methodology for Physician Reimbursement

DMAS' current system for physician reimbursement is essentially based on the Medicare methodology described in Figure 9 and the addition of a budget neutrality factor. However, according to DMAS staff, the Department does not use the geographic adjustment factors that Medicare uses for Virginia. DMAS staff indicated that that when they implemented the RBRVS system they had a work group assist the Department with the development of the methodology. "The department's policy for reimbursement to physicians had always been to pay the urban and rural physicians the same fees for similar services and the work group recommended continuing this policy." Therefore, DMAS uses an RBRVS system without geographic adjustment factors.

Figure 10 provides a representation of Virginia's physician reimbursement methodology. The budget neutrality factor is approximately the percentage of Medicare that Virginia can afford to pay based on the funding that is available. Currently, the budget neutrality factor equates to approximately 70.72 percent of Medicare. This is down from rates of approximately 78 percent in 1998 (Urban Institute study). This decline has resulted from the lack of increased funding for physician reimbursement since the implementation of the RBRVS system in FY 1995.

Figure 10

DMAS Physician Reimbursement Methodology

$$(CF) \times (RVU_{total}) \times (\text{Budget Neutrality Factor})$$

CF = Conversion Factor ($36.1992)
RVU = Relative Value Units (total RVUs for physician work, practice expense, & malpractice)
Budget Neutrality Factor = (.7072)

Source: Information provided by DMAS staff.

It should be noted that the methodology described above is used in calculating the reimbursement rates of all physician specialties except for obstetrics and gynecological services (OB/GYN). The RVUs for OB/GYN were frozen at their 1999 levels. At that time, it was perceived that decreases in the Medicare RVUs for OB/GYN services might cause the rates to drop to the point where Medicaid patients might begin to have issues with access to OB/GYN care. This concern was based on previous

access issues associated with rates paid for OB/GYN services prior to the implementation of an RBRVS system. DMAS staff estimate that the OB/GYN services are paid at approximately 74.43 percent of Medicare at this time.

States Overall Medicaid Physician Fees Declined Between 1993 and 1998

In examining Virginia's methodology for reimbursing physicians under the Medicaid program, it is important to review the environment and trends in other states as well as Virginia. A study conducted by the Urban Institute, *Recent Trends in Medicaid Physician Fees 1993-1998,* completed in September 1999 provides information that not only examines physician fees in Virginia but also in other states. The Urban Institute study generally compares Medicaid physician reimbursement based on a set of 19 procedure codes. Therefore, statistics cited from the study will be based on research associated with those codes. Figure 11 lists the procedures and their associated codes. In addition, the study is focused on fee-for-service programs, which are found in 49 states (this includes the District of Columbia). There were seven states that declined to participate.

The Urban Institute study examined the change in physician fees from 1993 to 1998. Their study used the 19 procedure codes referred to in Figure 11 as a group defined as "all services." This examination found that the fees in the all services category of physician fees for the participating states collectively increased by 4.6 percent. However, during the same five-year time period, the Consumer Price Index (CPI) increased by 11 percent. Therefore, in real terms, physician fees decreased nationally between 1993 and 1998.

Examining physician reimbursement in Virginia from 1993 to 1998 shows:

- all services physician fees **decreased** by approximately 22.2 percent (12 additional states had decreases of more than 10 percent);
- primary care fees **increased** by approximately 31.5 percent (nine additional states had increases of at least 30 percent);
- obstetric care fees **decreased** by approximately 18.3 percent (three additional states had decreases of 10 percent or more); and

- other services fees **decreased** by approximately 44.1 percent (four other states had decreases of over 30 percent).

Figure 11

Urban Institute Study Codes Used for Analysis, FY 19998

Category and Code	Procedure
Primary Care:	
99203	Office Visit, New Patient, 30 Minutes
99213	Office Visit, Established Patient, 15 Minutes
99214	Office Visit, Established Patient, 25 Minutes
99244	Office Visit, New Patient, 60 Minutes
93000	Electrocardiogram
Obstetric Care:	
59410	Vaginal Delivery and Postpartum Care
59515	Cesarean Delivery and Postpartum Care
Other Fees:	
99222	Initial Hosp. Care, New or Establ. Patient, 50 Minutes
99254	Initial Inpatient Consultation, 80 Minutes
43235	Upper Gastrointestinal Endoscopy
58120	Dilation and Curettage
66984	Cataract Removal with Lends Implant
70450	Computerized Axial Tomograpghy Scan, Head or Brain
71020	X-Ray, Chest, Two Views
76805	Echography, Pregnant Uterus
81000	Urinalysis, Routine
87091	Culture, Bacterial, Screening Only
88035	Surgical Pathology

Source: *Recent Trends in Medicaid Physician Fees, 1993-1998*, September 1999, Appendix 1. The three categories together are defined as all services.

Changes in physician fees in Virginia can be explained by the fact that Virginia phased-in an RBRVS system beginning in 1995. Systems modeled after the Medicare RBRVS system emphasize preventive care services which has the consequence of shifting resources away from specialty services. According to the Urban Institute study, "As of 1995, 19 states had adopted the Medicare RBRVS (Arizona, Florida, Georgia, Indiana, Iowa, Louisiana, Maine, Massachusetts, Michigan, Missouri, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Texas, Utah, and Washington)." Additionally, as mentioned previously, research conducted by Price Waterhouse Coopers found that as of 2001, almost half

of the states had adopted an RBRVS system. This could account for why 70 percent of the states as reported in the Urban Institute study had increased primary care services fees (more than any other service). In addition, 60 percent of participating states had a reduction of payment levels for other services.

The Urban Institute study also examined the Medicaid to Medicare fee ratios for the 19 procedure codes listed in Figure 11. This research found that the average Medicaid to Medicare ratio was 64 percent. In 1998, only Texas and Alaska had Medicaid rates for physician fees that were higher than the comparable Medicare fees. Virginia had a ratio of .78 or paid 78 percent of what Medicare paid for comparable services in 1998. As mentioned previously, Virginia currently pays at 70.72 percent of Medicare fees. The results of the Medicaid to Medicare fee ratios are summarized in Figure 12.

Overall, Medicaid to Medicare fees decreased approximately 14 percent for all services between 1993 and 1998. In Virginia, during the same time period, the Medicaid to Medicare fee ratios for all services decreased 15.3 percent while primary care fee ratios increased by 0.9 percent. Medicaid to Medicare fee ratios in Virginia for obstetric care and other services also decreased by 38.1% and 28.4% respectively.

The Urban Institute has not updated its study with more recent information but may do so within the next six to nine months. Considering that Virginia's Medicaid to Medicare ratio is currently is at 70.72 percent, it is expected that the Urban Institute update will indicate that Virginia has not increased its Medicaid reimbursement to physicians or its reimbursement in comparison to Medicare fees.

JCHC Survey of Other States Finds Many Use RBRVS Methodology and that Rates in Comparison to Medicare Vary

JCHC staff conducted a telephone survey of other states concerning Medicaid reimbursement for physician services to examine reimbursement methodology, comparison of payments to Medicare rates, and some other general questions. The states surveyed included Alabama, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Tennessee, and West Virginia.

Figure 12
Medicare to Medicaid Fee Ratios for All Services, 1998

State	All Services
Alabama	0.78
Alaska	1.26
California	0.47
Colorado	0.75
Connecticut	0.64
District of Columbia	0.48
Florida	0.61
Georgia	0.81
Hawaii	0.63
Idaho	0.90
Illinois	0.52
Indiana	0.72
Iowa	0.72
Kansas	0.60
Kentucky	0.77
Louisiana	0.67
Maine	0.66
Maryland	0.64
Massachusetts	0.71
Michigan	0.50
Minnesota	0.80
Missouri	0.46
Nevada	0.97
New Hampshire	0.67
New Jersey	0.34
New Mexico	0.81
New York	0.30
North Carolina	0.85
North Dakota	0.89
Ohio	0.65
Oklahoma	0.61
Oregon	0.65
Rhode Island	0.44
South Carolina	0.59
South Dakota	0.87
Texas	1.19
Utah	0.63
Vermont	0.69
Virginia	**0.78**
Washington	0.80
West Virginia	0.84
Wisconsin	0.81
National Average	**0.64**

Source: *Recent Trends in Medicaid Physicians Fees, 1993-1998,* September 1999, Urban Institute.

Figure 13 provides a summary of the survey results as well as the comparison of the Medicaid to Medicare fee ratios that were provided in the Urban Institute report for 1998. As shown, the majority of surveyed states (7 of 11 states) plus Virginia use some form of an RBRVS system for calculating physician reimbursement. In addition, if Virginia is included, the following conclusions can be drawn when comparing Medicaid rates as a percentage of Medicare between 1998 and 2001:

- three states plus Virginia experienced a decrease,
- four states experienced an increase, and
- four states did not have data available for one or both years.

An increasing number of states are using a RBRVS system for reimbursement of Medicaid physician services. According to research done by Price Waterhouse Coopers in 2001, "Almost half of the Medicaid programs across the country have adopted the Medicare Resource-Based Relative Value Scale (RBRVS) as a benchmark for establishing physician fee-for-service payments."

Figure 13

Other State Review of Medicaid Methodology and Rates as Compared to Medicare Physician Services

State	RBRVS Methodology for Physicians (Y/N)	Medicaid Reimbursement as a Percent of Medicare, FY 2002	Medicare to Medicaid Fee Ratio for All Services, FY 1998
Alabama	N/A	0.63	0.78
Florida	Y	0.57	0.61
Georgia	Y	0.90*	0.81
Kentucky	Y	N/A	0.77
Louisiana	Y	0.70**	0.67
Maryland	N	0.40	0.64
Mississippi	Y	0.90	N/A
North Carolina	Y	0.95	0.85
South Carolina	N	0.74	0.59
Tennessee	N/A	N/A	N/A
Virginia	**Y**	**0.71**	**0.78**
West Virginia	Y	N/A	0.84

Source: JCHC staff analysis of other state survey and *Recent Trends in Medicaid Physicians Fees, 1993-1998,* September 1999, Urban Institute.

Note: * 90 percent of the 2000 fee schedule.
** Certain codes are paid at 90%,

Provider Groups Express Concerns Over Low Reimbursement Rates and Reimbursement Methodology

As part of the evaluation of physician reimbursement rates under Medicaid, JCHC staff met with provider groups and/or representatives. From these meetings, several concerns were expressed with regard to Virginia's Medicaid physician reimbursement system. One concern that was generally expressed by most groups was that the current reimbursement rates are too low and are beginning to limit the number of Medicaid patients that doctors can afford to see in their practice. Concerns were expressed that the low rates will eventually lead to access issues for Medicaid patients, in regard to being able to see certain specialists. Also, providers stated that they did not want to limit the number of Medicaid patients that they see but that they have to be concerned about covering their costs. Some providers stated that this becomes a greater concern when a practice sees a large percentage of Medicaid clients because there are fewer opportunities to subsidize costs through other patients (private insurance). One policy option that will be discussed in the following section addresses those providers that may see a disproportionate number of Medicaid patients.

An additional concern is the fact that specialties in general do not fare as well under an RBRVS system in comparison to preventive services. Evaluating this concern would require a more in-depth analysis of alternative methodologies, which is beyond the scope of this study. Additionally, an option that would be available for future consideration would be to conduct additional research to determine what if any increases in reimbursement specific types of specialists should receive. For example, OB/GYN services already receive rates that appear slightly higher than those provided for other specialties.

Options That Address Increasing Reimbursement Rates Would Have Substantial Costs

One reimbursement option that could be considered would be to raise Virginia Medicaid physician reimbursement to the level of Medicare rates. This would essentially mean that there would no longer be a budget neutrality factor in the formula for Virginia Medicaid reimbursement for physicians. DMAS staff estimate that this option would cost approximately $85.5 million in total additional funding per year. If you

apply the FY 2003 federal to state match for Medicaid this would mean an additional $42.3 million (49.47%) needed in state funding and $43.2 million (50.53%) in federal funding per year.

A second option to consider is to provide a gradual increase in Medicaid rates. DMAS staff were asked to provide cost estimates to raise Medicaid rates to 75%, 80%, and 85% of Medicare. To raise the current Medicaid rates for physician reimbursement to 75% of Medicare rates would require an additional $9.3 million in total funding per year. If you apply the FY 2003 federal to state match for Medicaid this would mean an additional $4.6 million needed in state funding and $4.7 million in federal funding per year. Raising rates to 80% of Medicare would require $24.1 million in additional funding per year, or $11.9 million in state funds and $12.2 million in federal funds. Lastly, raising rates to 85% of Medicare would require an additional $38.8 million in funding per year, or $19.2 million in state funds and $19.6 million in federal funds.

A third option addresses the concern of providers who accept a disproportionate share of Medicaid patients. One option that could address this concern would be to provide some additional compensation to those providers for whom Medicaid patients make up a higher percentage of patient caseload. DMAS staff were asked to provide cost estimates for giving a five percent increased rate of reimbursement to physicians who practice in a locality that has greater than 10 percent and greater than 15 percent of its total population eligible for Medicaid. Providing an additional five percent increase in reimbursement in those localities that have greater than 10 percent of its total population eligible for Medicaid would require an additional $6.2 million, or $3.1 million in state funds and $3.1 million in federal funds. Providing an additional five percent increase in reimbursement in those localities that have greater than 15 percent of its total population eligible for Medicaid would require an additional $2.8 million, or $1.4 million in state funds and $1.4 million in federal funds.

> Note: The cost estimates that were provided in the draft version of the study were updated to accommodate additional information provided by DMAS after the report date. All cost estimates contain associated increases in managed care programs.

In conclusion, there are many options that could be considered to increase reimbursement rates to physicians under the Virginia Medicaid

program. Physician representatives indicated that they realize obtaining additional funding would be difficult at this time. But the representatives indicate that reimbursement rates should be increased whenever possible. Therefore, there are several options that would allow for continuing research so that reimbursement recommendations could be refined. One option would be to request that HJR 42 and SJR 38 be reported from their respective Committees on Rules. This would allow JLARC to conduct a more thorough review of this topic. Another option would be to include this topic on JCHC's workplan for 2003 to allow for additional research and contemplation of additional options to address physician reimbursement rates.

IV.
Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to recommend with regard to physician reimbursement under the Medicaid fee-for-service program.

Option I: **Take no Action.**

Option II: **Introduce budget amendment (language and funding) to recommend that Medicaid physician reimbursement be paid at approximately the same rate as Medicare (excluding geographic adjustment factors); the estimated general fund amount for FY 2003 would be $42.3 million.**

Option III: **Introduce budget amendment (language and funding) to recommend that:**

A. Medicaid physician reimbursement be paid at 75 percent of Medicare (excluding geographic adjustment factors); the estimated general fund amount for FY 2003 would be $4.6 million.

B. Medicaid physician reimbursement be paid at 80 percent of Medicare (excluding geographic adjustment factors); the estimated general fund amount for FY 2003 would be $11.9 million.

C. Medicaid physician reimbursement be paid at 85 percent of Medicare (excluding geographic adjustment factors); the estimated general fund amount for FY 2003 would be $19.2 million.

Option IV: Introduce budget amendment (language and funding) to recommend that Medicaid physician reimbursement be altered to provide a five percent increased rate of reimbursement to physicians who practice in a locality that has:

A. Greater than 10 percent of their total population eligible for Medicaid; the estimated general fund amount for FY 2003 would be $3.1 million.

B. Greater than 15 percent of their total population eligible for Medicaid; the estimated general fund amount for FY 2003 would be $1.4 million.

Option V: Include in the 2003 workplan for the Joint Commission on Health Care, further study and analysis of issues related to Medicaid physician reimbursement.

Option VI: Recommend to the House Committee on Rules that HJR 42 be reported.

Option VII: Recommend to the Senate Committee on Rules that SJR 38 be reported.

Appendix A:

Senate Joint Resolution 38
House Joint Resolution 42

SENATE JOINT RESOLUTION NO. 38

Offered January 9, 2002

Prefiled January 7, 2002

Requesting the Joint Legislative Audit and Review Commission (JLARC) to study Medicaid reimbursement of physicians.

Patron-- Bolling

Referred to Committee on Rules

WHEREAS, Medicaid provides access to needed health care services for Virginia's low-income, uninsured persons; and

WHEREAS, in order for Medicaid recipients to have appropriate access to care, it is critical that an adequate number of physicians participate in Medicaid; and

WHEREAS, Medicaid reimbursement for rendered services is an important consideration for physicians in deciding whether to participate in the program; and

WHEREAS, Medicaid Physician Fee Surveys conducted by the Urban Institute in 1993 and 1998 found that while physician reimbursement by the Virginia Medicaid program for some services had increased, overall reimbursement for all physician services decreased approximately 22 percent; and

WHEREAS, the plan to eliminate the Certificate of Public Need program recommended by the Joint Commission on Health Care in 2001 called for a study of Virginia Medicaid reimbursement for physician services across all specialties; and

WHEREAS, the Joint Legislative Audit and Review Commission has conducted studies for Medicaid reimbursement of nursing homes and hospitals in recent years, and in both studies recommended increases in reimbursement amounts and changes in reimbursement methodologies; and

WHEREAS, a review of Medicaid reimbursement for physicians is needed to determine whether the current level of reimbursement is appropriate for the various types of physician services and specialties provided to Medicaid recipients; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission be requested to conduct a study of Medicaid reimbursement of physicians. The study shall include, but not be limited to, an analysis of (i) the appropriateness of current reimbursement levels and methods of payment for the various physician specialties; (ii) how physician reimbursement in Virginia compares to that in other states; (iii) whether changes in the amount and method of reimbursement are needed to compensate physicians adequately for their services; and (iv) the additional cost, if any, of recommended changes in the amount of physician reimbursement.

All agencies of the Commonwealth shall provide assistance to the Joint Legislative Audit and Review Commission for this study, upon request.

The Joint Legislative Audit and Review Commission shall complete its work in time to submit its written findings and recommendations by November 1, 2002 to the Chairmen of the Senate Finance Committee, the House Appropriations Committee, and the Joint Commission on Health Care, and to the Governor and the 2003 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

HOUSE JOINT RESOLUTION NO. 42

Offered January 9, 2002

Prefiled January 2, 2002

Requesting the Joint Legislative Audit and Review Commission (JLARC) to study Medicaid reimbursement of physicians.

Patrons-- Bryant, Hull and McQuigg

Referred to Committee on Rules

WHEREAS, Medicaid provides access to needed health care services for Virginia's low-income, uninsured persons; and

WHEREAS, in order for Medicaid recipients to have appropriate access to care, it is critical that an adequate number of physicians participate in Medicaid; and

WHEREAS, Medicaid reimbursement rates for the various rendered services must be considered by physicians when deciding whether to become participating providers in Virginia's program; and

WHEREAS, Medicaid Physician Fee Surveys conducted by the Urban Institute in 1993 and 1998 found that, while physician reimbursement by the Virginia Medicaid program for some services had increased, overall reimbursement for all physician services had decreased approximately 22 percent; and

WHEREAS, the Joint Commission on Health Care's 2001 plan to eliminate the Certificate of Public Need program would have required a study of Virginia Medicaid reimbursement for physician services across all specialties; and

WHEREAS, the Joint Legislative Audit and Review Commission has conducted studies of Medicaid reimbursement to nursing homes and hospitals in recent years, and in both studies recommended increases in reimbursement amounts and changes in reimbursement methodologies; and

WHEREAS, a review of Medicaid reimbursement for physicians is needed to determine whether the current level of reimbursement is appropriate for the various types of physician services and specialties provided to Medicaid recipients; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Legislative Audit and Review Commission be requested to conduct a study of Medicaid reimbursement of physicians. The Commission's study shall include, but need not be limited to, an analysis of (i) the appropriateness of current reimbursement levels and methods of payment for the various physician specialties; (ii) how physician reimbursement in Virginia compares to that in other states; (iii) whether changes in the

amount and method of reimbursement are needed to compensate physicians adequately for their services; and (iv) the estimated cost, if any, of any recommended changes in the amount of physician reimbursement.

All agencies of the Commonwealth shall provide assistance to the Joint Legislative Audit and Review Commission, upon request.

The Joint Legislative Audit and Review Commission shall complete its work by November 1, 2002, and provide a preliminary report to the Governor and the chairmen of the Senate Committee on Finance, the House Committee on Appropriations, and the Joint Commission on Health Care. The Joint Legislative Audit and Review Commission shall also submit its written findings and recommendations to the Governor and the 2003 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B:

Summary of Public Comments

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:

Medicaid Reimbursement of Physicians (SJR 38/HJR 42)

Organizations/Individuals Submitting Comments

Two individuals/organizations submitted comments in response to the Medicaid reimbursement of physicians study:

- Medical Society of Virginia
- Virginia Chapter of the American Academy of Pediatrics (VA-AAP)

Policy Options Included in the Issue Brief Evaluating the Medicaid Reimbursement of Physicians

Option I: **Take no Action.**

Option II: **Introduce budget amendment (language and funding) to recommend that Medicaid physician reimbursement be paid at approximately the same rate as Medicare (excluding geographic adjustment factors); the estimated general fund amount for FY 2003 would be $42.3 million.**

Option III: Introduce budget amendment (language and funding) to recommend that:

D. Medicaid physician reimbursement be paid at 75 percent of Medicare (excluding geographic adjustment factors); the estimated general fund amount for FY 2003 would be $4.6 million.

E. Medicaid physician reimbursement be paid at 80 percent of Medicare (excluding geographic adjustment factors); the estimated general fund amount for FY 2003 would be $11.9 million.

F. Medicaid physician reimbursement be paid at 85 percent of Medicare (excluding geographic adjustment factors); the estimated general fund amount for FY 2003 would be $19.2 million.

Option IV: Introduce budget amendment (language and funding) to recommend that Medicaid physician reimbursement be altered to provide a five percent increased rate of reimbursement to physicians who practice in a locality that has:

C. Greater than 10 percent of their total population eligible for Medicaid; the estimated general fund amount for FY 2003 would be $3.1 million.

D. Greater than 15 percent of their total population eligible for Medicaid; the estimated general fund amount for FY 2003 would be $1.4 million.

Option V: Include in the 2003 workplan for the Joint Commission on Health Care, further study and analysis of issues related to Medicaid physician reimbursement.

Option VI: Recommend to the House Committee on Rules that HJR 42 be reported.

Option VII: Recommend to the Senate Committee on Rules that SJR 38 be reported.

Overall Summary of Comments

Of the two comments, one commenter would support Option II but is not requesting action until Virginia's budget deficit is addressed. The other commenter would support an increase in physician reimbursement but is not requesting action until the economic outlook improves.

Summary of Individual Comments

Medical Society of Virginia

Ryan S. Viner, Associate Director of Health Policy, commented in support of Option V, "Include in the 2003 work plan for the Joint Commission on Health Care further study and analysis of issues related to Medicaid physician reimbursement." Mr. Viner stated: "That being said, the Medical Society of Virginia recognizes and appreciates the unprecedented budget shortfalls the Commonwealth is experiencing and is sympathetic to such plight. However, it is of paramount importance to the physicians and patients of the great Commonwealth that once the economic outlook brightens, an increase in physician Medicaid reimbursement should be a top priority for the Commission and the Commonwealth."

Virginia Chapter of the American Academy of Pediatrics (VA-AAP)

Robin Foster, MD, FAAP, Legislative Chair, commented in support of Option V, to include further study and analysis of Medicaid physician reimbursement in the Joint Commission's 2003 work plan. Dr. Foster also indicated:

"...also requests that the Joint Commission consider implementation of Policy Option II, as soon as Virginia's budget deficit is addressed. This option provides budget language and funding to raise Medicaid physician reimbursement to approximately the same rate at Medicare. Increasing reimbursement across the state, not according to geographic areas, is the best incentive for physicians to include Medicaid patients in their practice. This shares the burden of caring for Medicaid patients, without further separating physicians into geographic interest groups."

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