

## **Report to the Legislature**

### ***Options for Providing Financial Incentives for Private Practice Physicians to Serve Uninsured, Medicare, and Medicaid Patients***

**As Required by Engrossed Substitute Senate Bill 6090**

**December 1, 2006**

Department of Social and Health Services  
In Consultation With  
Department of Revenue  
Health Care Authority

Department of Social and Health Services  
P.O. Box 45500  
Olympia, Washington 98504  
(360) 725-1880  
Fax: (360) 586-9551

# ***Table of Contents***

---

<b><i>Overview &amp; Summary</i></b>	1
<b><i>Part I: B&amp;O Tax Credit Proposal</i></b>	5
A. Current law	5
B. Tax credit proposal	5
C. Administrative issues	6
D. Policy questions	7
E. Conclusions	7
<b><i>Part II: Washington’s Medicaid Program</i></b>	9
A. Medicaid physicians rate comparisons	9
• A state-by-state comparison of Medicaid agencies	9
• Washington’s Medicaid as a percentage of Medicare	10
• Washington’s Medicaid as a percentage of the Uniform Medical Plan	10
• Washington’s Medicaid as a percentage of a commercial medical insurance carrier	11
• Washington’s Medicaid as a percentage of physicians’ prevailing charges	11
B. Existing Medicaid payment incentive programs	11
• Federal Programs with Increased Rates	12
○ Federally-Qualified Health Centers	12
○ Rural Health Clinics	12
○ Tribal Clinics	13
• State Payment Incentives	13
○ Maternity-Related Services	13
○ Services for Children	14
○ Targeted Vendor Rate Increases	14
C. Physician participation in Washington’s Medicaid Program	15
<b><i>Part III: Payment Incentives</i></b>	19
A. Literature Review of the Impact of Rate Increases on Provider Access and Participation	19
B. Payment Incentive Options	21
• Modeling Medicaid Rates at Other Payers’ Levels	22
○ Increase Professional Fees to 80% of UMP	23
○ Increase Medicaid Rates using UMP’s Inflation Index	24
○ Targeted Payment Rate Increases	25
C. Conclusions	27
<b><i>Part IV: What Are Other States Doing?</i></b>	29

## ***Overview & Summary***

---

This report examines the creation of incentives for private practice physicians to serve uninsured and Medicare and Medicaid patients. The report arises out of an instruction from the 2006-2007 legislature.

***ESSB 6090 Section 209(22):*** *By November 15, 2006, the department of social and health services, in consultation with the department of revenue and the health care authority, shall report to the health care and fiscal committees of the legislature on options for providing financial incentives for private practice physicians to serve uninsured, Medicare, and Medicaid patients. The report shall include an assessment of the relative costs and effectiveness of strategies including, but not limited to, tax credits and payment rate increases. The report shall further suggest alternative mechanisms and thresholds for varying tax credits and payment enhancements according to the extent to which a provider serves uninsured, Medicare, and Medicaid patients.*

*This report is presented in four sections. The first part describes a Business & Occupations (B&O) tax credit for providing incentives for physicians serving Medicare, Medicaid and uninsured patients. The second part describes Washington's Medicaid physician payment program, the third part provides Medicaid payment enhancement options to improve access and participation in the program, and the fourth part provides information from a survey of other state Medicaid programs on provider access. Following is a summary of findings from the study.*

### **Tax Credit Options**

- Given Washington's existing tax structure, the best option for providing tax incentives for serving Medicare, Medicaid and uninsured patients is a B&O tax credit. Physicians providing health care services to Medicare and Medicaid patients could claim a credit against the total amount of tax due on their excise tax return. The credit would be equal to 1.5% of the amounts received for providing services to Medicare and Medicaid patients, and the value of services provided to such patients for whom there are no reimbursements.
- It is recommended that the B&O credit also include services provided to patients in all DSHS financed health programs and Basic Health Program (BHP) enrollees.
- The credit would reduce the B&O tax burden on physicians by approximately \$21 million per year.

- There are no estimates on how much access would be affected by this credit.
- This option would have relatively little administrative burden on physicians or the Department of Revenue to implement.

### **Washington's Medicaid Physician Program**

- In assessing payment incentives it is important to know how Washington's Medicaid payment rates compare to other payers.
  - ✓ Compared to other states, Washington's Medicaid physician payment rates are relatively high for maternity services and children's office visits. However payment rates for specialty services are low compared to other states – ranking 40<sup>th</sup> among states.
  - ✓ On average, Washington's Medicaid rates are 73% of Medicare's rates, and are 53% of Uniform Medical Plan (UMP) and commercial rates.
- Federal Medicaid requirements include incentive payments to promote access to care for Medicaid clients and to assist so-called "safety-net providers" who provide services to low-income, uninsured patients.
  - ✓ Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC) and Tribal facilities receive enhanced payments. There are some 280 clinic sites in Washington. These physicians provided about 20% of all physician services in state fiscal year 06 (SFY06) and account for 47% of physician-related Medicaid expenditures.
- Washington State has also implemented a number of payment incentives to promote access to care for Medicaid and other low-income groups. These include maternity services, services for children and other targeted payment enhances for adult office visits, anesthesia, laboratory services and AV fistula procedures.
- Overall, physician participation in DSHS' medical assistance programs has been stable.
  - ✓ Over the past five years, the number of physicians has increased about 3.0% each year. Participating physicians per 1,000 clients has also increased.
  - ✓ Even though there are more providers, the top quartile of physicians continues to provide over 70% of all visits.

- ✓ Not all counties have seen recent increases in the number of physicians. In CY 2005, 17 (44%) counties had decreases in specialty care providers. These 17 counties accounted for 26.4% of the FFS client population and 18.9% of CY 2005 FFS specialty providers.
- ✓ In comparing CY 2004 to CY 2005 participation rates, there were reductions in seven specialty areas – urology, ophthalmology, neurology, physical medicine and rehabilitation, plastic surgery, pulmonary (internal) and pediatrics.

### **Medicaid Physician Payment Incentives**

- This report includes a literature review to help assess what impact Medicaid payment incentives may have in increasing access and participation.
  - ✓ Research to date indicates that higher rate levels can increase the acceptance, but not necessarily the access, of Medicaid patients by physicians.
  - ✓ Studies, informal discussions with providers and Washington’s prior Medicaid experience suggest that Medicaid payment rates would need to approach commercial rates to have a material impact on physician participation.
- State government does not have a mechanism to directly increase Medicare payment rates because the program is federally administered.
- While the state could implement a physician payment program that would pay physicians for services they provide to uninsured patients, a more appropriate approach would be to provide subsidized health insurance coverage for low-income residents.
- In response to the Legislative requirements on payment increases, this study modeled a series of Medicaid payment enhancements.
  - ✓ The Washington State Medical Association (WSMA) has recommended that Medicaid payment rates be increased to 100% of the state’s Uniform Medical Plan (UMP) for maternity and children’s office visits and 80% of UMP for all other services. It is estimated that during the 2007-09 biennium, this would cost approximately \$352 million (\$187 million state) per year. It also would have a \$57 million per year impact on BHP expenditures.
  - ✓ Historically, UMP physician payment inflation factors have been greater than Medicaid. It is estimated that it would cost about \$17 million (\$9 million state) per year to adopt UMP’s historical inflation factors during the 2007-09 biennium.

- ✓ The B&O tax credit would cost about \$21 million per year. If this amount was combined with federal matching funds, Medicaid payment rates could be increased about 17.5%.
- ✓ Increasing Medicaid orthopedic rates to their UMP equivalent would cost about \$17 million (\$9 million state) per year
- ✓ Increasing Medicaid pediatric rates to their UMP equivalent would cost about \$50 million (\$26 million state) per year.
- Physician rate increases should be linked to outcome requirements. In addition to the possibility of improving access to care, the rate increases should provide financial incentives to improve the health care delivery system's efficiency and cost-effectiveness. To the extent possible, the performance requirements would be adopted in collaboration with other state agencies, and where possible, they should also be consistent with existing public/private initiatives.

### **Other Medicaid State Programs**

- Of 36 respondents, 32 (89%) states indicated they were experiencing at least minor difficulty with physician participation.
- When asked if the problem was getting better or worse, 27 (75%) replied that it was remaining the same.
- Orthopedics and pediatrics were the specialties of most concern. There were also seven reports of concern over coverage in specific geographic areas, such as rural communities or areas with a disproportionate number of retirees.
- Seventeen states indicated that they provide some type of financial incentive to retain fee-for-service physicians.

## ***PART I: B&O Tax Credit Proposal***

---

Section 209, chapter 518, Laws of 2005 directed DSHS in consultation with the DOR to report on options for providing financial incentives to private practice physicians for serving uninsured, Medicare and Medicaid patients. Financial incentives include the potential of providing tax credits to physicians serving these patients.

### ***A. Current law***

RCW 82.04.4311 allows public and nonprofit hospitals as well as nonprofit community health centers and networks to deduct the amounts received as compensation (excluding patient co-payments and/or patient deductibles) for the provision of health care services. The deduction is available for only the amounts received for services covered under the following programs:

- Medicare
- Medicaid
- Children's Health Care
- Any other program under chapter 74.09 RCW
- Basic Health Plan

RCW 82.04.4297 allows health and social welfare organizations to deduct amounts received from a governmental entity for providing health and/or social welfare services. The deduction does not include amounts that are received under an employee benefits plan.

Private practice physicians are not eligible for either deduction. As a result, the gross income derived by physicians in Washington who provide health care services is subject to the 'service and other activities' classification of the B&O tax. The B&O tax rate for physicians is currently 1.5% of their gross income.

### ***B. Tax credit proposal***

Private practice physicians providing health care services to Medicare and Medicaid patients would claim a credit against the total amount of tax due on their excise tax return. The credit would be equal to 1.5% of the amounts received for providing services to Medicare and Medicaid patients. Amounts received from patient co-payments and/or patient deductibles, if any, would be excluded from the credit computation. As an incentive to provide services to uninsured patients, the credit could be expanded to include the value of services provided to such patients for whom there are no reimbursements.

A credit for private practice physicians providing services to Medicare, Medicaid and uninsured patients could be structured so that any unused credit could be carried over to subsequent years. The credit could not exceed the amount of tax otherwise due. No refunds would be allowed for unused credit.

It is estimated that adoption of a B&O tax credit as outlined above would reduce the overall tax impact on physicians by approximately \$21 million per year.<sup>1</sup> If revenue associated with services provided to Basic Health Program (BHP) patients were included, the impact from such a B&O tax credit would be approximately \$22.6 million per year.

<b>PHYSICIAN B&amp;O TAX CREDIT ESTIMATES</b>		
<b>Payer Type</b>	<b>SFY 2008 B&amp;O Tax Credit (11 Months)</b>	<b>SFY 2009 B&amp;O Tax Credit (12 Months)</b>
Medicare	\$9,591,000	\$10,881,000
Medicaid <sup>2</sup>	\$8,366,000	\$9,491,000
Charity Care	\$629,000	\$714,000
<b>Subtotal</b>	<b>\$18,586,000</b>	<b>\$21,086,000</b>
SCHIP	\$100,000	\$114,000
Basic Health Program	\$1,188,000	\$1,400,000
<b>Total</b>	<b>\$19,874,000</b>	<b>\$22,600,000</b>

### *C. Administrative issues*

The credit mechanism raises administrative issues that are easily addressed. One issue involves the excise tax return. There is limited space on the excise tax return to add lines for new deductions and credits. As a result, the DOR recommends that any proposal to provide a credit to private practice physicians include a requirement that the taxpayer file excise tax returns with the DOR electronically.

Another issue is that, for tax purposes, there is no definition of a “private practice physician.” Consequently, a definition of the term should be included in any proposal to specifically identify who may take the credit. It will be necessary to provide a definition of “private practice physician” that takes into account that a taxpayer can be an individual physician or an entity comprised of a group of physicians.

<sup>1</sup> See Appendix A for information on the assumptions and calculations used for these estimates.

<sup>2</sup> The Medicaid estimate includes all DSHS medical programs authorized under Chapter 74.09 RCW, except SCHIP.

## ***D. Policy questions***

Section 209, chapter 518, Laws of 2005 referred to tax credits for serving Medicare, Medicaid and uninsured patients. However, the tax credit could also be extended to physicians serving all state-subsidized low-income patients, including other DSHS medical programs authorized in Chapter 74.09 RCW (e.g., Medical Care Services, State Children's Health Insurance Program (SCHIP) and Children's Health Program), as well as the state's Basic Health Program. Given that all the DSHS programs use the same payment rates for physicians as Medicaid, and that BHP contractors often use Medicaid payments as the basis for their payments to providers serving BHP members, there is a compelling argument that the tax credit should also apply for services rendered to these low-income populations.

A tax policy question arises with the use of a credit mechanism when compared to the existing deductions for health care services provided by RCW 82.04.4297 and 82.04.4311. These existing deductions do not include services provided to uninsured patients for whom there are no reimbursements. This, in turn, raises the question of whether the existing deductions should be expanded to include the value of services provided to these uninsured patients.

Another tax policy question is whether the proposed tax incentive for private practice physicians should contain accountability measures similar to the accountability provisions for other tax incentives, such as:

- Annual reporting requirements for taxpayers claiming the incentive, which could include the number of uninsured, Medicaid and Medicare patients served by the taxpayer during the year;
- A requirement that the legislature or some other government entity such as DSHS or the HCA study the effectiveness of the tax incentive; and
- An expiration date so that the legislature will have to determine whether the tax incentive is worthy of being extended.

## ***E. Conclusions***

The B&O tax credit is the one option for the state to provide a financial incentive to physicians to service Medicare, Medicaid and uninsured patients. Other incentive options such as Medicaid rate increases encourage physicians to provide services to only DSHS patients.

Another advantage of the tax credit is that it rewards physicians who currently are serving Medicare, Medicaid and uninsured patients, and it would reward physicians as they serve more of these patients over time.

If the legislature were to adopt this option, the credit should be extended to all DSHS medical assistance programs covered under Chapter 74.09 RCW and to revenue derived from serving BHP enrollees.

The B&O tax credit option is relatively easy for physicians and the DOR to implement and operate, particularly if the credit includes a requirement that the taxpayer electronically file its excise tax returns with the DOR.

There are two downsides to the B&O tax credit, however. In contrast to Medicaid-financed payment enhancements, the state is not able to leverage federal funds. For example, the tax credit annually results in \$20 million of revenue off-set for physicians and a corresponding \$20 million in loss to the State General Fund (GFS) revenue to the state. The state could infuse \$20 million in new revenue to physicians serving Medicaid through a payment increase that would only cost \$10 million in GFS funds.

The second downside is that it is not known how many additional physicians would be willing to serve Medicare, Medicaid or uninsured patients from a savings on the B&O tax, which is only 1.5% of their taxable income. Nor is it known how many existing physicians would expand their existing practice to serve more Medicare, Medicaid or uninsured patients.

ESSB 6090, Section 209(22) requested suggestions on thresholds for varying the tax credit according to the extent to which a provider serves uninsured, Medicare and Medicaid patients. One of the positive aspects of the B&O tax credit option is that the incentive is directly tied to the objective – the more uninsured, Medicare and Medicaid patients the physician serves, the greater the credit.

The concept of adopting a minimum threshold that would determine when a provider could receive a credit was rejected. The state does not have information upon which to set a threshold. Secondly, setting thresholds would introduce an administrative burden on physicians and the DOR. In addition, setting a threshold may not motivate additional physicians to expand their practice because they would not receive any tax incentive until they met the threshold.

## ***PART II: Washington's Medicaid Program***

---

### ***A. Medicaid physician rate comparisons***

It is necessary to know how Washington's existing Medicaid payment rates compare to other payers in order to have a benchmark for evaluating payment incentives. There are many ways to gauge Washington Medicaid rates: a state-by-state comparison of Medicaid agencies; Medicaid as a percentage of Medicare; Medicaid as a percentage of a commercial medical insurance plan; Medicaid as a percentage of commercial insurance rates; and Medicaid as a percentage of physicians' prevailing charges.

- ***A state-by-state comparison of Medicaid agencies***

In 2001, California's Medicaid program, Medi-Cal, commissioned a consulting firm, the Lewin Group, to compare each state's Medicaid program to the others. As a reference point, the states were ranked according to their fees as a percentage of Medicare's rates broken down by particular service areas. Washington's Medicaid rates ranked as follows:

- Evaluation and Management (E&M)<sup>3</sup> – 33<sup>rd</sup>
- Surgical Services – 44<sup>th</sup>
- Maternity and Delivery – 11<sup>th</sup>
- Radiology- 40<sup>th</sup>
- Lab/Pathology – 44<sup>th</sup>
- Psychiatry – 38<sup>th</sup>
- Vision/Ophthalmology – 24<sup>th</sup>
- Dental Services – 26<sup>th</sup>

A copy of the tables from the Lewin report showing each state's rankings is included in Appendix B.

Another healthcare watch-group, the Henry J. Kaiser Family Foundation, is a non-profit, private operating foundation focusing on the major health care issues facing the nation. Their website, [www.statehealthfacts.org](http://www.statehealthfacts.org), provides a wealth of information on the state of healthcare in the U.S. Using CY 2003 data, the Kaiser Foundation ranked each state's physician payments as an index to the overall U.S. average. Washington's Medicaid program was ranked<sup>4</sup> as follows:

---

<sup>3</sup>Washington's E&M codes in this study included office visits for adults only; office visits for children are paid a higher rate.

<sup>4</sup> Washington's primary care services in this study include children's primary care services, which are paid using a much higher conversion factor than other primary care services, thus raising the overall ranking in this category.

- Overall – 11th
- Primary Care – 15th
- OB Care – 5th
- All Other – 40th

Given Washington's prior focus on increasing rates for children's primary care services and maternity services, these targeted areas undoubtedly contribute to the state's overall high ranking. However, considerable payment disparities exist between the vast majority of services covered by the program and the targeted areas of children's primary care and maternity services.

A complete copy of the Kaiser Family Foundation study detailing Washington's Medicaid program compared to the rest of the United States can be found in Appendix C.

- ***Washington's Medicaid as a percentage of Medicare***

For this project, DSHS' actuarial firm, Milliman, completed a study comparing Washington's Medicaid rates for those services most often billed by each of the functional specialty areas to those of other industry payers, including Medicare.

Washington's Medicaid rates are, on average, 73% of Medicare's rates. Medicaid's rates range from a high of 118% of Medicare's rate for maternity deliveries,<sup>5</sup> to a low of about 60% for many other services, including some surgical and radiology services.

- ***Washington's Medicaid as a percentage of the Uniform Medical Plan***

Washington's Medicaid rates were compared further to one of the state employees' insurance plans, the Uniform Medical Plan (UMP).

Washington's Medicaid rates are, on average, 53% of UMP's rates. Medicaid's rates range from a high of 87% of UMP's rate for maternity deliveries, to a low of about 45% for nearly all other services.

---

<sup>5</sup> Although the report shows anesthesia services as slightly higher than maternity deliveries as compared to Medicare, these were excluded due to some limitations in the Milliman analysis for anesthesia services.

- ***Washington's Medicaid as a percentage of a commercial medical insurance carrier***

Since commercial insurance carrier rates are typically proprietary, our actuaries estimate that an average commercial insurer's payments are about 65% of the 75<sup>th</sup> percentile of physicians' prevailing charges.

Washington's Medicaid rates are, on average, 53% of estimated commercial rates. Medicaid's rates range from a high of 168% of the estimated commercial rate for epidural anesthesia done during a maternity delivery, to a low of about 16% for collection of venous blood by venipuncture.

- ***Washington's Medicaid as a percentage of physicians' prevailing charges***

Finally, Washington's Medicaid rates were examined as a percentage of physicians' prevailing charges. Specifically, Medicaid's rates were compared to the 50<sup>th</sup> percentile of physicians' billed charges.

Washington's Medicaid rates are, on average, 38% of physicians' billed charges. Medicaid's rates range from a high of 114% of the 50<sup>th</sup> percentile of billed charges for epidural anesthesia done during a maternity delivery, to a low of about 16% for collection of venous blood by venipuncture.

A complete copy of the Milliman comparison rate study can be found in Appendix D.

## ***B. Existing Medicaid payment incentive programs***

Federal Medicaid requirements include incentive payment requirements to promote access to care for Medicaid clients and to assist so-called "safety-net providers" who provide services to low-income, uninsured patients. Washington State also has implemented payment incentives to promote access to care for Medicaid and other low-income groups. The following section outlines the federal programs and key state payment enhancements that support access to medically necessary care.

**Federal Programs with Increased Rates**

<b>SFY 2006 Physician Related Services</b>				
	<b>Units</b>		<b>Expenditures</b>	
	<b>Number</b>	<b>%Total</b>	<b>Amount</b>	<b>%Total</b>
Private (FFS) Providers	8,744,796	81%	\$61,280,124	53%
FQHCs	1,836,301	17%	\$27,194,013	23%
RHCs	170,644	2%	\$13,193,841	11%
Tribal Facilities	67,680	1%	\$14,832,215	13%
Total	10,819,421	100%	\$116,500,193	100%

***Federally-Qualified Health Centers***

A federally-qualified health center (FQHC) is a health center that qualifies for federal Section 330 grants. Federal law requires Medicaid agencies to pay an FQHC an all-inclusive encounter rate based on 100% of the center’s audited costs for Medicaid-covered services. Once a center’s base year encounter rate is set, the rate is increased each year thereafter by the Medicare Economic Index (MEI). In addition, the state must make a supplemental payment (known as an “enhancement”) to the FQHC for clients enrolled in a managed care plan and assigned to the FQHC. The enhancement is intended to make up the difference between what the FQHC receives from the managed care plan on a service or per capita basis and what the center is entitled to under its encounter rate.

There are currently 45 main FQHCs in Washington, with a total of 106 clinic locations. FQHCs are often referred to as “safety-net” providers since federal law requires an FQHC to treat Medicaid and uninsured clients. FQHCs account for 23% of all payments made to physicians for services provided to Medicaid clients in the fee-for-service program. The table above details total payments for physician services for state fiscal year 2005 by provider type.

***Rural Health Clinics***

A rural health clinic (RHC) is a primary care provider located in a rural area that is federally designated as having a health professional shortage or as being medically underserved. Like an FQHC, federal law requires Medicaid programs to reimburse RHCs on an all-inclusive encounter rate basis for certain Medicaid services and to make supplemental enhancement payments for managed care clients assigned to the clinic. Covered RHC services are defined by the Medicare RHC guidelines, and the encounter rates are determined using the RHC’s audited Medicare cost report. Once the base year is set, the rate is updated annually by the MEI.

Unlike FQHCs, RHCs do not receive Section 330 grants and do not have to take all Medicaid and uninsured clients. There are currently approximately 150 RHCs in Washington. RHC expenditures account for about 11% of total physician payments.

### ***Tribal Clinics***

Tribal clinics are medical providers owned and operated by federally recognized tribes, established to primarily serve Native Americans enrolled in the Medicaid program. Tribal clinics are paid using an all-inclusive encounter rate that is set by the federal government. Tribal clinics are reimbursed using 100% federal funding for Natives. Tribal expenditures represent 13% of total physician payments.

### **State Payment Incentives**

#### ***Maternity-Related Services***

- ***Dedicated higher conversion factor*** – In order to ensure that pregnant Medicaid clients have access to a full range of maternity services, including early prenatal care, delivery services, and postpartum care, Medicaid payment rates for maternity services are very nearly equal to those of commercial insurers. Medicaid physician rates are set using the Resource-Based Relative Value Scale (RBRVS) methodology. An individual procedure's rate is determined by multiplying the procedure's "value" (as determined on a national basis by a federal committee) by a conversion factor. Maternity-related service rates are set using a dedicated conversion factor that is higher than that used when calculating rates for other non-maternity services.
- ***High-risk add-on payment*** – In addition to the regular payment for a maternity delivery, DSHS will reimburse the delivering physician an additional flat fee of \$282.81 for those deliveries considered to be high-risk. These additional payments help ensure that the additional expenses related to the increased time and resources needed to treat these clients are compensated.
- ***Delivery add-on payment for family practice physicians in rural counties*** – Beginning in state fiscal year 2006, the legislature dedicated funding for a maternity delivery add-on payment to family practice physicians in rural counties. This additional payment was created to help offset increased malpractice insurance rates for those physicians who perform maternity deliveries and to encourage rural family practice physicians to treat pregnant Medicaid clients in the communities they live in. For dates of service of August 1, 2005 to July 1, 2006 the delivery add-on payment

was \$194.00. For dates of service of July 1, 2006 to July 1, 2007 the delivery add-on payment is \$410.00.

### ***Services for Children***

- ***Dedicated conversion factor for office visits***

In order to ensure physician access for children to primary care services and well-child exams, the conversion factor for children’s office calls and EPSDT visits is higher than that of adult services. Examples of non-facility setting (NFS) rate comparisons are:

<b>Services Provided</b>	<b>Maximum Allowable Fee</b>
Adult New Patient Office Call	\$25.00
Child New Patient Office Call	\$34.30
Adult Established Patient Office Call	\$14.80
Child Established Patient Office Call	\$20.30

- ***Foster care children***

In addition to the enhanced payments for children’s EPSDT screenings achieved through the higher conversion factor, DSHS pays an additional flat fee of \$120.00 for EPSDT screenings for children in foster care.

### ***Targeted Vendor Rate Increases***

The 2003-2005 biennial budget allocated additional funding to be used to target specific areas where current rates may be contributing to access issues. The additional funding equated to about 5% of the total budget for physician-related services. The following areas were targeted for the additional funding:

- ***Adult Office Visits*** – In an effort to ensure adult Medicaid patients have a primary care “medical home,” the adult office visit conversion factor was increased 22% from \$20.44 to \$25.00 per relative value unit.
- ***Anesthesia*** – Evidence suggested that minor surgical and dental procedures that could normally be done in an office setting were being done in the more expensive hospital setting due to the inability to get anesthesiologists to provide services to Medicaid clients due to low reimbursement rates. Therefore, the anesthesia conversion factor was increased 29% from \$15.70 to \$20.23 per anesthesia base unit.

- **Laboratory Services** – Provider payment studies showed that Washington Medicaid’s payments for laboratory services were some of the lowest in the nation when compared to all lab payment rates in the United States. Therefore, laboratory services were increased 9% from 72% to 81% of Medicare’s laboratory fee schedule.
- **AV Fistula Procedures** – Research showed that payment rates for open arteriovenous anastomosis (AV fistula) placement and revision procedures had grossly inadequate reimbursement. In addition, Doppler vein mapping often must be done prior to placement of the AV fistula. Therefore, HRSA increased the rates for these targeted procedures approximately 25%, which is equal to Medicare’s payment levels.

### ***C. Physician participation in Washington’s Medicaid program***

Medical Assistance clients receive their medical services through two delivery systems. Most families and children obtain their health care through the Healthy Options (HO) managed care program. Some 476,000 (56%) of all Medical Assistance clients are enrolled in either HO or small managed care pilot projects.

HRSA is currently contracting with seven health carriers to provide HO coverage. There are plans in 36 (92%) of the state’s 39 counties. Thirty-two (82%) of the counties have two or more plans and mandatory HO enrollment requirements.

Other Medical Assistance clients obtain their care through a fee-for-service (FFS) delivery system. Under this system, clients obtain care through health providers who contract with DSHS. Some 374,000 (44%) clients use this system.

HRSA has been monitoring access in its FFS system over that past three years. The monitoring has focused on the number of participating physicians and Advanced Registered Nurse Practitioners (ARNP) on a statewide and by-county basis.<sup>6</sup> The monitoring measures are able to provide general trends in participation.

It is important to note two key factors in assessing this data. The fact that there are physicians participating in Medicaid does not account or measure the ability of clients to have access to timely appointments. For example, a physician may not be accepting new patients and still be counted as a participating provider if he provided services to a DSHS client already in his practice. Also, this data does not adjust for emergency room usage. Also, it is important to

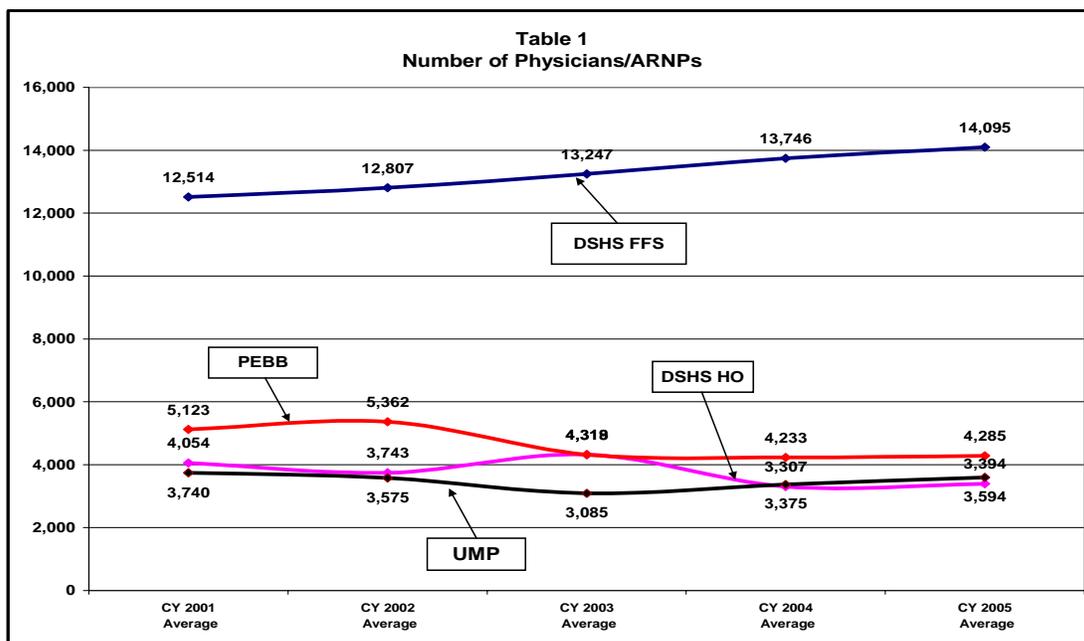
---

<sup>6</sup> FFS participating providers are defined as a provider who provided one service in a given quarter. The calendar year average is the average number of providers in each of the four quarters. HO, PEBB and UMP network providers are defined as the number of physicians/ARNPs reported in the health plan’s network in that period.

acknowledge the critical role played by “safety net” providers. In SFY 2005, FQHC, RHC and Tribal facilities accounted for about 20% of physician related services provided on a FFS basis.

Overall, physician participation in the FFS system has been stable. Over the past five-year period (calendar year (CY) 2001 through CY 2005), the number of total active physicians increased 3.0% per-year (see Table 1). There was a 2.5% increase from 13,746 in CY 2004 to an average of 14,095 in CY 2005.

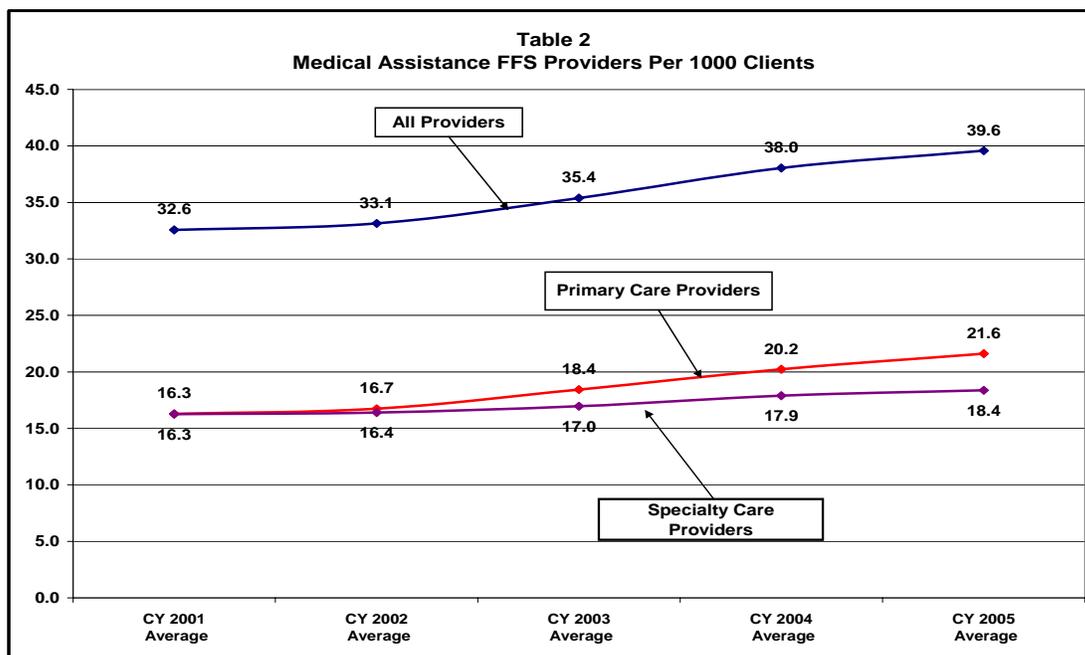
In comparison, HO, the state’s PEBB and UMP physician networks did not increase over this period; although the three networks did increase in CY 2005 – HO increased 2.6%, PEBB increased 1.2% and UMP increased 1.2%.

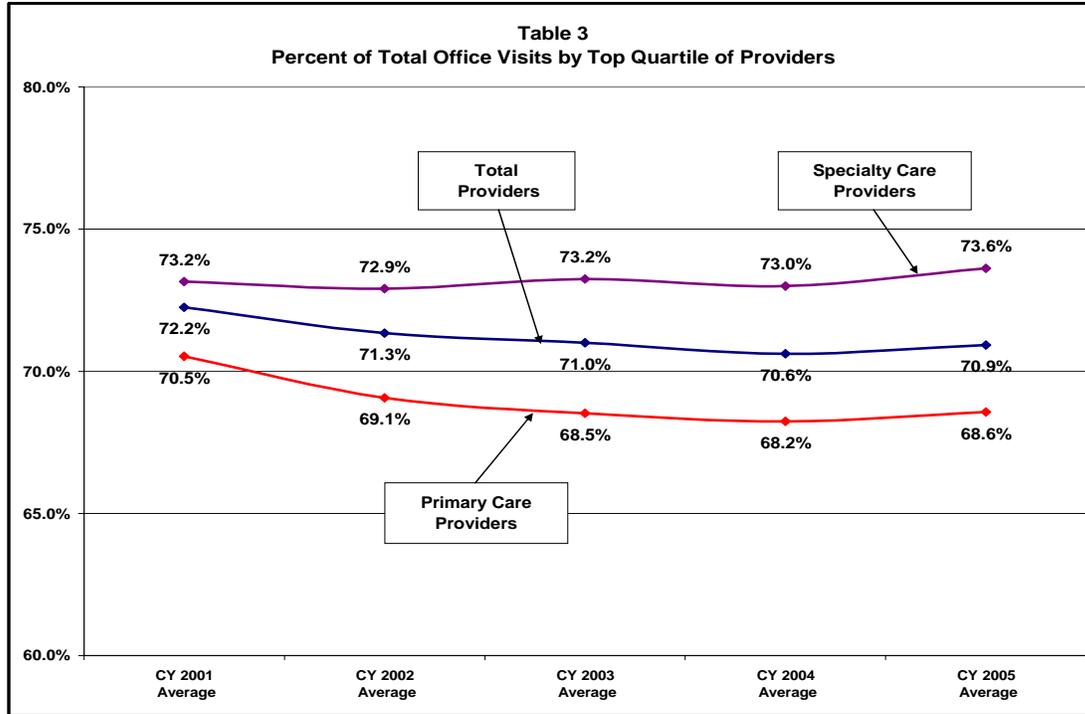


The ratio of FFS providers per 1,000 FFS clients (a measure of capacity) has increased (see Table 2). Over the five year period, the ratio increased 5.0 % per-year average, from 32.6 per 1,000 per-year average to 39.6 per 1,000 during CY 2005. In part, the increase in the ratio of providers reflects a reduction in the number of FFS clients due to HO mandatory expansions in counties. Primary care providers (PCP) increased at a greater rate (7.4% per-year average) than did specialty care providers (SCP) (3.1% per-year average).

While there was been a statewide increase in the number of FFS providers, the top quartile continue to provide 70% of all office visits (see Table 3). This ratio has not changed over the CY 2001 through 2005 period. This would suggest a need to give incentives to existing providers to serve more Medicaid clients.

Although statewide trends were positive, this was not the case across all counties. Unlike primary care providers, the increase in specialty care providers was not broad-based. In CY 2005, 17 (44%) counties had decreases in specialty care providers. These 17 counties accounted for 26.4% of FFS client population and 18.9% of CY 2005 FFS specialty providers. The increase in FFS specialty care providers per 1,000 clients also was not broad-based, with 18 (46%) having a decrease.





Preliminary analysis of sub-specialty provider types also found reductions. In comparing CY 2003 to CY 2005 participation rates, there was a reduction in the number of specialists in urology, radiation-diagnosis, physical medicine and rehabilitation, otology-laryngology, general surgery, ophthalmology, pediatrics, orthopedic surgery, pulmonary internal, plastic surgery and obstetrics and gynecology. However excluding King County, there was a reduction in only five subspecialty areas - urology, physical medicine, otology-laryngology, ophthalmology, and plastic surgery. In comparing CY 2004 to CY 2005 participation rates, there were reductions in seven specialty areas – urology, ophthalmology, neurology, physical medicine and rehabilitation, plastic surgery, pulmonary (internal) and pediatrics.

## ***PART III: Payment Incentives***

---

In considering whether to increase Medicaid physician payment rates, policy makers want to know the impact of rate increases on improving access to physician services. The question asked is if rates were to be increased by “x” percent, would access to services be improved? And if so, then by how much?

Washington’s Medicaid program has not conducted studies on the effect of Medicaid rate changes on physician participation in the program. However, the program did undertake a major social experiment in improving access to physicians’ services through the “First Steps” program, which was implemented in 1989. As part of a comprehensive strategy to improve birth outcomes for low-income children, the Medicaid program was expanded to cover pregnant women up to 185% of the federal poverty level. To ensure access to care, delivery and related payment rates were increased to commercial rate levels. This increase reportedly made maternity services available to most Medicaid clients. This experience is similar to what the department has informally heard from its providers – access will materially improve as Medicaid rates approach the levels of commercial rates.

### ***A. Literature Review of the Impact of Rate Increases on Provider Access and Participation***

To help answer the question about payment rate increases, the department contracted with its consulting actuary, Milliman, to conduct an initial literature search. Following is a brief summary of findings from articles found on the effect on member access due to Medicaid physician reimbursement rates.<sup>7</sup> The referenced articles are included in full in the appendix and should be reviewed for additional details.

Research to date on this topic reveals that higher rate levels can increase the acceptance of Medicaid patients by physicians, but not necessarily access to timely services. The number of physicians that will accept Medicaid patients depends on a multitude of factors. For example, significant differences in the acceptance rate can be seen in physician practices within an institutional setting, solo-practitioner practices, or group practices.

---

<sup>7</sup> The literature search was performed using several on-line tools including: Google, Google Scholar, Dogpile, and the University of Washington Library’s Medical Research Database. Other specific websites reviewed include: healthaffairs.org, kff.org, rwjf.org, hschange.org, and gao.org. In all searches, the keywords included combinations of Medicaid, physician, access, trend, reimbursement, specialty, fees, and RBRVS. Unfortunately, the search did not reveal many specific effects on access by sub-specialties such as surgical services.

Article 2 is a longitudinal study of physician survey data by the Center for Studying Health System Change. The article summarized findings in physician participation by insurance type for three time periods. The survey found that the rate for solo physicians not accepting new Medicaid patients was 29.0% in 1996 and 35.3% in 2005<sup>8</sup> whereas those providers in a hospital, medical center, community health center, or clinic setting had rates of 8.3% in 1996 and 6.6% in 2005.<sup>9</sup>

The article also notes the percentage of practice revenue from Medicaid, the location of the practice, and the administrative hassles as factors driving the difference among acceptance rates of physicians. Survey data from 2004-2005 found that 84% of physicians not accepting new Medicaid patients cited inadequate reimbursement as a moderate or very important reason.<sup>10</sup> The second and third most noted reasons of no acceptance were billing requirements and paperwork as well as delayed reimbursement.

Article 1 builds upon the study of acceptance by physicians in Article 2 and uses this to evaluate the “supply” of physicians in the relative area of need by Medicaid patients. The characteristics of acceptance are used to estimate what access an individual Medicaid enrollee will experience.<sup>11</sup> The area of Seattle is one of the specific geographic areas used to estimate the acceptance rates, presented along with the other 12 specific Community Tracking Study sites.<sup>12</sup>

The study estimated that for Seattle a 20% increase in Medicaid fees relative to Medicare fees would create a marginal increase in the acceptance of patients of 4.8%.<sup>13</sup> Compare this to the estimate for the marginal increase of 10.6% for the total United States under the same relative 20% increase in fees.<sup>14</sup> The study attributes the variation by site to differences in the level of managed care penetration and the percentage of physicians in institutional-based practices.<sup>15</sup> A fee increase is likely to have greater effects on enrollee access in areas with fewer institutional providers and lower levels of managed care penetration.<sup>16</sup>

These results are reaffirmed in Article 4, which compared the use of specific procedures between a Medicaid population and a commercially insured population. Payment rates had small and limited effects on access and use for both adults and children.<sup>17</sup> The study found that higher payment rates increased the probability of having a usual source of care and having at least one

---

<sup>8</sup> Source 2; page 3

<sup>9</sup> Source 2; page 3

<sup>10</sup> Source 2; page 5

<sup>11</sup> Source 1; page 678

<sup>12</sup> Source 1; page 686

<sup>13</sup> Source 1; page 690

<sup>14</sup> Source 1; page 690

<sup>15</sup> Source 1; page 694

<sup>16</sup> Source 1; page 695

<sup>17</sup> Source 3; page 734

visit to a doctor. However, payment rates did not have an effect on other measures, such as the probability of receiving preventive care or unmet needs.

Article 5 is a comparison study of physician participation in Maine and Michigan where there were changes in Medicaid physician reimbursement during the period 1988-1992. The study found that the number of primary care physician or obstetrical/gynecologist participating in Medicaid does not materially change in response to reimbursement changes.<sup>18</sup> It is worth noting that the study data were not able to say what would have happened had there been no increases in reimbursement rates.

The findings from this literature suggest that Medicaid fee increases may improve acceptance of Medicaid, but not necessary improved access or new participation. Payment rate increases of greater magnitude or frequency may lead to different results than found in the studies cited in this literature review. Based on informal discussions with providers and prior experience, Medicaid payment rates may need to approach commercial rate levels to have a material impact on access.

We also do not have definitive estimates on what a Medicaid rate increase would yield. Based on the literature, the Article 1 findings give at least a measure for discussion. A complete list of the articles reviewed can be found in Appendix E.

## ***B. Payment Incentive Options***

ESSB 6090 Section 209(22) requested the Department to encourage providers to participate in the program by “*assess[ing] the relative costs and effectiveness of strategies including...payment rate increases. The report shall further suggest alternative mechanisms and thresholds for...payment enhancements according to the extent to which a provider serves uninsured, Medicare, and Medicaid patients.*” The state does not have a direct mechanism with which to increase Medicare physician payment rates. This would require federal Congressional action to increase the Medicare Resource-Based Relative Value Scale’s (RBRVS) geographic practice cost index (GPCI) for Washington State. It also could require Congressional action to not adopt forthcoming reductions in physician payment rates. Short of providing subsidies to the federal government to increase Washington’s Medicare payment rates, the B&O tax credit appears to be the only state option with which to influence physicians’ propensity to provide services for Medicare clients.

---

<sup>18</sup> Source 4: page 273-275

While the state could implement a physician payment program that would pay physicians for services they provide to uninsured patients, this would require a new payment program that would have to address a number of issues.

- What payment rates would be used by this system, particularly given physicians' concerns over the adequacy of the current Medicare and Medicaid payment rates?
- Would physicians bill and be paid using a Medicare/Medicaid RBRVS type payment system?
- Would physicians be paid for serving uninsured persons who could afford health insurance?
- Would the program be administered by an existing state agency? How would the program be financed?

Rather than attempting to create a new uncompensated care payment system, a more appropriate approach to serving the uninsured would be to provide subsidized health insurance coverage for low-income residents.

### **Modeling Medicaid Rates at Other Payers' Levels**

The state can affect physician participation in serving Medicaid clients through rate increases in its fee-for-service physician payment system and Healthy Options (HO) payment rates. Increasing these payment rates may indirectly expand access for low-income uninsured patients because physicians would have an increased revenue stream to help subsidize these patients. Following is a set of Medicaid payment rate option estimates. The options were revised from a request by the Washington State Medical Association to estimate the cost of increasing Medicaid payment rates to 80% of the states' Uniform Medical Plan (UMP) rates. Another option was to index the Medicaid physician payment rate increases to the UMP rate increases. There also are a set of targeted rate increases to subspecialty types. These examples were obtained from a review of departmental participation rates, discussions with community groups that work with their provider community and low-income patients to access needed health care, and observations from other stakeholder and provider groups on access issues.

The set of options should not be construed as comprehensive. DSHS has developed a RBRVS model that can estimate the cost of adopting other targeted rate increases. The agency would be glad to provide estimates for other options that the legislature may want to consider.

The following estimates cover the associated cost to DSHS' medical programs authorized under Chapter 74.09 RCW. This includes the Medicaid fee-for-service and Healthy Options managed care programs, the State Children's Health Insurance Program and the Medical Care Services (GAU/ADATSA) programs.

The increases in Medicaid payment rates would have a direct effect on the Basic Health Program's (BHP) capitation payment rates. Most of the BHP carriers also use Medicaid FFS payment rates as the basis for their contract rates with BHP network physicians. The following options include an example of the impact on BHP from increasing Medicaid payment rates to 80% of UMP's payment rates. Due to resource constraints, the other options do not include BHP estimates. If the legislature should elect the option of targeted Medicaid payment increases, the fiscal note will include the impact on both DSHS' medical programs and BHP.

### ***Increase Professional Fees to 80% of UMP***

We have consulted with the actuarial firm of Milliman to estimate the impact of increasing the medical assistance program's physician-related services fees under the following scenario linked to the UMP's fee schedule:

- Medicaid professional fees increased to 80% of UMP, except for children's E&M and EPSDT services and maternity care, which are increased to 100% of UMP for both the Medicaid FFS population and for the HO program.

The following assumptions were applied to the baseline costs and used throughout our analysis:

- 5% utilization increase per year due to caseload and per capita utilization growth for the fee-for-service model
- 2% annual caseload growth for HO
- 1% vendor rate increases in state fiscal years 2008 and 2009
- 3.5% annual HO capitation rate increase
- No increase in utilization due to increased access has been incorporated in the model

Actual results will vary from these projections for many reasons, including caseload growth and changes in the health care delivery system. Experience would need to be monitored, with budgetary modifications as necessary.

The scenario above was modeled by inserting FFS and HO utilization by Current Procedural Terminology (CPT)<sup>™</sup> codes into a cost projection model. Because the HO utilization data was taken from the health plans' reported encounter data, we expect that, in aggregate, it is underreported. Therefore, we performed an additional step in the HO model of applying the computed percentage increase in professional costs to the per member, per month (PMPM) component of the HO capitation rate. All other assumptions in the HO model are the same as in the fee-for-service model.

The results are summarized as follows:

<b>PHYSICIAN SERVICE PAYMENT INCREASE EQUAL TO 80% OF UMP'S RATES</b>						
	<b>SFY 2008</b>		<b>SFY 2009</b>		<b>2007-09 Total</b>	
	<b>Total</b>	<b>State</b>	<b>Total</b>	<b>State</b>	<b>Total</b>	<b>State</b>
Fee-For-Service	\$204,327,776	\$108,293,721	\$211,069,665	\$111,866,922	\$415,397,441	\$220,160,644
Healthy Options	\$142,535,027	\$75,543,564	\$146,900,385	\$77,857,204	\$289,435,412	\$153,400,768
<b>Total</b>	<b>\$346,862,803</b>	<b>\$183,837,286</b>	<b>\$357,970,050</b>	<b>\$189,724,127</b>	<b>\$704,832,853</b>	<b>\$373,561,412</b>

This results in a 57.1% biennium increase in HO professional costs, which equates to a 21.4% increase in HO capitation costs. The impact on the FFS population is a 66.9% biennium increase in professional costs.

The above estimates are for payments made by DSHS to its FFS providers and HO contractors. Based on consultation with our actuary and Health Care Authority (HCA) staff, the proposed increase in DSHS payments could have a direct effect on the BHP. It is our understanding that some BHP plans base their payment rates to providers on our Medicaid FFS schedule. Thus, increases in Medicaid payment rates could drive increases in BHP premiums. The projected impact to the BHP program, assuming a start date of CY 2007, is:

<b>Benefits Total Costs, FY basis</b>	<b>FY 07</b>	<b>FY 08</b>	<b>FY 09</b>
<b>State Subsidy</b>	\$ 26,000,069	\$ 52,000,137	\$ 52,000,137
<b>Member Premiums</b>	\$ 2,659,810	\$ 5,319,619	\$ 5,319,619
<b>TOTAL COST IMPACT</b>	<b>\$ 28,659,878</b>	<b>\$ 57,319,757</b>	<b>\$ 57,319,757</b>

***Increase Medicaid Rates using UMP's Inflation Index***

Another manner in which we could inflate Medicaid rates is to increase the conversion factors by the same percentage increase that UMP has traditionally given its contracted providers each year. In looking at UMP's rate of increase over the past six years, UMP's rate of increase for the anesthesia conversion factor has been 3.5%, while the increase for everything else has been 2.8%.<sup>19</sup> The following table summarizes the cost of providing the same inflation rates as UMP:

---

<sup>19</sup> UMP has not increased its lab conversion factor for six years; therefore, we increased our lab conversion factor by the same increase that UMP gave to all other services.

PHYSICIAN SERVICE PAYMENT INCREASE EQUAL TO UMP'S INFLATION INDEX						
	SFY 2008		SFY 2009		2007-09 Total	
	Total	State	Total	State	Total	State
Fee-For-Service	\$7,121,379	\$3,774,331	\$13,448,857	\$7,127,895	\$20,570,237	\$10,902,226
Healthy Options	\$4,341,190	\$2,300,831	\$9,410,545	\$4,987,589	\$13,751,735	\$7,288,420
Total	\$11,462,569	\$6,075,162	\$22,859,403	\$12,115,483	\$34,321,972	\$18,190,645

### *Targeted Payment Rate Increases*

Yet another manner in which to model the cost impact of increasing rates in the Medicaid program is to target specific areas for the increased funding. As discussed in our literature review, evidence suggests that access to physician services does not materially increase until reimbursement rates begin to approach commercial levels. Therefore, the following two models determine the cost impact of raising Medicaid's rates to UMP's rates for certain service areas.

- Increasing payment rates for pediatric and orthopedic services*** – In working with our community partners, as well as analyzing our access data, the general consensus is that our most critical access concerns continue to be children's primary care services, which includes office visits and well-child preventive exams, as well as access to orthopedic surgeons. Therefore, our model shows the impact of increasing the conversion factors for orthopedic and children's primary care services to 100% of UMP's, which would result in a **134% increase for orthopedic services and a 51% increase for children's services**. The results are summarized in the following table:

PHYSICIAN SERVICE PAYMENT INCREASE TO 100% OF UMP'S CONVERSION FACTOR FOR ORTHOPEDIC SERVICES AND CHILDREN'S PRIMARY CARE SERVICES						
	SFY 2008		SFY 2009		2007-09 Total	
	Total	State	Total	State	Total	State
FFS Ortho	\$10,906,972	\$5,889,765	\$11,362,960	\$6,135,998	\$22,269,932	\$12,025,763
HO Ortho	\$5,623,876	\$2,755,699	\$5,858,993	\$2,870,907	\$11,482,869	\$5,626,606
FFS Children	\$14,396,686	\$7,774,210	\$14,810,992	\$7,997,936	\$29,207,678	\$15,772,146
HO Children	\$34,331,296	\$16,822,335	\$35,319,277	\$17,306,446	\$69,650,573	\$34,128,781
Total	\$65,258,829	\$33,242,010	\$67,352,223	\$34,311,286	\$132,611,052	\$67,553,296

- Increasing payment rates for adult office visits and children’s primary care services** – The department also continues to hear that clients are unable to find a primary care doctor to manage their overall health care needs. Therefore, our next model shows the impact of increasing the conversion factors for adult office visits and children’s primary care services to 100% of UMP’s, which would result in a **107% increase for adults and a 51% increase for children’s services**. The results are summarized in the following table:

PHYSICIAN SERVICE PAYMENT INCREASE TO 100% OF UMP’S CONVERSION FACTOR FOR ADULT OFFICE VISITS AND CHILDREN’S PRIMARY CARE SERVICES						
	SFY 2008		SFY 2009		2007-09 Total	
	Total	State	Total	State	Total	State
FFS Adults	\$42,965,940	\$23,201,608	\$44,684,920	\$24,129,857	\$87,650,860	\$47,331,464
HO Adults	\$16,161,035	\$7,918,907	\$16,807,605	\$8,235,726	\$32,968,640	\$16,154,634
FFS Children	\$14,396,686	\$7,774,210	\$14,810,992	\$7,997,936	\$29,207,678	\$15,772,146
HO Children	\$34,331,296	\$16,822,335	\$35,319,277	\$17,306,446	\$69,650,573	\$34,128,781
Total	\$107,854,957	\$55,717,060	\$111,622,794	\$57,669,965	\$219,477,751	\$113,387,025

Using our assumption that providing a B&O tax credit to physicians who treat Medicare, Medicaid and uninsured patients would reduce GFS revenues by \$21 million, what if the same \$21 million were taken from the GFS budget and used by the Medicaid program to leverage the federal match of about a dollar for every state dollar spent to make available an additional \$42 million to the program? Using this assumption, the last model is offered.

- Increasing HRSA’s “all other” conversion factor** – Of the several different conversion factors HRSA uses to set reimbursement rates, the “all other” conversion factor lags far behind the others. The “all other” conversion factor is used to set the rates for all services except anesthesia, maternity services, children’s primary care services and lab services. Some of the areas included in the “all other” category are surgeries, dermatology, orthopedics, urology, and gastroenterology. Infusing \$42 million per year (\$84 million for the 2007-2009 biennium) would result in a **17.5% increase** for services in the “all other” category. The results are summarized in the following table:

PHYSICIAN SERVICE PAYMENT INCREASE OF \$42 MILLION TO “ALL OTHER” SERVICES						
	SFY 2008		SFY 2009		2007-09 Total	
	Total	State	Total	State	Total	State
Fee-For-Service	\$26,905,668	\$14,529,061	\$26,524,958	\$14,323,477	\$53,430,626	\$28,852,538
Healthy Options	\$15,173,502	\$7,435,016	\$14,958,800	\$7,329,812	\$30,132,302	\$14,764,828
Total	\$42,079,170	\$21,964,077	\$41,483,758	\$21,653,289	\$83,562,929	\$43,617,366

## *C. Conclusions*

Based on Washington's prior Medicaid payment experience and a literature review, Medicaid rates would need to approach commercial rates to have a material impact on physician participation and timely access to appointments. While small rate increases may help address general inflation, they may not have a material impact on participation rates.

Rate increases should be linked to outcome requirements. In addition to improving access to care, the rate increases should provide financial incentives to improve the health care delivery system's efficiency and cost-effectiveness. To the extent possible, the performance requirements would be adopted in collaboration with other state agencies (Health Care Authority, Department of Labor & Industries, and Department of Health). Where possible, they would also be consistent with public/private initiatives, such as those being developed by the Puget Sound Health Alliance. Also when possible, performance measures should come from nationally recognized sources, such as HEDIS or National Institute of Medicine.

Following are examples of strategies that link payment increases to performance.

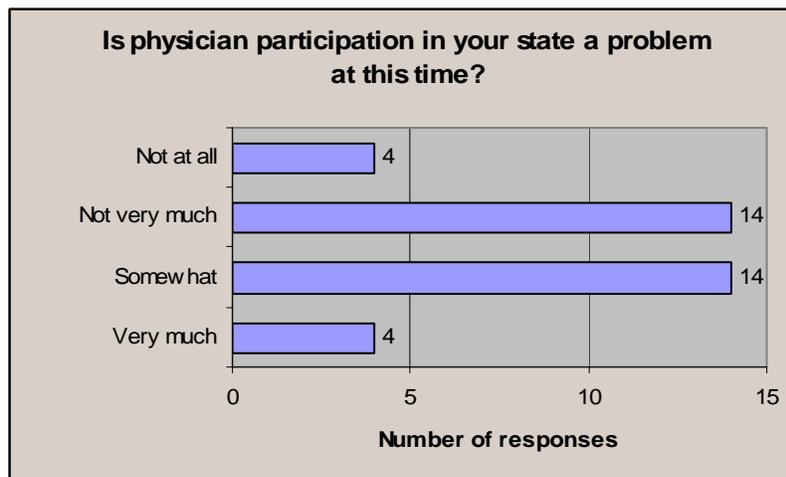
- **Orthopedics** – In order to reduce surgery (e.g., back surgery, knee replacement) variance across the state, orthopedic surgeons would be required to reduce surgery (e.g., back surgery, knee replacement) variance across the state. This could be accomplished through a partial withhold of the amount appropriated for rate increases. Surgeons who brought their surgical rates in line with standards developed by orthopedic surgeons and state agencies would receive bonus payments. Another model would be to provide rate increases through selective contracting or centers of experience that were able to achieve the surgical rates. To support the use of centers of experience, DSHS could eliminate prior authorization requirements for certain procedures when provided at a center of experience.
- **Pediatrics** - While Washington has made improvements in preventive care for children, our childhood immunization, well child examination and developmental screening rates should be improved. DSHS could establish a set of HEDIS performance measures, such as: two-year old immunizations, well child screens, appropriate treatment for children with URI, and appropriate testing for children with pharyngitis. Pediatricians would receive a payment rate increase. However, there would be a portion of the amount appropriated for the rate increase withheld. Pediatricians who made progress in improving the preventive care rates and those pediatricians above a defined standard would receive bonus payments from the withhold amount. In order for this pay-for-performance model to work, children would have to be in a "medical home" with their pediatrician through either a manage care (Healthy Options) or a primary care case management (PCCM) type model.

- Family Practice Physicians/ARNPs - Providers in Washington Medicaid have generic use rates that vary from 13% to 99% with an all state mean of 56%. A best practice model is at 73%. Significant saving could be achieved with improved generic utilization (i.e. every 1% change in generic rates returns a 1-2% total savings in pharmacy costs). To promote access and incentive use of generic drugs, there could be “partial” rate increase coupled with a shared savings model. Physicians/ARNPs would share savings with the state by increasing overall generic utilization in the Medicaid program. Another option would be to adopt a similar generic savings option but focus on certain therapeutic drug classes. For example, the Puget Sound Health Alliance is adopting performance measures for generic usage of Statins (cholesterol lowering agents), SSRIs (antidepressants), proton pump inhibitors (gastric acid reduction), and NSAIDs (non-steroidal anti-inflammatory drugs).

## ***PART IV: What Are Other States Doing?***

---

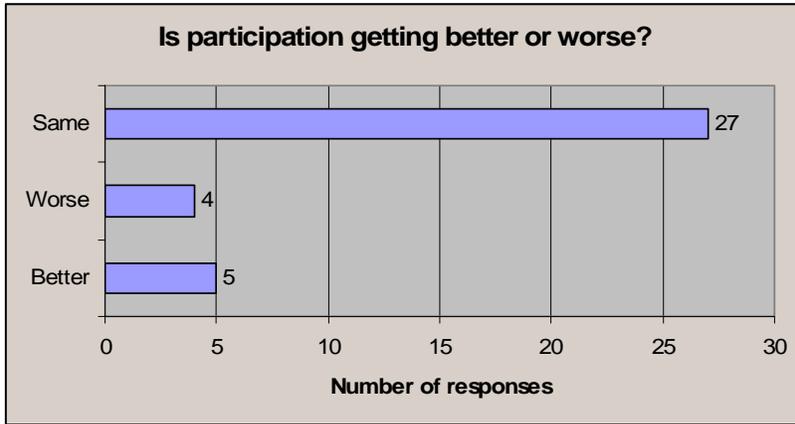
A survey was taken to determine what other states are doing to retain and recruit physicians who serve uninsured, Medicare and Medicaid patients. A total of 36 responses were received.<sup>20</sup> The survey was designed to determine initially if states were experiencing difficulties with physician participation in Medicaid programs and then to determine the scope and magnitude of those difficulties. Further questions then were asked to determine the steps being taken to encourage physician participation.



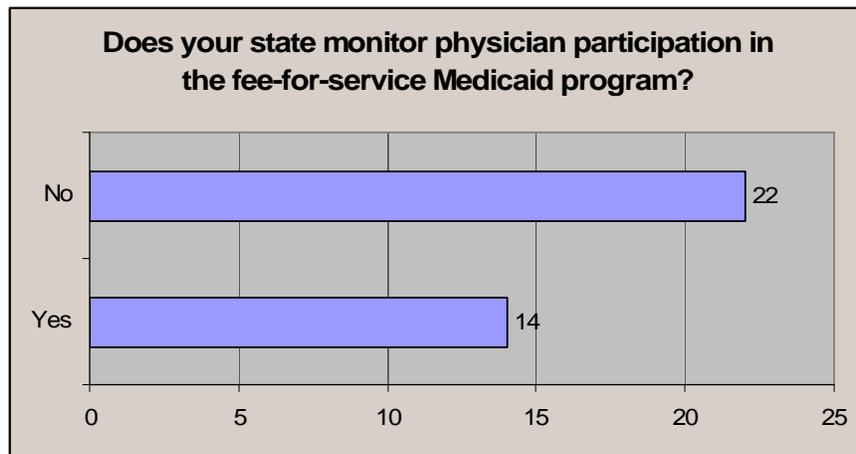
Of the states responding, 32 (89%) indicated that they were experiencing at least minor difficulty with physician participation. When asked if the problem was getting better or worse, 27 (75%) replied that it was remaining about the same.

---

<sup>20</sup> Responses were received from May 31 – October 5, 2006. The full results are located at: <http://www.surveymonkey.com/DisplaySummary.asp?SID=2199528&U=219952886095>.



Of the 36 states that responded, 61% indicated they did not monitor physician participation in the Medicaid fee-for-service program.



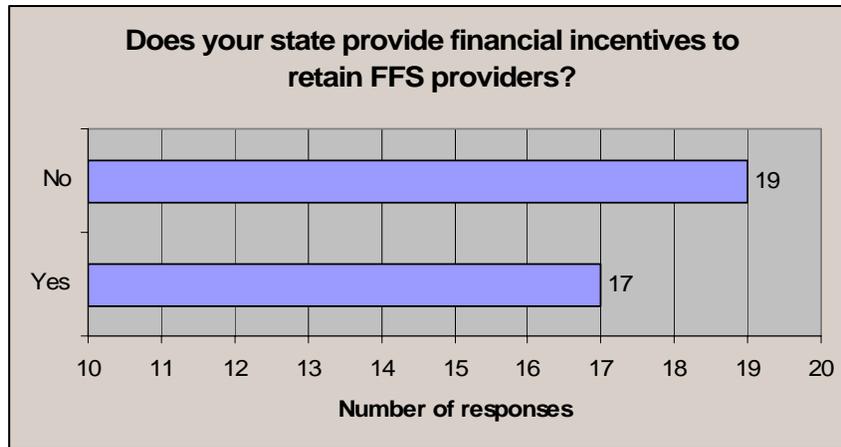
Of those who did monitor their participation, the most frequent ways cited were through claims systems reports (e.g. number of physicians with at least some claims billed per year, number of physicians requesting new contract or terming contract), and complaints and/or grievances from clients.

Orthopedics and pediatrics were the specialties of most concern.<sup>21</sup> There were also seven reports of concern over coverage in specific geographic areas, such as rural communities or areas with a disproportionate number of retirees.

---

<sup>21</sup> Orthopedics was reported by eight states, and pediatrics was reported by six.

Seventeen states indicated that they provide some type of financial incentive to retain fee-for-service physicians.



Of these, ten<sup>22</sup> indicated that they use reimbursement rate increases as the incentive. The full list of incentives provided is as follows:

- Increased reimbursement rates
- Loan repayment programs
- Medical student scholarship programs
- Enhanced rates for specific services
- Per-member, per-month fee reimbursement for retaining providers
- Allowing physicians with limited licenses to participate in Medicaid programs in underserved areas
- Incentive money divided between high-volume Medicaid providers

The amount of money states appropriated for incentive programs varied widely, ranging from no specific appropriation of funds to \$16.6 million.

Provider recruitment methods also were solicited. Some states do not perform active recruiting. The following methods were reported:

---

<sup>22</sup> Several states answered “yes” to the question about financial incentives as well as including specific information under “other.” Florida and Oklahoma answered twice each and were counted once.

- Medical and dental school recruitment
- Direct contact with providers by phone or by mail
- Radio
- Yellow pages
- Newspaper advertisements
- Contact through medical associations

In summary, the majority of the 36 states responding indicated they had at least some difficulty with physician participation in their Medicaid programs, with most of these indicating the problem continues to be the same in severity from year to year. About two-thirds of the states indicated they don't have a formal method of monitoring physician participation in their Medicaid programs. Orthopedics and pediatrics were those specialty areas of particular concern, as well as access to physicians in rural areas and areas with a disproportionate share of retirees. Slightly less than half provided at least some type of incentive to retain and recruit physicians, with increased payment rates being the most often noted.

A complete copy of the survey results can be found in Appendix F.

## **Physician B&O Tax Credit Assumptions & Estimates**

### *Assumptions*

#### *Medicare:*

The Medicare estimate above is based on the assumption that in Fiscal Year 2007 Medicare will spend about \$3.6 billion in Washington State. This amount represents all Medicare expenditures for Washington. However, the tax incentive study applies only to physician reimbursements. As such, assumptions and professional judgment have to be made before arriving at an estimate for Medicare physician revenue. The revenue impact above is based on the assumptions below.

It is assumed that Medicare Part B makes up about 45 percent of total Medicare spending in Washington. It is further assumed that 80 percent of Part B is fee-for-service and 20 percent is managed-care. Of the fee-for-service amount, 43 percent is physician revenue and of the managed-care amount, 35 percent is physician revenue.

Medicare revenue is currently taxed at the rate of 1.5 percent.

For purposes of this estimate, it is assumed that physician revenue from Medicare will grow 4.0% annually.

*Sources:* Medicare (Seattle Office); Medicare website; health/medical literature. The trend factor is based on CMS 2005-15 National Health Expenditure (NHE) projects for Medicare physician and clinic services.

#### *Medicaid:*

The Medicaid estimate above is based on data provided by DSHS. According to DSHS, it is estimated that in Fiscal Year 2007, about \$225.0 million in fee-for-service and \$360.0 million in managed-care will be reimbursed to physicians for services provided to Medicaid beneficiaries.

Medicaid revenue is currently taxed at the rate of 1.5 percent.

For purposes of this estimate, it is assumed that physician revenue from Medicaid will grow 4.0% annually.

*Sources:* DSHS and OFM. The trend factor is based on DSHS/OFM November 2006 forecast for Medical Assistance physician services for SFY2005 through SFY 2009.

# ***Appendix A***

---

## ***State Children's Health (SCHIP):***

The State Children's Health impact above is based on data available from Medicare. It is estimated that in Fiscal Year 2007 about \$7.0 million will be physician revenue from this program. This is roughly 38.5 percent of CHIP expenditures.

Revenue from this program is currently taxed at the rate of 1.5 percent.

For purposes of this estimate, it is assumed that physician reimbursement from SCHIP will grow 4.0% annually.

*Sources:* DSHS; OFM. The trend factor is based on DSHS/OFM November 2006 forecast for Medical Assistance physician services for SFY2005 through SFY 2009.

## ***Basic Health Program:***

The Basic Health Program estimate is based on data provided by Milliman USA Consulting. Milliman estimated that about \$80.0 million will be Basic Health reimbursement to physicians in Fiscal Year 2007.

Basic Health revenue is currently taxed at the rate of 1.5 percent.

For purposes of this estimate, it is assumed that physician reimbursement from SCHIP will grow 8.0% annually.

*Sources:* HCA/Milliman USA Consulting.

## ***Charity Care:***

The Charity Care estimate is based on data provided by the Washington State Medical Association. Based on a study/survey done recently by the Washington Research Council, it was found that each year about \$44.0 million in charity care is provided by Washington physicians.

Charity care revenue is currently taxed at the rate of 1.5 percent.

For purposes of this estimate, it is assumed that physician reimbursement from SCHIP will grow 4.0% annually.

*Sources:* Washington State Medical Association and Washington Research Council.

# Appendix A

---

## PHYSICIAN B&O TAX CREDIT ESTIMATES

Payer Type	B&O Tax Rate	Program Trend Factors	SFY 2007 Base Year	SFY 2008 Physician Revenue	SFY 2008 B&O Tax Credit (11-Months)	SFY 2009 Physician Revenue	SFY 2009 B&O Tax Credit (12-Months)
Medicare	1.5%	4.00%	\$670,680,000	\$697,507,000	\$9,591,000	\$725,407,000	\$10,881,000
Medicaid <sup>1</sup>	1.5%	4.00%	\$585,000,000	\$608,400,000	\$8,366,000	\$632,736,000	\$9,491,000
Charity Care	1.5%	4.00%	\$44,000,000	\$45,760,000	\$629,000	\$47,590,000	\$714,000
<b>Subtotal</b>					<b>\$18,586,000</b>		<b>\$21,086,000</b>
SCHIP	1.5%	4.00%	\$7,000,000	\$7,280,000	\$100,000	\$7,571,000	\$114,000
Basic Health Program	1.5%	8.00%	\$80,000,000	\$86,400,000	\$1,188,000	\$93,312,000	\$1,400,000
<b>Total</b>					<b>\$19,874,000</b>		<b>\$22,600,000</b>
Notes:							
<sup>1</sup> The Medicaid estimate includes all DSHS medical programs authorized under Chapter 74.09 RCW, except SCHIP.							

## ***Appendix B***

---

[Full text of Lewin report on Medi-Cal](#)

[Lewin report appendices showing state rankings](#)

## Appendix C

Data is Medicaid Physician Fee Index 2003 from statehealthfacts.org

Rank	State	All Services	Primary Care	OB Care	Other Services
1	Alaska	2.28	2.50	1.90	2.19
2	Arizona	1.55	1.63	1.44	1.49
3	Delaware	1.49	1.64	1.09	1.41
4	Nevada	1.43	1.17	1.67	1.79
5	Wyoming	1.40	1.47	1.25	1.41
6	North Carolina	1.34	1.47	1.15	1.28
7	New Mexico	1.31	1.41	1.11	1.31
8	Connecticut	1.30	1.33	1.53	0.96
8	Iowa	1.30	1.39	1.12	1.28
10	Massachusetts	1.25	1.28	1.28	1.16
11	Arkansas	1.24	1.37	0.83	1.39
11	Washington	1.24	1.27	1.46	0.90
13	North Dakota	1.23	1.33	0.97	1.16
14	Idaho	1.22	1.31	1.08	1.18
14	Nebraska	1.22	1.13	1.01	1.70
16	Alabama	1.21	1.23	1.35	0.97
16	Maryland	1.21	1.28	1.20	1.05
16	West Virginia	1.21	1.22	1.35	1.09
19	Mississippi	1.19	1.32	0.75	1.23
19	Wisconsin	1.19	1.13	1.20	1.35
21	Oregon	1.18	1.17	1.33	1.03
22	South Carolina	1.17	1.12	1.62	0.97
23	Hawaii	1.14	1.21	0.99	1.13
24	Georgia	1.13	1.05	1.18	1.24
24	Montana	1.13	1.11	1.08	1.26
26	Vermont	1.12	1.00	1.30	1.22
27	Minnesota	1.09	1.00	0.94	1.47
28	Virginia	1.08	1.15	0.97	1.05
29	Colorado	1.06	1.08	1.03	1.04
30	South Dakota	1.05	0.98	0.94	1.35
31	Louisiana	1.04	1.05	1.05	0.97
32	New Hampshire	1.03	1.09	1.15	0.77
33	Kentucky	1.01	0.94	1.20	1.07
33	Utah	1.01	1.02	0.98	1.00
35	Kansas	1.00	0.93	1.05	1.10
36	Texas	0.99	0.96	0.93	1.09
37	Ohio	0.97	1.03	0.89	0.87
38	Michigan	0.96	1.06	0.82	0.89
39	Florida	0.95	0.96	1.04	0.83
39	Oklahoma	0.95	1.00	0.88	0.93
41	Illinois	0.92	0.89	1.03	0.93
41	Indiana	0.92	0.91	0.84	1.02
43	California	0.91	0.87	0.83	1.09
44	Maine	0.89	0.84	0.96	0.93

Appendix  
 Department of Social and Health Services  
 November XX, 2006

## Appendix C

---

45	District of Columbia	0.78	0.62	1.24	0.63
46	Missouri	0.76	0.75	0.83	0.71
47	Pennsylvania	0.74	0.67	1.04	0.80
48	New York	0.70	0.71	0.88	0.46
49	Rhode Island	0.62	0.58	0.63	0.72
50	New Jersey	0.56	0.61	0.41	0.65

*Data is Medicaid Physician Fee Index 2003 from statehealthfacts.org*

Rank	State	Primary Care
1	Alaska	2.50
2	Delaware	1.64
3	Arizona	1.63
4	Wyoming	1.47
4	North Carolina	1.47
6	New Mexico	1.41
7	Iowa	1.39
8	Arkansas	1.37
9	Connecticut	1.33
9	North Dakota	1.33
11	Mississippi	1.32
12	Idaho	1.31
13	Massachusetts	1.28
13	Maryland	1.28
15	Washington	1.27
16	Alabama	1.23
17	West Virginia	1.22
18	Hawaii	1.21
19	Nevada	1.17
19	Oregon	1.17
21	Virginia	1.15
22	Nebraska	1.13
22	Wisconsin	1.13
24	South Carolina	1.12
25	Montana	1.11
26	New Hampshire	1.09
27	Colorado	1.08
28	Michigan	1.06
29	Georgia	1.05
29	Louisiana	1.05
31	Ohio	1.03
32	Utah	1.02
33	Vermont	1.00
33	Minnesota	1.00
33	Oklahoma	1.00
36	South Dakota	0.98
37	Texas	0.96

## Appendix C

---

37	Florida	0.96
39	Kentucky	0.94
40	Kansas	0.93
41	Indiana	0.91
42	Illinois	0.89
43	California	0.87
44	Maine	0.84
45	Missouri	0.75
46	New York	0.71
47	Pennsylvania	0.67
48	District of Columbia	0.62
49	New Jersey	0.61
50	Rhode Island	0.58

**Data is Medicaid Physician Fee Index 2003 from statehealthfacts.org**

<b>Rank</b>	<b>State</b>	<b>OB Care</b>
1	Alaska	1.90
2	Nevada	1.67
3	South Carolina	1.62
4	Connecticut	1.53
5	Washington	1.46
6	Arizona	1.44
7	Alabama	1.35
7	West Virginia	1.35
8	Oregon	1.33
10	Vermont	1.30
11	Massachusetts	1.28
12	Wyoming	1.25
13	District of Columbia	1.24
14	Maryland	1.20
14	Wisconsin	1.20
14	Kentucky	1.20
17	Georgia	1.18
18	North Carolina	1.15
18	New Hampshire	1.15
20	Iowa	1.12
21	New Mexico	1.11
22	Delaware	1.09
23	Idaho	1.08
23	Montana	1.08
25	Louisiana	1.05
25	Kansas	1.05
27	Florida	1.04
27	Pennsylvania	1.04
29	Colorado	1.03
29	Illinois	1.03

## Appendix C

---

31	Nebraska	1.01
32	Hawaii	0.99
33	Utah	0.98
34	North Dakota	0.97
34	Virginia	0.97
36	Maine	0.96
37	Minnesota	0.94
37	South Dakota	0.94
39	Texas	0.93
40	Ohio	0.89
41	Oklahoma	0.88
41	New York	0.88
43	Indiana	0.84
44	Arkansas	0.83
44	California	0.83
44	Missouri	0.83
47	Michigan	0.82
48	Mississippi	0.75
49	Rhode Island	0.63
50	New Jersey	0.41

**Data is Medicaid Physician Fee Index 2003 from [statehealthfacts.org](http://statehealthfacts.org)**

<b>Rank</b>	<b>State</b>	<b>Other Services</b>
1	Alaska	2.19
2	Nevada	1.79
3	Nebraska	1.70
4	Arizona	1.49
5	Minnesota	1.47
6	Delaware	1.41
6	Wyoming	1.41
8	Arkansas	1.39
9	Wisconsin	1.35
9	South Dakota	1.35
11	New Mexico	1.31
12	North Carolina	1.28
12	Iowa	1.28
14	Montana	1.26
15	Georgia	1.24
16	Mississippi	1.23
17	Vermont	1.22
18	Idaho	1.18
19	Massachusetts	1.16
19	North Dakota	1.16
21	Hawaii	1.13
22	Kansas	1.10
23	West Virginia	1.09

## Appendix C

---

23	Texas	1.09
23	California	1.09
26	Kentucky	1.07
27	Maryland	1.05
27	Virginia	1.05
29	Colorado	1.04
30	Oregon	1.03
31	Indiana	1.02
32	Utah	1.00
33	Alabama	0.97
33	South Carolina	0.97
33	Louisiana	0.97
36	Connecticut	0.96
37	Oklahoma	0.93
37	Illinois	0.93
37	Maine	0.93
40	Washington	0.90
41	Michigan	0.89
42	Ohio	0.87
43	Florida	0.83
44	Pennsylvania	0.80
45	New Hampshire	0.77
46	Rhode Island	0.72
47	Missouri	0.71
48	New Jersey	0.65
49	District of Columbia	0.63
50	New York	0.46

# Appendix D

Department of Social and Health Services  
Health and Recovery Services Administration  
State of Washington

Procedure Code	Description	Paid Units	July 2006 M'caid Facility Fee	July 2006 M'caid Non-Facility Fee	July 2006 M'caid Combined Fee	Jan 07 Prevailing Charge (64% of 75th Percentile)		July 2006 UMP Payment Rates		2006 Medicare Payment Rates	
						Fee	M'caid Ratio	Fee	M'caid Ratio	Fee	M'caid Ratio
<b><u>Evaluation and Management Services</u></b>											
<b>Adult Office Visits</b>											
99212	expanded problem focused history & exam & straightforward decision making	95,575	\$16.33	\$26.28	\$26.10	\$44.99	0.58	\$52.57	0.50	\$38.73	0.67
99213	detailed history & exam & medical decision making low complexity	393,866	\$23.98	\$35.71	\$35.58	\$61.80	0.58	\$71.70	0.50	\$53.00	0.67
99214	comprehensive history & exam & medical decision making of moderate complexity	238,695	\$40.05	\$56.12	\$55.81	\$96.21	0.58	\$112.45	0.50	\$82.89	0.67
<b>Children Office Visits</b>											
99212	expanded problem focused history & exam & straightforward decision making	49,059	\$22.40	\$36.05	\$35.80	\$44.99	0.80	\$52.57	0.68	\$38.73	0.92
99213	detailed history & exam & medical decision making low complexity	170,131	\$32.90	\$49.00	\$48.82	\$61.80	0.79	\$71.70	0.68	\$53.00	0.92
99214	comprehensive history & exam & medical decision making of moderate complexity	60,719	\$54.95	\$77.00	\$76.57	\$96.21	0.80	\$112.45	0.68	\$82.89	0.92
<b>Hospital Services</b>											
99231	Subsequent hospital care, per day; about 15 minutes	40,785	\$20.64	\$20.64	\$20.64	\$52.26	0.39	\$46.26	0.45	\$34.21	0.60
99232	Subsequent hospital care, per day; about 25 minutes	98,243	\$33.94	\$33.94	\$33.94	\$76.36	0.44	\$76.07	0.45	\$55.93	0.61
99233	Subsequent hospital care, per day; about 35 minutes	59,549	\$48.15	\$48.15	\$48.15	\$112.83	0.43	\$107.94	0.45	\$79.49	0.61
99283	Emergency department visit; expanded problem focused	120,882	\$37.61	\$37.61	\$37.61	\$117.40	0.32	\$84.30	0.45	\$62.00	0.61
99284	Emergency department visit; detailed exam with moderate complexity	72,343	\$58.47	\$58.47	\$58.47	\$184.19	0.32	\$131.07	0.45	\$96.78	0.60
99285	Emergency department visit; comprehensive exam with high complexity	31,610	\$91.72	\$91.72	\$91.72	\$285.82	0.32	\$205.60	0.45	\$151.51	0.61
99291	Critical care services; 30-74 minutes	15,178	\$125.89	\$156.38	\$126.46	\$329.88	0.38	\$283.48	0.45	\$208.95	0.61
99431	History and examination of the normal newborn infant	10,564	\$56.00	\$56.00	\$56.00	\$227.67	0.25	\$82.24	0.68	\$60.81	0.92
<b>Preventive Medicine Services (EPSDT screenings)</b>											
99381	Initial evaluation & mgt, new patient; infant (age under 1 year)	4,001	\$56.70	\$78.75	\$78.58	\$98.66	0.80	\$141.95	0.55	\$104.70	0.75
99391	Initial evaluation & mgt, established patient; infant (age under 1 year)	23,590	\$40.95	\$60.20	\$60.10	\$87.26	0.69	\$107.78	0.56	\$79.49	0.76
99392	early childhood (age 1-4 years)	18,089	\$49.00	\$68.95	\$68.85	\$97.64	0.71	\$120.62	0.57	\$88.98	0.77
99393	late childhood (age 5-11 years)	9,377	\$52.50	\$72.80	\$72.68	\$99.62	0.73	\$119.07	0.61	\$87.81	0.83
99394	adolescent (age 12-17 years)	7,081	\$59.50	\$79.80	\$79.67	\$111.32	0.72	\$131.37	0.61	\$96.98	0.82

# Appendix D

## Anesthesia - Medicaid paid at \$1.40 per minute plus base time

00170	Anesthesia for intraoral procedures (dental anesthesia)	7,968			\$183.28	\$236.85	0.77	\$419.12	0.44	\$153.70	1.19
00790	Anesthesia for intraperitoneal procedures in upper abdomen	2,356			\$280.98	\$331.60	0.85	\$642.56	0.44	\$235.65	1.19
00840	Anesthesia for intraperitoneal procedures in lower abdomen	2,659			\$236.46	\$284.22	0.83	\$540.73	0.44	\$198.30	1.19
01961	Anesthesia for caesarean delivery only	2,768			\$240.92	\$331.60	0.73	\$550.95	0.44	\$202.05	1.19
01967	Neuraxial labor analgesia/anesthesia (epidural); planned vaginal delivery	5,229			\$389.20	\$236.85	1.64	\$890.02	0.44	\$326.40	1.19

## Surgery

### **Integumentary**

11721	Debridement of nails, six or more	3,542	\$18.57	\$24.08	\$23.92	\$41.96	0.57	\$53.61	0.45	\$39.53	0.61
17000	Destruction, all benign or premalignant lesions; first lesion	3,034	\$27.06	\$37.15	\$37.03	\$72.22	0.51	\$83.01	0.45	\$61.19	0.61
17003	second through 14 lesions, each	4,025	\$5.27	\$6.19	\$6.18	\$16.95	0.36	\$13.86	0.45	\$10.27	0.60

### **Musculoskeletal**

20550	Injections, single tendon sheath or ligament, aponeurosis	1,380	\$24.31	\$35.54	\$35.29	\$88.08	0.40	\$79.11	0.45	\$58.46	0.60
20610	Arthrocentesis, aspiration, and/or injections; major joint or bursa	4,359	\$30.04	\$42.65	\$42.30	\$100.20	0.42	\$94.81	0.45	\$69.75	0.61
29075	Applications, cast; elbow to finger (short arm)	953	\$36.23	\$49.76	\$49.49	\$102.50	0.48	\$110.93	0.45	\$81.75	0.61

### **Respiratory System**

36410	Collection of venous blood by venipuncture	2,630	\$5.50	\$11.24	\$11.04	\$54.78	0.20	\$24.74	0.45	\$18.08	0.61
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years and older	1,731	\$78.42	\$193.53	\$84.09	\$345.86	0.24	\$188.50	0.45	\$139.10	0.60
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion	2,010	\$33.25	\$33.25	\$33.25	\$132.99	0.25	\$74.53	0.45	\$54.86	0.61

### **Digestive System**

43239	Upper gastrointestinal endoscopy, simple primary examination;with biopsy, single or multiple	4,409	\$98.14	\$204.76	\$116.80	\$441.44	0.26	\$261.81	0.45	\$193.01	0.61
45378	Colonoscopy	2,404	\$125.20	\$235.26	\$146.40	\$545.06	0.27	\$328.16	0.45	\$241.78	0.61
45380	Colonoscopy; with biopsy, single or multiple	2,216	\$149.50	\$277.91	\$172.21	\$609.56	0.28	\$386.04	0.45	\$284.45	0.61

### **Urinary System**

51726-26	Complex cystometrogram; professional component	591	\$55.03	\$55.03	\$55.03	\$110.84	0.50	\$123.36	0.45	\$90.83	0.61
51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, non-imaging	638	\$9.40	\$9.40	\$9.40	\$28.42	0.33	\$21.07	0.45	\$15.67	0.60
52000	Cystourethroscopy	634	\$66.73	\$126.57	\$115.42	\$295.17	0.39	\$258.73	0.45	\$190.78	0.60

### **Male Genitourinary System**

54050	Destruction of lesions, penis, simple; chemical	141	\$54.34	\$69.02	\$68.69	\$149.92	0.46	\$153.97	0.45	\$113.50	0.61
54056	Destruction of lesions, penis, simple; cryosurgery	145	\$56.18	\$69.25	\$68.95	\$197.26	0.35	\$154.55	0.45	\$114.09	0.60
55250	Vasectomy, unilateral or bilateral	508	\$132.54	\$350.37	\$319.47	\$517.88	0.62	\$716.12	0.45	\$527.91	0.61

# Appendix D

## Female Genitourinary System

57800	Dilation of cervical canal, instrumental (separate procedure)	1,290	\$30.50	\$37.38	\$36.21	\$120.70	0.30	\$81.16	0.45	\$59.66	0.61
58300	Insertion of intrauterine device (IUD)	4,484	\$34.40	\$58.93	\$58.45	\$136.42	0.43	\$131.02	0.45	\$96.44	0.61
58301	Removal of intrauterine device (IUD)	1,132	\$43.34	\$63.06	\$61.79	\$48.15	1.28	\$138.51	0.45	\$102.09	0.61
G0101	Cervical or vaginal cancer screening; pelvic and breast exam	11,428	\$14.68	\$22.93	\$22.72	\$61.08	0.37	\$50.92	0.45	\$37.56	0.60

## Maternity

59025	Fetal non-stress test	24,692	\$49.63	\$49.63	\$49.63	\$78.44	0.63	\$57.05	0.87	\$41.89	1.18
59400	Routine ob care incl ante & postpartum,vaginal delivery	6,596	\$1,937.73	\$1,937.73	\$1,937.73	\$2,080.93	0.93	\$2,227.68	0.87	\$1,642.20	1.18
59514	C-Section delivery only	3,268	\$966.18	\$966.18	\$966.18	\$1,440.60	0.67	\$1,110.75	0.87	\$966.23	1.00

## Endocrine System

60220	Total thyroid lobectomy	67	\$443.01	\$443.01	\$443.01	\$1,474.48	0.30	\$993.05	0.45	\$731.97	0.61
60240	Thyroidectomy, total or complete	36	\$582.42	\$582.42	\$582.42	\$1,817.84	0.32	\$1,305.56	0.45	\$962.57	0.61
60500	Parathyroidectomy or exploration of parathyroid(s)	30	\$584.94	\$584.94	\$584.94	\$1,858.24	0.31	\$1,311.21	0.45	\$966.72	0.61

## Nervous System

62270	Spinal puncture, lumbar, diagnostic	1,498	\$40.59	\$97.91	\$50.46	\$174.57	0.29	\$113.10	0.45	\$83.49	0.60
62311	Injection, single; lumbar, sacral	1,259	\$56.41	\$158.45	\$91.31	\$364.61	0.25	\$204.68	0.45	\$141.86	0.64
64721	Neuroplasty and/or transposition; median nerve at carpal tunnel	782	\$238.47	\$238.47	\$238.47	\$968.99	0.25	\$534.56	0.45	\$394.19	0.60

## Eye and Ocular Adnexa

66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis	2,920	\$417.10	\$417.10	\$417.10	\$1,159.68	0.36	\$934.97	0.45	\$689.19	0.61
67820	Correction of trichiasis; epilation, by forceps only	429	\$34.40	\$35.31	\$35.30	\$118.25	0.30	\$79.13	0.45	\$58.35	0.60
68761	Closure of lacrimal punctum; by plug, each	1,078	\$63.52	\$85.99	\$85.61	\$184.11	0.47	\$191.91	0.45	\$141.42	0.61

## Auditory System

69200	Removal of foreign body from external auditory canal; without general anesthesia	174	\$31.87	\$74.98	\$67.08	\$156.57	0.43	\$150.37	0.45	\$110.77	0.61
69210	Removal of impacted cerumen, one or both ears	3,567	\$20.41	\$29.81	\$29.60	\$61.88	0.48	\$66.35	0.45	\$48.85	0.61
69436	Typanostomy, general anesthesia	1,862	\$102.73	\$102.73	\$102.73	\$294.66	0.35	\$230.27	0.45	\$169.69	0.61

## Radiology All are the professional component only

70450-26	CT, head or brain; without contrast material	51,060	\$26.83	\$26.83	\$26.83	\$90.92	0.30	\$60.14	0.45	\$44.45	0.60
71010-26	Radiological examination, chest, one view, frontal	203,853	\$5.73	\$5.73	\$5.73	\$19.78	0.29	\$12.85	0.45	\$9.49	0.60
71020-26	Radiological examination, chest, two views, frontal and lateral	144,789	\$6.88	\$6.88	\$6.88	\$22.94	0.30	\$15.42	0.45	\$11.40	0.60
72193-26	CT pelvis; with contrast material	28,647	\$36.46	\$36.46	\$36.46	\$109.61	0.33	\$81.73	0.45	\$60.43	0.60
74000-26	Radiologic examination, abdomen; single anteroposterior view	26,889	\$5.73	\$5.73	\$5.73	\$19.29	0.30	\$12.85	0.45	\$9.49	0.60
74160-26	CT, abdomen; with contrast material	29,505	\$40.13	\$40.13	\$40.13	\$132.54	0.30	\$89.95	0.45	\$66.48	0.60
76805-26	Ultrasound, pregnant uterus, transabdominal approach; single or first gestation	27,582	\$31.41	\$31.41	\$31.41	\$82.96	0.38	\$70.42	0.45	\$52.10	0.60

## Appendix D

---

<b>Clinical</b>		<b>All are professional component only; not technical lab components</b>									
<b>Pathology</b>											
88305-26	Surgical pathology, gross and microscopic examination; Level III	17,002	\$25.68	\$25.68	\$25.68	\$82.26	0.31	\$57.57	0.45	\$42.27	0.61
88307-26	Surgical pathology, gross and microscopic examination; Level V	4,984	\$53.66	\$53.66	\$53.66	\$141.52	0.38	\$120.28	0.45	\$88.74	0.60
88313-26	Special stains; Group I and II, all other, each	3,592	\$8.03	\$8.03	\$8.03	\$27.11	0.30	\$17.99	0.45	\$13.32	0.60
88342-26	Immunohistochemistry, each antibody	3,732	\$28.66	\$28.66	\$28.66	\$90.37	0.32	\$64.25	0.45	\$47.24	0.61
<b>Medicine</b>											
92015	Determination of refractive state	66,770	\$12.38	\$44.03	\$43.67	\$37.04	1.18	\$97.88	0.45	\$71.96	0.61
97110	Therapeutic procedure, one or more areas, each 15 minutes	125,487	\$16.97	\$16.97	\$16.97	\$29.33	0.58	\$38.04	0.45	\$28.22	0.60
97530	Therapeutic activities, direct patient contact by the provider, each 15 minutes	366,865	\$17.89	\$17.89	\$17.89	\$30.52	0.59	\$40.09	0.45	\$29.47	0.61
97533	Sensory integrative techniques to enhance sensory processing; each 15 minutes	199,638	\$16.05	\$16.05	\$16.05			\$35.98	0.45	\$26.36	0.61
90862	Pharmacological management	47,246	\$29.81	\$31.64	\$31.51	\$68.46	0.46	\$70.63	0.45	\$52.06	0.61
90817	Individual psychotherapy, 30 minutes, inpatient hospital or residential care facility; with E&M	8,790	\$43.80	\$43.80	\$43.80	\$82.97	0.53	\$98.17	0.45	\$72.43	0.60
90805	Individual psychotherapy, 30 minutes; with E&M	2,762	\$41.96	\$43.80	\$43.74	\$83.85	0.52	\$98.05	0.45	\$72.36	0.60
Total Including Anesthesia			33.98	41.15	42.42	79.68	0.53			58.31	0.73
Total Excluding Anesthesia			34.24	41.47	40.78	78.28	0.52	77.21	0.53	57.11	0.71

\*97533 has not been included in subtotals due to data not available for the prevailing charges.

## *Appendix E*

---

### **Initial Literature Search Results**

1. Cunningham, Peter. Nichols, Len. "The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective." *Medical Care Research and Review* (62 No. 6). December 2005.
2. Cunningham, Peter. May, Jessica. "Medicaid Patients Increasingly Concentrated Among Physicians." Center for Studying Health System Change. Tracking Report No. 16, August 2006.
3. Shen, Yu-Chu. Zuckerman, Stephen. "The Effect of Medicaid Payment Generosity on Access and Use Among Beneficiaries." *Health Services Research* 40.3 (June 2005): 723-746.
4. Coburn, Andrew. Long, Stephen. Marquis, Susan. "Effects of changing Medicaid fees on physician participation and enrollee access." *Inquiry* 36 (Fall 1999): 265-279.
5. Cohen, Frederick... Rosenberg, Mark... "Medicaid and Physician Reimbursement." *Journal of the American Academy of Pediatrics*. 2006: 118; 808-809.
6. Cunningham, Peter. McFeeters, Joshua. Nichols, Len. Zuckerman, Stephen. "Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation." *Health Affairs – Web Exclusive*. June 23, 2004.
7. Ellis, Eileen. Gifford, Kathleen. O'Malley, Molly. Ramesh, Rekha. Smith, Vernon. Wachino, Victoria. "States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions." Kaiser Commission, January 2004.
8. Davidoff, Amy. Garrett, Bowen. Yemane, Alshadye. "Effects of Medicaid Managed Care Programs on Health Services Access and Use." *Health Services Research* 38:2 (April 2003): 575-594.
9. Davis, Jean C. Tang, Suk-fong. Yudkowsky, Beth. "Medicaid Participation by Private and Safety Net Pediatricians, 1993 and 2000." *Pediatrics* 2003: 112; 368-372.
10. Berman, Steve. Dolins, Judith. Tang, Suk-fong. Yudkowsky, Beth. "Factors that Influence the Willingness of Private Primary Care Pediatricians to Accept more Medicaid Patients." *Pediatrics* 2002: 110; 239-248.
11. Cohen, Joel. Cunningham, Peter. "Medicaid Physician Fee Levels and Children's Access to Care." *Health Affairs*, Spring 1995: 255-262.
12. Medows, Rhonda. "Access to Medicaid Physician Specialists." Agency for Health Care Administration. December 2002. [http://www.fdhc.state.fl.us/Medicaid/deputy\\_secretary/recent\\_presentations/medicaid\\_physician\\_specailist/index.shtml](http://www.fdhc.state.fl.us/Medicaid/deputy_secretary/recent_presentations/medicaid_physician_specailist/index.shtml)

## Appendix F

State	Is physician participation a problem?	Is participation getting better or worse?	Which specialties are of biggest concern?
<b>Alabama</b>	Somewhat	Same	Specialties in general are the problem area.
<b>Alaska</b>	Not very much	Better	
<b>Arizona</b>	Not at all	Same	N/A
<b>Arkansas</b>	Not very much	Same	Adult primary care physicians in one county with a high percentage of retirees.
<b>Connecticut</b>	Somewhat	Same	Orthopedics, Psychiatry and 11 pediatric subspecialties
<b>Delaware</b>	Somewhat	Worse	OB/GYN, Orthopedists
<b>Florida</b>	Not very much	Same	Orthopedics, Dermatology, Plastic Surgery
<b>Georgia</b>	Not at all	Better	N/A
<b>Idaho</b>	Not very much	Same	N/A
<b>Iowa</b>	Somewhat	Same	OB/Gyn, Pediatrics
<b>Kansas</b>	Not very much	Same	Physician coverage in rural areas.
<b>Louisiana</b>	Somewhat	Same	Orthopedists, neurologists, specialty surgeons, gynecologists, obstetricians
<b>Massachusetts</b>	Not very much	Same	N/A
<b>Michigan</b>	Not very much	Same	Pediatric specialists
<b>Missouri</b>	Not very much	Same	N/A
<b>Montana</b>	Somewhat	Same	Primary care physicians in some areas. Specialty care access in 1 of 7 major cities.
<b>N. Carolina</b>	Not at all	Same	
<b>N. Dakota</b>	Somewhat	Same	Dentists, pareo neonatologists, and various other specialties.

## Appendix F

---

<b>Nebraska</b>	Somewhat	Same	Pediatricians, subspecialty care, orthopedists, primary care in rural areas.
<b>Nevada</b>	Somewhat	Better	Urology, orthopedic surgeons, dermatologists, various specialized surgeons
<b>New Hampshire</b>	Somewhat	Worse	Dermatology, orthopedics, ophthalmology
<b>New Jersey</b>	Very much	Same	All specialties
<b>New Mexico</b>	Somewhat	Worse	Dental
<b>New York</b>	Not very much	Same	N/A
<b>Oklahoma</b>	Very much	Same or better	Pediatric specialties, Ortho surgeons, Neurology and Oncology
<b>S. Carolina</b>	Not very much	Same	N/A
<b>S. Dakota</b>	Not very much	Same	Participation in Primary Care Program in certain geographic areas of the state for family practice and pediatric doctors.
<b>Utah</b>	Not very much	Same	N/A
<b>Vermont</b>	Not at all	Same	N/A
<b>Washington, DC</b>	Not very much	Same	Lack of specialists in some specialty areas. Primary care providers are sufficient.
<b>Wisconsin</b>	Somewhat	Same	Generally not a problem. Psychiatry and some other unique specialties sometimes cited. Some rural areas have few physicians and no HMOs.
<b>Wyoming</b>	Somewhat	Same	OB/GYN, Neurologists, Psychiatrists

## Appendix F

State	Monitor fee-for-service (FFS) Medicaid Program?	How do you monitor FFS?	Financial incentives offered to retain FFS providers?
<b>Alabama</b>	Yes	Through complaints and grievances and comparing the numbers from time to time.	No
<b>Alaska</b>	No	N/A	Yes
<b>Arizona</b>	No	N/A	No
<b>Arkansas</b>	No	N/A	No
<b>Connecticut</b>	Yes	SURS to look at physicians by specialty who bill on a quarterly basis. No monitoring for physicians who are enrolled but not taking new patients. Reviewing to use MMIS to check provider availability.	No
<b>Delaware</b>	No	N/A	No
<b>Florida</b>	Yes	Periodic review of enrollment	Yes
<b>Georgia</b>	Yes	N/A	No
<b>Idaho</b>	No	N/A	No
<b>Iowa</b>	No	N/A	No
<b>Kansas</b>	No	Capable of monitoring through MMIS.	Yes
<b>Louisiana</b>	Yes	Limited to one paid claim in a year. Reviewing to change method.	Yes
<b>Massachusetts</b>	Yes	* Capacity reports * Communication with Massachusetts Medical Society * Recertification of provider credentials * Ongoing communications w/customer service	No
<b>Michigan</b>	No	N/A	Yes

## Appendix F

---

<b>Missouri</b>	Yes	Monthly management reports.	Yes
<b>Montana</b>	No	N/A	Yes
<b>N. Carolina</b>	No	N/A	No
<b>N. Dakota</b>	No	N/A	Yes
<b>Nebraska</b>	No	N/A	No
		Capable of monitoring, but haven't implemented a provider recruitment, retention plan.	
<b>Nevada</b>	No		Yes
<b>New Hampshire</b>	No	N/A	No
<b>New Jersey</b>	Yes	Geoaccess reporting	No
<b>New Mexico</b>	No	N/A	No
		Monitored by the Department's policy area.	
<b>New York</b>	Yes		Yes
<b>Oklahoma</b>	Yes	MMIS reports	Yes
<b>S. Carolina</b>	No	N/A	Yes
<b>S. Dakota</b>	No	N/A	No
<b>Utah</b>	No	N/A	Yes
<b>Vermont</b>	No	No formal process.	Yes
<b>Washington, DC</b>	No	N/A	No
		No active monitoring because of high percentage of participating physicians (nearly 93%).	
<b>Wisconsin</b>	No		Yes
		Through COLD reports from MMIS.	
<b>Wyoming</b>	Yes		Yes

## Appendix F

State	Incentive provided	Annual appropriation for incentives	Methods used to recruit providers
<b>Alabama</b>	N/A	N/A	Medical and dental school recruitment
	RBRVS formula for reimbursement with conversion factor over \$49 (well above Medicare).		
<b>Alaska</b>		Not separately budgeted.	None reported
<b>Arizona</b>	N/A	N/A	None reported
<b>Arkansas</b>	N/A	N/A	None reported
<b>Connecticut</b>	N/A	N/A	None reported
<b>Delaware</b>	N/A	N/A	None reported
<b>Florida</b>	Increased reimbursement rates	\$12.1 million (all used to improve pediatric access)	None reported
<b>Georgia</b>	N/A	N/A	None reported
<b>Idaho</b>	N/A	N/A	None reported
<b>Iowa</b>	N/A	N/A	None reported
	* Increased reimbursement rates * Loan repayment programs * Medical student scholarship programs		
<b>Kansas</b>		N/A	Contact by program managers, provider service and managed care representatives.
<b>Louisiana</b>	Increased reimbursement rates	Part of base appropriation and not separated out.	None reported
<b>Massachusetts</b>	N/A	N/A	Medical school recruitment
	Increasing preventative evaluation & management codes & newborn codes by 47%		
<b>Michigan</b>		\$16,623,600	None reported

## Appendix F

		SFY 1999 added \$10.3 million to physician codes; SFY 2000 added over \$3 million for specific pediatric codes; SFY 2005 added \$2.6 million for emergency room physician codes; SFY 2007 added \$9.1 million for physician office visit codes.	
<b>Missouri</b>	Increased reimbursement rates		None reported
<b>Montana</b>	Increased reimbursement rates	\$2 million	None reported
<b>N. Carolina</b>	N/A	N/A	None reported
<b>N. Dakota</b>	Per-member-per-month fee reimbursement for retaining providers.	N/A	None reported
<b>Nebraska</b>	Loan repayment and student scholarships are available through the Office of Rural Health.	N/A	None reported
<b>Nevada</b>	Enhanced rates for pediatric services	N/A	Plan under development.
<b>New Hampshire</b>	N/A	N/A	None reported
<b>New Jersey</b>	None	None	None reported
<b>New Mexico</b>	N/A	N/A	None reported
<b>New York</b>	* Increased reimbursement rates * Physicians on limited license may participate in underserved areas.	N/A	None reported

- \* Medical/Dental Schools
- \* Newspaper ads
- \* Radio
- \* Yellow pages
- \* MD and DO website
- \* Local community newspaper
- \* Internet
- \* Reports from the Licensor Board

**Oklahoma**      Increased reimbursement rates      Information not provided

## Appendix F

<b>S. Carolina</b>	Increased reimbursement rates	No specific appropriations; comes from general budget.	None reported
<b>S. Dakota</b>	N/A	N/A	None reported
<b>Utah</b>	A pool of money is divided between physicians with high Medicaid volume. An annual check is sent to providers with a letter explaining the criteria for selection.	\$300,000 - \$500,000	None reported
<b>Vermont</b>	Attempt to keep rates at a level that will retain providers	Not an annual event. Done when funds are available.	None reported
<b>Washington, DC</b>	N/A	N/A	None reported
<b>Wisconsin</b>	Increased reimbursement rates	No specific allocation for HPSA & primary care. These are part of the overall budget. FQHCs and RHCs have their own budget.	No active recruiting.
<b>Wyoming</b>	Increased reimbursement rates	No funds specifically appropriated.	None reported