Medicaid Issues -

PHYSICIAN SERVICES PROVIDED UNDER MEDICAID

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Issue Statement

North Carolina Medicaid spent nearly $200 million in FY92 for the provision of physician services to Medicaid patients, an increase of 236 percent from FY87. Physicians serve a unique role in the health care system, serving as gatekeepers to other health care services, including admission of patients to acute care facilities and prescribing of drugs. For this reason, the delivery of timely and effective primary care is critical to an efficient health care system. North Carolina, like many other states, faces the problem of Medicaid patient access to primary care, particularly in the rural areas of the State. Additionally, the State recognizes its high infant mortality rate relative to other states and has identified as a top priority issue the improvement of infant health.

The Division of Medical Assistance has taken positive steps to address the problems of access to care and infant health. Recognizing the importance of primary care services for Medicaid patients, the State developed Carolina Access, a primary care case management program which currently serves 12 counties and will serve an additional four counties by year end. Additionally, the Division of Medical Assistance is in the process of revising its physician fee schedule, which is based on the Medicare Resource-Based Relative Value Scale (RBRVS) schedule. Both initiatives are designed to encourage access to primary care.

Background

While expenditures for physician services increased 236 percent since FY87, the number of recipients increased by 158 percent over the same time period. (See Exhibit 1.) The Medicaid program experienced a large increase in the number of recipients between FY91 and FY92, primarily resulting from federal mandates which expanded eligibility, and the poor economy. The State of North Carolina spent $82.79 per Medicaid recipient for physician services in FY92, an increase of 30 percent from FY87. The increase in the medical component of Consumer Price Index over the same time period was 55 percent.

The Division of Medical Assistance plans to implement a new fee schedule based on Medicare's RBRVS by the beginning of the calendar year. RBRVS is the result of a study which identified the actual resources necessary to perform particular procedures and assigned relative weights to each procedure. In order to determine payment amount for a particular procedure, its relative weight is multiplied by a base amount. Under Medicare's fee schedule, the base amounts vary by regions, reflecting differences in area wages. RBRVS serves two important goals:

- The system more equitably distributes payments across physician specialties, as payment is based on the actual amount of resources necessary to perform procedures.

EXHIBIT 1

NORTH CAROLINA MEDICAID PROGRAM 1987-1992
PHYSICIAN HOSPITAL SERVICES EXPENDITURES

Fiscal Year	Payments	Percent Increase (Decrease)	Recipients	Percent Increase (Decrease)	$ Per Recipient	Percent Increase (Decrease)
1987	$58,766,185.28		925,238		$63.51	
1988	$68,164,543.99	15.99	1,004,022	8.51	$67.89	6.89
1989	$89,265,461.11	30.96	1,162,121	15.75	$76.81	13.14
1990	$125,488,826.45	40.58	1,489,010	28.13	$84.28	9.72
1991	$160,423,356.28	27.84	1,762,500	18.37	$91.02	8.00
1992	$197,467,796.61	23.09	2,385,074	35.32	$82.79	-9.04
1987-1992		236.02		157.78		30.35

Source: HCFA 2082 Data

- The system shifts reimbursement from surgeons and other specialists to general and family practitioners, thereby encouraging primary care physicians to participate in the program.

Where possible, Medicaid will use relative weights developed by Medicare. However, due to differences in the Medicare and Medicaid populations, weights do not exist for all procedures provided to Medicaid patients (e.g., newborn delivery). The Division of Medical Assistance will develop payment amounts for these procedures.

The recently implemented Carolina Access program is modelled after successful primary care case management programs of other states. The goals of Carolina Access are to improve access to primary care services, encourage development of physician/patient relationships and encourage appropriate utilization of all health care services. The program is implemented on a countywide basis. Once a county is enrolled, all non-institutionalized Medicaid patients within the county select a primary care case manager. Case managers are responsible for providing primary care services and authorizing the use of other non-emergency health services. Case managers receive a monthly fee of $3.00 for each patient. If a case manager serves more than 250 Medicaid enrollees, the monthly fee for enrollees in excess of 250 is $2.50.

The DMA intends to expand Carolina Access into most counties by FY96 and DMA indicates counties are anxious to participate. However, development of the program within counties requires substantial State staff resources. Delays in developing the program in these counties are the result of insufficient State staff time.

Findings

Finding 1: North Carolina Medicaid expenditures for physician services are above the national average.

North Carolina expenditures per recipient were $260 in 1990, slightly above the national average of $234 per recipient. (See Exhibit 2.) Data reported by the National Governor's Association and the Physician Payment Review Commission indicate that 1990 average visit fees paid by North Carolina Medicaid are higher than the average of Medicaid fees for all states. (See Exhibit 3.) North Carolina's average Medicaid fee was equal to 107 percent of the average fee for all states. Based on 1989 data, North Carolina Medicaid fees were 93 percent of Medicare prevailing charges. (See Exhibit 4.) Exhibit 5 presents a comparison of payment methodologies employed by Southeastern states. When North Carolina Medicaid implements a new fee schedule for the payment of physician services, fee comparison data will likely change. However, North Carolina intends to establish fees under the new schedule such that total expenditures will equal total expenditures under the current schedule, plus a six percent inflation factor.

EXHIBIT 2

MEDICAID EXPENDITURES PER RECIPIENT FOR PHYSICIAN SERVICES

	1989	1990	Percent Change
Georgia	$363	$406	12.0
Tennessee	273	294	7.8
Virginia	228	293	28.6
South Carolina	227	285	25.9
Florida	220	265	20.4
North Carolina	227	261	15.1
National Average	217	234	7.7
Kentucky	226	241	6.2
Alabama	209	223	6.9
West Virginia	136	150	10.0

Source: Health Care Financing Administrator, Report of State Medicaid Expenditures

EXHIBIT 3

COMPARISON OF MEDICAID FEES FOR PHYSICIAN SERVICES

	Average Fees as a Percent of National Average Medicaid Fees
Georgia	164
Florida	135
Alabama	107
North Carolina	107
Tennessee	105
South Carolina	92
Virginia	81
Mississippi	68
Kentucky	62
West Virginia	61

Source: National Government Association and Physician Payment Review Commission, 1990; Health Care Financing Administration, 1989

EXHIBIT 4

COMPARISON OF STATE MEDICAID AND MEDICARE FEES

	Average State Medicaid Fees as a Percent of Medicare Prevailing Changes
Georgia	112
North Carolina	93
Tennessee	92
South Carolina	81
Virginia	73
Alabama	72
Florida	71
Mississippi	66
Kentucky	63
West Virginia	35

Source: National Government Association and Physician Payment Review Commission, 1990; Health Care Financing Administration, 1989

EXHIBIT 5

COMPARISON OF PHYSICIAN PAYMENT METHODOLOGIES

	North Carolina	Alabama	Florida	Georgia	Kentucky	Mississippi	South Carolina	Tennessee	Virginia
Payment Methodology	Fee schedule based on charges	Fee Schedule based on 90 percent of the 75th percentile of submitted charges	Fee schedule	Fee schedule based on charges	Reasonable charges	Fee Schedule based on 1974 California Relative Value Study	Fee Schedule based on 1974 California Relative value Study	Percentage of usual, customary or prevailing charges	Fee Schedule based on charges
Service Limits	24 per State Fiscal Year; limit includes clinic, outpatient, chiropractor, podiatrist and optometrist visits	14 visits per year	Limits for certain types of services	12 visits per year	One initial or extensive visit per 12-month period	12 per fiscal year; includes outpatient and clinic visits	18 per year	24 visits per year	18 visits per year
Medicaid payment (SFY 1989) as Percent of Medicare Prevailing Charges (1988)	98%	86%	72%	111%	72%	96%	81%	124%	73%
Physician Payments per Medicaid Recipient, 1990	$261	$223	$265	$407	$241	$193	$285	$294	$293
Payment per Physician Visit, 1990	$62	$24	$32	$52	$43	$15	$25	$17	$34

Sources:
- CCH Medicare and Medicaid Guide
- HCFA 2082 Data
- Physician Payment Review Commission

A physician fee schedule based on Medicare's RBRVS will not decrease Medicaid expenditures for physician services. The fee schedule, however, does offer several benefits relative to the current fee schedule. The revised fee schedule is intended to re-distribute payments, resulting in reduced fees for services provided by specialists and enhanced fees for services provided by general practitioners. Consequently, the fee schedule encourages provision of primary care services and discourages specialty services. Increased provision of primary care services positively impacts the amount of wellness and preventive care received by Medicaid patients. Ultimately, a healthier Medicaid population will produce savings for the Medicaid program across the array of health care services purchased by the Medicaid program.

Finding 2: Access to primary care for Medicaid patients is limited in certain areas of the State.

According to prior studies and advocacy groups, North Carolina Medicaid patients often encounter difficulty in gaining access to physician care. Access is a particular concern in the rural areas of the State where the number of practitioners is limited. Additionally, North Carolina Medicaid patients face difficulty in obtaining obstetrical and pregnancy-related care. In a 1990 Physician Payment Review Commission report, over half of the states reported similar access problems. North Carolina Medicaid has responded to the problem of limited availability of OB/Gyn specialists by increasing the global fee for pregnancy care and infant delivery. Additionally, the revised fee schedule will enhance fees for neonatal and pregnancy-related care. Federal regulations require State Medicaid programs to establish payment rates which are sufficient to ensure access to obstetrical and pediatric care to the same extent such care is available to the general population.

Evidence varies with regard to the correlation between physician payment amounts and access to care. Regardless of fee amounts, some providers are unwilling to accept Medicaid patients. Other physicians, however, are hesitant to care for Medicaid patients, but will accept such patients if fees are considered adequate. In a study of physician participation in the North Carolina Medicaid program, fee levels were one of several factors which influenced the physician participation rate. Other reasons cited included various administrative burdens, including the complexity of billing requirements. Because of the unique role of the physician and the identified access problems, reducing physician fees may be a less than desirable option.

Finding 3: Carolina Access has produced significant savings across Medicaid program areas.

Carolina Access is a well-designed program which has produced savings to the Medicaid program. Additionally, the program appears to improve patient access to primary care services and encourage the delivery of preventive care. Total Medicaid expenditures per recipient have decreased in counties enrolled in Carolina Access due to reduced utilization of health care services.

The program has achieved successes in reducing inappropriate utilization of health services through a combination of participation requirements, reimbursement policies and efforts to educate patients regarding the appropriate utilization of services. Providers must receive authorization from primary care physicians in order to be reimbursed for all non-emergency services. Because authorization by the primary care physician is required to receive reimbursement, referrals are controlled and the primary care physician is in a better position to track and manage the care of patients. Another program feature which controls utilization is the requirement that primary care physicians provide 24-hour access via telephone. Additionally, the Division of Medical Assistance issues written materials to enrollees which requests patients to contact their primary care physician prior to seeking any health services. These policies enable primary care physicians to effectively manage the continuum of health care provided to patients.

Every state Medicaid program is confronted by the issue of inappropriate utilization of hospital emergency rooms. Because emergency rooms are geared toward provision of high intensity care, the cost of providing routine care in emergency rooms is much higher than the cost of providing the same care in physician offices. The Carolina Access program will implement an emergency room policy in the near future which is designed to reduce the inappropriate utilization of emergency rooms. Reimbursement for non-emergencies is limited to a triage fee of $22.00 which is intended to cover the costs of assessing the patient's condition and referring the patient back to the primary care physician. During traditional physician office hours, hospitals are eligible to receive the triage fee only. Hospitals will be reimbursed for non-emergency care provided between the hours of 6:00 p.m. and 8:00 a.m. if the primary care physician authorizes the care. This policy enlists the assistance of hospitals in educating patients that the emergency room should not be used for routine care. It is an important first step in controlling hospital expenditures.

The Division of Medical Assistance estimated that the Carolina Access program produced savings of three million dollars over a five-month period. Additionally, a study of the program by the Office of State Budget and Management reported a one percent reduction in costs per Medicaid eligible in participating counties over a five-month time period. The Office estimated costs per eligible in demographically comparable counties increased by two percent over the same time period. This is consistent with findings in other states. The State of Kentucky, for example, experienced significant savings as a result of its statewide

primary care case management program. Kentucky estimated savings of $125 million over a five-year period.

The success of Carolina Access demonstrates the importance of managing patient care. The program is a significant first step in the development of a managed care program. While the program enables primary care physicians to coordinate patient care, the effectiveness of the program could be increased through implementation of policies designed to modify physician behavior. The program is perhaps in the its early stages of addressing this goal.

Primary care physicians receive monthly reports which provide information regarding the utilization of health services by patients enrolled with the physician, patients enrolled with physicians practicing the same specialty and all program enrollees. This data enables each physician to assess his or her performance and referral patterns relative to other physicians. Additionally, the Division of Medical Assistance plans to hire a nurse to review and investigate practice patterns and provide guidance to primary care physicians regarding effective utilization of health services.

Potential modifications to the current program exist which more effectively control utilization of services. One option is to implement a program whereby physicians share in the savings which result from the reduced utilization of health care services. A second option is to pay physicians a capitated amount for providing all primary care to enrollees. The capitation amount may include payment for other health services, such as prescription drugs. These options recognize the unique role of physicians as gatekeepers to health care and provide incentive for physicians to carefully manage patient care and to develop treatment patterns which are both appropriate and cost-effective.

There are several concerns regarding policies which put physicians at risk. As physicians are generally averse to risk, a capitation model may compromise physician participation in the program. However, if capitation amounts are set at adequate levels, physicians which effectively manage patient care are likely to increase their net revenues. Additionally, policies may be implemented which limit a physician's risk, providing additional payment for particular patients which inherently require a more intense level of services.

Recommendations

Recommendation 1: Implement Carolina Access on a statewide basis.

Given the notable savings achieved by Carolina Access in a 5-month period, it is important to move quickly to statewide implementation. Additional administrative costs can be more than offset by savings; improved quality of care will also contribute to long-term savings.

Implications:

- Medicaid program expenditures will be significantly reduced over the next two years.
- Additional State staff time is needed to move the implementation schedule forward.
- Access for Medicaid patients over next two years will be enhanced.
- Physicians and patients statewide will be introduced to coordinated care concepts.

Recommendation 2: Expand use of managed care options.

Managed care options which the State of North Carolina should consider include implementation of a savings sharing program or capitation of all primary care services. Under these options, physicians are encouraged to coordinate and monitor utilization of services. Additionally, because physicians benefit from the overall reduction in expenditures, they have incentives to use low-cost facilities and to make referrals to cost-effective hospitals. The State should capitate payments for physician services to guarantee certain savings levels (generally 5 percent of fee-for-service payments).

Implications:

- The Medicaid Program must continue to work with physicians to educate them regarding the importance of managed care programs as they can improve quality as well as achieve cost savings.
- Savings-sharing provisions require extensive data regarding utilization of services in order to determine savings payment amounts. Reports of such data currently to not exist. The Medicaid Management Information System must track utilization of groups of services used by specific recipients assigned to primary care physicians.
- Developing managed care options with rural hospitals and health clinics circumvents arguments that managed care is not viable in North Carolina and lacks of physicians willing to participate.
- Physicians are given greater incentives to monitor and control utilization.
- Medicaid expenditures across several program areas (e.g., prescription drugs, inpatient and outpatient hospital) can be reduced.
- Requires enhanced utilization review to ensure quality care and access are not compromised.

Cost Savings

Both of the above recommendations are also presented in the managed care issue paper. Recommendations presented here refer more specifically to the physician component.

Cost savings could be achieved by moving the Carolina Access schedule forward. Exhibit 6 provides an estimate of the amount of savings which could be achieved. The estimate is based on reduced utilization of physician services for recipients enrolled in Carolina Access program. Cost savings for moving the Carolina Access schedule forward would net $2.9 million in savings for the first year and $23.2 million over the next ten years. It should be noted the projected savings that would be realized from reduced utilization of outpatient, pharmaceuticals, and inpatient services are not included in the savings projections presented in Exhibit 6, nor are additional staff costs. Programmatic savings from statewide implementation of Carolina Access are presented in the managed care issue paper.

Implementation Considerations

Because physicians may be reluctant to participate in risk-sharing programs, the State should conduct further analysis to ensure that access is not compromised by such programs. Also, the State should consider mechanisms which limit a physician's risk. For example, physician risk may be limited to ten percent above the total amount of capitated payments. Furthermore, patients requiring large amounts of health care may be exempted from the capitation plan. The State may sponsor an insurance program which limits provider risk.

Because physicians are paid a flat amount per patient, there is potential for certain patients to receive inadequate care. For this reason, the State must enhance its utilization review activities to ensure that appropriate care is delivered.

Additionally, the State should implement other mechanisms which encourage appropriate care, including a disenrollment process and patient complaint process. With proper State oversight and safeguard procedures in place, access to care and quality of care will improve under a capitated primary care program.

EXHIBIT 6

PROJECTED SAVINGS - IMPLEMENT CAROLINA ACCESS STATEWIDE (In Millions)

Physician Services	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Current System Expenditures	$58.8	$61.5	$62.9	$64.7	$67.3	$70.0	$72.8	$75.7	$78.7	$81.9
Expenditures under Statewide Carolina Access	$55.9	$58.1	$60.4	$62.8	$65.3	$68.0	$70.7	$73.5	$76.4	$79.5
Savings Per Year	$2.9	$3.0	$2.4	$1.9	$2.0	$2.0	$2.1	$2.2	$2.3	$2.4
Cumulative Savings	$2.9	$5.9	$8.3	$10.2	$12.2	$14.2	$16.3	$18.5	$20.8	$23.2

Assumptions:

- Projections based on implementation of the Carolina Access program within twelve months rather than the scheduled 48-month implementation timeframe.
- Reduced utilization of physician services for recipients enrolled in the Carolina Access program estimated at 5 percent.