



# Medicaid Rates and Provider Participation: Considerations for Missouri Policy Makers

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## Introduction

Medicaid is a partnership between the Federal Government and the states. While the Federal Government provides financial matching payments to the states and is responsible for overseeing the Medicaid program, state Medicaid programs exercise significant discretion in setting reimbursement levels. Federal Medicaid law requires states to ensure access to Medicaid services, and most state reimbursement methodologies are subject to federal review and approval. Beyond these requirements, state Medicaid programs and budget officials have a measure of control over reimbursement rates. In many states, this results in a persistent tension between limited state funding for Medicaid reimbursement, anemic provider participation, and reasonable access to services by beneficiaries.

As state policy makers struggle with budgets related to Medicaid entitlement spending for acute and long term services, some policy makers have sought to reduce or limit the growth of reimbursements (e.g., medical cost inflation factors) as a cost containment strategy. However, this approach can be counterproductive. Reducing or limiting reimbursement rates when the budgets are tight and only marginally increasing the rates when state revenues are strong accentuates the complications related to beneficiary access and provider participation. Eliminating or postponing reasonable growth in provider reimbursement rates produces a “base” that does not adequately compensate providers for their costs. When rates increase in times of positive economic circumstances, the resulting enhancements may only make insignificant progress towards “catching up” with costs and do little to increase either access or provider participation.

States may expect that simply increasing rates will directly result in more providers participating in the Medicaid program and improved beneficiary access. Literature on this issue suggests reimbursements rates to be positively correlated with physician participation, but producing measurable improvements in access requires a more comprehensive approach.

This paper presents background material on Medicaid reimbursement, a sampling of the literature on the subject, and considerations for improving provider participation in and beneficiary access to Missouri’s Medicaid program, MO HealthNet. It should be noted that the information in this briefing focuses on primary care, ambulatory care, and physician reimbursement. Due to the complexity of Medicaid reimbursement systems for inpatient care, the briefing does not address Medicaid hospital reimbursement. Similarly, Medicaid dental reimbursement and dentist participation is better treated as a separate subject due to the higher initial capital costs associated with most dental practices and the availability of specific studies on dental reimbursement changes.

## Background

One basis for making relative comparisons of state Medicaid fee-for-service rates is to calculate what percentage the rates constitute of Medicare fees for comparable services. Medicare reimbursement uses a nationally standardized reimbursement system to determine a physician fee schedule based on the Resource-based Relative Value Scale (RBRVS). Medicare uses RBRVS to determine a relative value for three pricing components: the physician’s work to provide a service, the overhead to maintain a practice, and liability insurance costs. The RBRVS units are

multiplied by a conversion factor along with geographic and other factors to obtain a dollar amount for a specific service. Variants of the RBRVS system have also become common among commercial payers.

Some state Medicaid programs also use similar systems, or they may use other established fee schedules that are occasionally adjusted. The table below compares Missouri's Medicaid fees to other states in the immediate region as well as to the U.S. overall average. This information is from 2003 and does not include managed care rates. However, in other states, capitation rates tend to reflect fee-for-service spending to some degree.<sup>1</sup>

Compared to other states in the immediate region and the U.S. average, Missouri's Medicaid rates appear low—the lowest in all categories in the immediate region. For example, Missouri paid approximately half the Medicare rate for primary care services, while some state Medicaid programs paid close to the full Medicare rate. Currently, Missouri is taking steps to gradually increase Medicaid physician rates to parity with Medicare fees.

#### **Medicaid Fees As a Percentage of Medicare Fees, 2003 (Fee for Service Rates)**

	<b>All Services</b>	<b>Primary Care</b>	<b>Obstetric Care</b>	<b>Other Services</b>
<b>United States</b>	<b>0.69</b>	<b>0.62</b>	<b>0.84</b>	<b>0.73</b>
<i>Missouri</i>	0.56	0.50	0.71	0.56
<i>Illinois</i>	0.63	0.54	0.84	0.68
<i>Oklahoma</i>	0.72	0.67	0.81	0.73
<i>Kansas</i>	0.75	0.63	0.92	0.86
<i>Kentucky</i>	0.76	0.63	1.11	0.83
<i>Arkansas</i>	0.95	0.96	0.78	1.15
<i>Iowa</i>	0.97	0.94	1.01	1.00

Source: Kaiser State Health Facts - <http://www.statehealthfacts.org/comparetable.jsp?ind=195&cat=4>

### **Selected Findings on the Relationship of Fees with Participation and Access**

A review of relevant subject-related research suggests that while reimbursement rate levels have a linear relationship with provider participation, other factors contributing to physicians deciding to accept Medicaid recipients. A sample of the key findings includes:

- “Physicians in states with the lowest Medicaid fees were less willing to accept most or all new Medicaid patients in both 1998 and 2003. However, large fee increases were associated with primary care physicians’ greater willingness to accept new Medicaid patients.”<sup>2</sup>
- “Higher payments increase the probability of having a usual source of care and the probability of having at least one visit to a doctor and other health professional for Medicaid adults... Higher payment rates can improve some aspects of access and use for Medicaid beneficiaries, but the effects are not dramatic.”<sup>3</sup>
- “There appears to be a strong association between the relative generosity of Medicaid reimbursement and the place where Medicaid children usually receive their medical care. In general, the higher the fee... the more likely children are to use a doctor’s office for their

usual source of care and the less likely they are to use a hospital-based or other health care facility.”<sup>4</sup>

- “A decline in physician’s income increased the likelihood that a physician would stop accepting new Medicaid patients but had no effect on his or her decision to provide charity care. Those physicians who switch from being owners to employees or from small to larger practices were more likely to drop charity care and to start accepting Medicaid patients, and physicians who made the opposite practice changes did the reverse.”<sup>5</sup>
- “[P]articipation increased with state Medicaid payment levels but decreased as the proportion of Medicaid enrollees with primary care capitated payments rose and as paperwork concerns rose...low payment, capitation, and paperwork concerns all relate to low Medicaid participation by primary care office-based pediatricians. It behooves state policy makers to address these 3 factors to ensure sufficient primary care physician capacity to serve appropriately children who are enrolled in state Medicaid programs.”<sup>6</sup>
- “Although high fee levels increase the probability that individual physicians will accept Medicaid patients, high fee levels do not necessarily lead to high levels of physician Medicaid acceptance in an area. Numerous other physician practice, health system, and community characteristics also affect Medicaid acceptance. The effects of Medicaid fees on Medicaid acceptance are substantially lower in areas with high Medicaid managed care penetration and for physicians who practice in institutional settings.”<sup>7</sup>

These findings suggest several observations:

- **State budgets often fail to take a long-term, strategic view of Medicaid financing.** In times of chronically tight state finances, state budget officials will naturally look to factors under their control to constrain or cut budgets, including rate reductions or the postponement of reasonable growth factors in reimbursement levels. This works as a short-term budget strategy but typically fails as a longer-term Medicaid health care policy. Provider participation declines, access degrades, and the state’s Medicaid program becomes increasingly inefficient, as primary care backs up into more expensive hospital emergency room settings, increasing costs to local taxpayers. Additionally, underfunding may only temporarily postpone the expenditures needed to sustain reasonable reimbursement levels. As rates fall below or further below providers’ reasonable costs of providing care, litigation alleging inadequate access under federal law becomes more likely to succeed. This may require new, large appropriations to “catch up” with more reasonable rate levels. Therefore, budgetary “pain” is only postponed.<sup>8</sup>
- **Fee levels are important, but are not the only factor that affects provider participation and beneficiary access.** To operate an efficient system, Medicaid reimbursement does not necessarily need to equal private-sector levels, but should be reasonable enough to ensure basic access to care. Other factors playing a role in access include:
  - *Community characteristics and demographics.* Medicaid does not have a particular impact on the general supply of primary care and specialty care providers. Medically underserved areas will have continued chronic access problems, unless the state or the locality can address the underlying causes of the provider shortage and recruit new providers to the area. This is not necessarily a Medicaid rate issue, and rate increases alone may do little

to address critical shortages of providers in underserved regions.

- *Practice type for primary care.* The number of single physician or small group practices versus the number of larger, clinic-type practices (where physicians work as employees rather than business owners) affects access. Larger practice settings are more likely to see more Medicaid patients since they can see larger patient volumes to offset the lower reimbursement levels and Medicaid claims paper work.
- *Medicaid managed care penetration.* Physicians may be less willing to accept the administrative overhead and patient volume associated with Medicaid managed care than fee-for-service reimbursement, particularly when states expand managed care into new areas.
- *Perceived administrative burden of Medicaid, under either Medicaid managed care or fee-for-service Medicaid (e.g. “hassle” factor).* Sole physicians or small group practices that see a significant volume of Medicaid patients may, as a business, operate on small margins. While the administrative burden of Medicaid managed care may not be materially different than private-sector managed care, lower Medicaid reimbursement may be a disincentive. Some states’ fee-for-service systems may have an inherent bias to “deny first” when processing claims. States wanting to encourage participation should conduct detailed reviews of both their managed care requirements and their own fee-for-service claims processing systems for features that discourage provider participation.
- *Specifics of rate increase implementation.* Implementation of across-the-board rate increases ignores both healthcare workforce dynamics and the strategic directions that a state may have for its Medicaid program. Available funding for provider rate increases should be allocated where it can do the most good. In other words, bolster participation in those provider types that can help advance the concept of the health care home and improve access to specialty care.

## Measuring Change in Provider Participation and Program Access

The ultimate goal of Missouri’s effort to move its MO HealthNet reimbursement to parity with Medicare fees includes better access and better quality of care for MO HealthNet beneficiaries. As noted earlier, other factors are also important, but Missouri’s rates certainly appear to lag behind the region and the U.S. It is important that the impact of the rate increases be measured against a “before rate increase” base period. This will allow the state to assess whether the fee increases are working and, if needed, make adjustments or better target increases towards particular problem areas. Outlined below are some general suggestions for possible outcome measures.

- **Measure the net increase in enrolled providers who are accepting new Medicaid patients (fee- for-service and managed care).** This measure can be broken down further by provider type and region, which may be particularly important for certain specialty types that are in short supply or for particular regions of the state facing acute healthcare workforce shortages. It is important to note that “accepting new Medicaid patients” needs an operational definition to be a measure of real, new access. Providers may say that they are accepting Medicaid but are only willing to see a few additional patients. A more operational definition might be “accepting up to fifty new Medicaid patients this year.” This measure can be operationalized by the entity responsible for MO HealthNet provider credentialing or

contracting by surveying statistically valid samples of MO HealthNet contracted providers.

- **Measure the net increase in the number of beneficiaries reporting a primary care setting as their usual source of care (fee-for-service and managed care).** One of the goals of MO HealthNet centers on giving each beneficiary a health care home and reducing the number of MO HealthNet patients receiving ambulatory care in inpatient hospital settings.<sup>9</sup> Research indicates that rate increases can effect improvements in the usual source of care and could be used as a measure of success. If this measure demonstrates improvement, then the proportion of Medicaid beneficiaries reporting a hospital setting as their usual source of primary care should show a corresponding decline. This measure can be operationalized through the Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS).
- **Measure net increases in overall network size for primary and specialty care in managed care areas.** Managed care plans are generally free to negotiate rates with providers in their networks, but managed care rates tend to approximate fee-for-service rates. Increases in capitation rates to improve provider payment and participation should include new contractual performance requirements that stipulate that the plans increase their overall network size for both primary care and specialty care.
- **Measure improvements in geographic access (distance and/or travel time) to primary and specialty care in managed care areas.** Most Medicaid managed care contracts set geographic distance and/or travel time requirements for a plan's network, to insure reasonable access to services. Increased capitation rates to improve provider payment and participation should include higher contractual performance standards for the number of primary care and specialty care providers that are within the distance and/or travel time of where enrollees live.

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