Report on Increasing Reimbursement Rates for Physicians participating in the Maryland Medical Assistance Program and Maryland Children's Health Program
May 2006

I. Introduction / Background

Chapter 702 (House Bill 1071) of the 2001 Session and Chapter 464 (Senate Bill 481) of the 2002 Session directed the Department of Health and Mental Hygiene (the Department) to establish a process to annually set the reimbursement rates for the Maryland Medical Assistance Program and the Maryland Children's Health Program in a manner that ensures participation of providers.

In September 2001, the Department prepared the first annual report in response to Chapter 702 (House Bill 1071) of the 2001 Session, analyzing the physician fees that are paid by the Maryland Medicaid and Children's Health Programs. The Department's 2001 report showed that Maryland's Medicaid reimbursement rates in 2001 were, on average, about 36 percent of Medicare rates in 2001. The report also included the results of a survey conducted by the American Academy of Pediatrics in 1998/1999 that showed that Maryland's physician reimbursement for a subset of procedures ranked 47th among all Medicaid programs in the country. Based on the 2001 report, the Governor and the legislature appropriated $50 million additional total funds ($25 million state funds) for increasing physician fees in the Medicaid program beginning July 2002. The increase was targeted to evaluation and management procedure codes used largely by primary care and office-based specialty care physicians.

Senate Bill 836 of the 2005 General Assembly session, entitled Maryland Patients' Access to Quality Health Care Act of 2004 – Implementation and Corrective Provisions, in an effort to retain health care providers in the State, alleviated the impact of recent increases in the cost of physicians' malpractice liability insurance. This bill created the "Maryland Health Care Provider Rate Stabilization Fund" to subsidize physicians for the cost of obtaining malpractice insurance. The main revenues of the Fund are from a tax imposed on managed care organizations (MCOs) and health maintenance organizations.

In addition to subsidizing physicians for the cost of obtaining malpractice liability insurance, Senate Bill 836 allocated funds to the Medical Assistance program to increase both fee-for-service physician fees and capitation payments to managed care organizations to enable these organizations to similarly raise their provider fees. The legislation allocated $15 million State Funds ($30 million Total Funds) in FY 2006 to be used by the Department to increase both fee-for-service physician fees and to pay physicians in managed care organizations' networks "consistent with fee-for-service health care provider rates for procedures commonly performed by obstetricians,

neurosurgeons, orthopedic surgeons and emergency medicine physicians". The legislation targeted the fee increase to these physician specialties because of the substantial rise in their malpractice insurance premiums. The bill also allocates additional funds each year to the Medical Assistance program for increasing and maintaining physician fee increases.

SB 836 also required the Department to consult with the Managed Care Organizations, the Maryland Hospital Association, the Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatricians, and the Maryland Chapter of the American College of Emergency Room Physicians in determining the new payment rates. For FY 2007, the Department convened this workgroup (referred to as Stakeholders in this report) to determine the procedures that would be the target of fee increases in FY 2007.

In addition, the Senate Bill 836 indicates that the Department shall submit its plan for Medicaid reimbursement rate increases to the Senate Budget and Taxation Committee, Senate Finance Committee, House Appropriations Committee, and House Health and Government Operations Committee "prior to adopting the regulations implementing the increase." In accordance with this requirement, the Department is submitting its plan for increasing Medicaid physicians' fees for FY 2007.

II. Comparisons of Maryland Medicaid Fees with Medicare Fees

Medicare fees are based on the Resource Based Relative Value Scale (RBRVS). This methodology relates payments to the resources and skills that physicians use to provide services. Three types of resources determine the relative weight of each procedure: physician work, malpractice expense and practice expense. A geographic cost index and a conversion factor are used to convert the weights to fees. Medicare rates are adjusted annually according to a complex formula designed to control overall spending, while accounting for factors that affect the cost of providing care. In some years, including 2002, overall Medicare rates have actually decreased. However, following federal legislative mandates, Medicare physician fees were increased by 1.6 percent in 2003, by 1.5 percent in 2004 and by 1.5 percent in 2005. Following a similar legislative mandate, Medicare fees were held constant at the 2005 level in 2006.

When the Department raised physicians' fees in 2002 and again in 2005, the Department used the Medicare physician payment methodology as a benchmark. (A summary of the methodology to determine the new Medicaid physicians' fees is presented in Appendix 2.) After the July 2005 increase in Medicaid fees, Maryland Medicaid's overall physician reimbursement rates were, on average, about 68 percent of 2005 Medicare rates. The 1,600 procedures targeted in the 2005 increase, though, increased from an average of 65 percent to 99.6 percent of Medicare fees. In addition, the evaluation and

management procedures targeted in the 2002 increase were about 75 percent of 2006 Medicare fees.

Anesthesia procedures and payments are a distinct exception to the RBRVS system. Prior to December 1, 2003, the Medicaid Program reimbursed anesthesia services based on a percentage of the surgical fee. The Program in general did not use the anesthesia CPT procedure codes, but rather the surgical CPT codes with a modifier.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) required that national standard code sets be used. The Program in late 2003 complied with the federal standards and since that time all anesthesia services have been identified based on the anesthesia CPT procedure codes. More than 5,000 surgical procedure codes exist but there are less than 300 anesthesia codes. Payment for anesthesia services could no longer be linked to individual procedures and the Program started the financial transition from a fixed anesthesia rate for each surgical procedure to the national methodology, which recognized anesthesia time as the key element. In retrospect the process resulted in an overall 20% reduction in anesthesia reimbursements with Medicaid payments 48% of what would have been paid under Medicare. The anesthesia payment system is presented in Appendix 1.

III. Plan for Increasing Medicaid Physicians' Fees for FY 2007

The Department's analysis of CPT procedure codes used by different physician specialties (from claims and encounter data) indicates that in addition to using their own specialty procedure codes, they use procedure codes that are the domain of other specialists. For this reason, targeting of fee increase by physician specialty may have limited usefulness.

The Department initially developed and evaluated five different options for targeting the $25.2 million fee increase in FY 2007 to procedures used by various specialties. The various options are described below:

1. Increase fees for anesthesia procedures to 100% of Medicare fees.

2. Allocate available funds to increase fees for the lowest paid surgery procedures. Implementing this option would raise Medicaid fees for surgery procedures with the lowest fees to 57 percent of Medicare fees.

3. Allocate available funds to all lowest procedures (excluding 4 specialties procedures that their fees were increased in FY2006). Because there are many procedures with low Medicaid fee compared to Medicare fee, implementing this option would raise the fees for procedures with the lowest fees to only 39 percent of Medicare fees.

4. Increase fees for the following 12 specialties that the MCOs are required to include in their local networks: allergy, cardiology, dermatology, endocrinology, otolaryngology, gastroenterology, infectious disease, nephrology, neurology, ophthalmology, pulmonology, and urology. Because there are many procedures that are used by these specialty physicians, implementing this option would raise the lowest fees for these procedures to only 45 percent of Medicare fees.

5. Allocate available funds to procedures whose malpractice cost components are greater than $10.00. The malpractice cost components for these procedures were determined based on Center for Medicare and Medicaid Services estimation of this component of Medicare fees. Implementing this option would raise the fees for procedures that their malpractice cost components are greater than $10.00 to about 64% of Medicare fees.

The Department presented the five options described above in the stakeholder meetings that were held in February 2006. The stakeholders were in favor of increasing fees for anesthesia and surgery procedures (options 1 and 2 above). However, option 2 would increase fees for all surgery procedures to only 57 percent of Medicare fees. Therefore, the stakeholders recommended targeting the fee increase to a more limited set of procedures that are mainly used for general surgery (10000-19396), digestive surgery/ gastroenterology (40490-49999), ENT (ear/nose/throat)/ otorhinolaryngology (69000-69990, 92502-92625), allergy/ immunology (95004-95199), and dermatology (96900-96999). The stakeholders were in agreement that there is a need to increase reimbursement rates for these procedures, in order to recruit and train new surgeons that would specialize in these fields. Also, there were requests from some of the stakeholders to increase fees for radiation oncology procedures (77261-77799).

In addition, the stakeholders recommended that the Department allocate any remaining funds to evaluation and management procedures that are used by both primary care physicians and specialists, so that almost all physicians receive some increase in their reimbursement rates.

For the FY 2007 fee increase, the total state and federal matching funds available for the physicians fee increase were $27.6 million. The remaining $2.4 million will be used to maintain the payment for the four specialties whose fees were increased in FY 2006. The following table shows the Department's allocation of FY 2007 fee increase funds among anesthesia, surgery, and evaluation and management procedures.

	Total Cost of Fee Increase (Million $)	Increase to Percent of Medicare
Anesthesia Procedures	$6.66	100%
Procedures including: Integumentary, Digestive Surgery, Radiation Oncology, Allergy/Immunology, and Dermatology	$10.92	80%
ENT Procedures	$2.44	100%
Evaluation & Management Procedures	$5.18	78%
Total Costs of Fee Increase For All Procedures Above	**$25.20**	

Appendix 1
Medicare Resource Based Relative Value Scale And Anesthesia Reimbursement

Medicare payments for physician services are made according to a fee schedule. For about 13,000 physician procedures, Medicare RBRVS assigns the associated relative value units and various payment policy indicators needed for payment adjustment. Medicare fees are adjusted depending upon the place of service that each procedure is performed. Medicare fees for some procedures are lower if they are performed in hospitals or skilled nursing facilities than if they are performed in offices or other places. Implementation of RBRVS resulted in increased payments to office-based procedures, and reduced payments to procedures that are provided in the hospital settings.

The Resource Based Relative Value Scale determines relative weights (relative value units) for all procedures. These weights reflect resource requirements of each procedure performed by physicians. The Medicare physician fees are adjusted to reflect the variations in practice costs from area to area. A geographic practice cost index (GPCI) has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and malpractice expense). The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component by the GPCI for that component.

The resulting weights are multiplied by a conversion factor to determine the payment for each procedure. The Centers for Medicare and Medicaid Services (CMS), annually updates the conversion factor based on the Sustainable Growth Rate (SGR) system, which ties the updates to growth in the national economy, as a measure of change in funds available for payments to physicians. The Sustainable Growth Rate system is based on formulas designed to control overall spending while accounting for factors that affect the costs of providing care.

Currently, there are efforts underway in the US Congress to change the Medicare physicians payments system to include "pay for performance" and quality improvement incentives instead of relying on the Sustainable Growth Rate (SGR) formula for updating the physicians' reimbursement rates.

The conversion factor for year 2000 was $36.6137. The conversion factor for 2001 was $38.2581, which represents a 4.5 percent increase over the year 2000 conversion factor. The conversion factor for 2002 decreased by 5.4 percent from its 2001 value to $36.1992. The conversion factor for 2003 increased by 1.6 percent from its 2002 value to $36.7856. The conversion factor for 2004 increased by 1.5 percent from its 2003 value to $37.3374. The conversion factor for 2005 also increased by 1.5 percent from its 2004 value to $37.8975. The conversion factor for 2006 was kept at its 2005 value of $37.8975.

Medicare payments for anesthesia services represent a departure from the RBRVS system. The most complex surgical, and usually primary procedure performed during any given surgical session is identified and linked to one and only one anesthesia code. The anesthesia time for any

additional procedures during the same operative session is added to the time for the primary procedure. This time is then converted to units with 15 minutes equal to 1 unit.

Each anesthesia procedure code has a non-variable number of base units. Similar to the RBRVS work value, the base units represent the difficulty associated with a given group of procedures. The base units for the selected anesthesia code are added to the units related to anesthesia time, and the result is multiplied by a conversion factor to convert to dollars. The Baltimore area Medicare conversion factor for 2006 is $18.04 per unit. The Program calculates the payment slightly differently by using minutes instead of quarter hour blocks, but the net result is the same.

Appendix 2

Summary of Methodology to Determine Maryland Medicaid Physicians Fees

The Department's methodology determines the new Medicaid fees for targeted procedures as a percentage of Medicare fees. First, we compare the existing Medicaid fee for each procedure with the corresponding Medicare fees. If the current Medicaid fee is higher than the Medicare fee then the Medicaid fee remains unchanged. The fees for the remaining procedures are set as a percentage of the corresponding Medicare fees. This percentage of Medicare fees is the same for all procedures that their fees increase.

The percentage of Medicare fees is the dependent variable in the process of determining the fees. The independent variable is the total amount of funds that are available for the fee increase. For the FY 2007 fee increase, the total state and federal matching funds available for the physicians fee increase were $25.2 million. For the FY 2007 fee increase, the percentage of Medicare fees was adjusted to 80% for integumentary, digestive surgery, radiation oncology, allergy / immunology, and dermatology procedures and to 100% of Medicare fees for ENT and anesthesia procedures. For evaluation and management procedures the fees were raised to about 78 percent of Medicare fees. The projected total cost of fee increase would be equal to the $25.2 million available funds. The projected cost of fee increase incorporates projected enrollment and utilization increases between the base year and the implementation year.

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