Are Surgeons Being Paid Fairly by Medicaid? A National Comparison of Typical Payments for General Surgeons

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BACKGROUND: Both the Medicare (MCR) and Medicaid (MCD) programs turn 50 this year. Medicare has developed a national resource-based payment methodology for physicians' services, with broad input by specialty societies, and MCD payments are set by individual states by various means.

STUDY DESIGN: We have conducted the first national comparison of payment methodology of MCD vs MCR for procedures commonly delivered by general surgeons. Using the most recent Centers for Medicare and Medicaid Services' Medicare data for frequency of allowed charges for general surgeons, we selected the most frequently billed procedures and gathered data from the 50 states for MCD and MCR payments. We determined the "Medicaid discount" (MCD payment minus MCR payment) expressed as dollars and percent, as well as dollars paid per relative value of work.

RESULTS: We have discovered wide variations in MCD payments among states for the same procedures, demonstrating unexplained "discounts" of MCD payments in relationship to MCR. We found that MCD payments show wide variations across the states, with many states paying far less than MCR for common, essential procedures.

CONCLUSIONS: These findings call into question the fairness of MCD reimbursement for general surgery services in the United States. This discount to MCR could act as a disincentive for surgeons to care for some patients, based on the state of residence. These unexplained discounts could have considerable long-term effects for patients dependent on the MCD program. Our study should act as a stimulus for states to examine their payment methodologies to provide more uniform and fairer payments for surgical procedures. (J Am Coll Surg 2016;222: 387−394. © 2016 by the American College of Surgeons. Published by Elsevier Inc. All rights reserved.)

In 1965, the Medicaid program was enacted by Congress as Title XIX of the Social Security Act, 42 U.S.C. § 1396 ("Medicaid Act") to provide "meaningful access to medical services" to poor or disabled Americans. Unlike Medicare, which is funded completely by the federal government, Medicaid is funded by the states, and the federal government provides matching payments on covered services that are consistent with minimum federal requirements.[1] Currently, Medicaid accounts for $1 of every $6 spent on health care in the United States and totals 48% of all federal funds spent by the states. Medicaid is financed by the following 4 mechanisms: Federal Medical Assistance Percentage, enhanced matching rates (for specific services/populations), Disproportionate Share Hospital payments, and state financing of their non-federal share.[2]

Medicaid financing therefore allows states to have broad flexibility in spending Medicaid dollars, including how providers are paid for services rendered. This results, however, in surgeons' fees for the care of Medicaid patients to be set by local state policy. To ensure that patients covered by Medicaid receive health care services, the "equal access provision" was added, requiring states to adopt payment rates that "are sufficient to enlist enough providers so that care and services are available

Disclosure Information: Nothing to disclose.

Presented at the Southern Surgical Association 127th Annual Meeting, Hot Springs, VA, December 2015.

Received December 19, 2015; Accepted December 21, 2015.

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http://dx.doi.org/10.1016/j.jamcollsurg.2015.12.044
ISSN 1072-7515/16

under the plan at least to the extent that such care and services are available to the general population in the geographic area."[1] Oversight of this provision and the overall Medicaid program is provided by the Centers for Medicare and Medicaid Services (CMS), part of the larger Department of Health and Human Services.

How can we be sure that individual state Medicaid payments for surgical services are fair reflections of the work delivered by surgeons? Comparing Medicaid payments with Medicare payments, at the state level, might offer a useful and robust mechanism to accomplish such a task. For a given procedure, and for a given state, we could use the Medicare payment as a relatively uniform and robust comparator with that state's Medicaid payment for the same service. In addition, using the underlying components of the Resource-Based Relatively Value Scale (RBRVS), we could also express those payments in terms of units of physician work, or dollars paid per relative value of work (RVW). How could we interpret these data? This process would allow us to understand, for a given procedure, the value that the federal government places on surgeon work via the Medicare payment vs the state's valuation via the Medicaid payment. Because many commercial payers now also base their fee schedules on some variant of Medicare, this becomes a potentially powerful calculation, as it can be used to assess the specter that Medicaid underpayment of procedures might negatively impact patient care, redirect referrals, or result in other undesired consequences for those patients covered under the state's Medicaid program.

METHODS

Selection of data to analyze

To determine the potential impact of Medicaid underpayment compared with Medicare, we first selected procedures, as defined by the CPT codes, that are common and familiar to general surgeons. We did that by analyzing the frequency of procedures listed in the Medicare allowed charges file, which is published annually by CMS,[3,4] and selected the procedures most commonly performed by general surgeons. We then trimmed the list to 13 codes that would represent the span of CPT surgical procedures performed, with both small and simple procedures, as well as more complex procedures being represented. Each state's Medicaid payment file was queried for the payment amounts for each CPT code. We also determined the Medicare payment for each selected CPT code by state, as modified by the geographic price costing index.[5]

State Medicaid and Medicare payments for CPT codes

The most current Medicaid fee schedules publicly available were obtained for each state (2014 or 2015 data). The Kansas and Tennessee Medicaid programs are not fee-for-service plans, and were therefore excluded. If modifiers for CPT codes were listed in the fee schedules, the CPT code with a single surgeon performing a unilateral surgery in a hospital setting was chosen. Medicare payment data were gathered from the CMS Medicare Physician Fee Schedule Carrier Specific file, which provided 2015 Medicare payment data for CPT codes for each state. In states with multiple Medicare payments based on different geographic regions, the nonspecific region was chosen indicated by "Rest of [state]." Facility rates were selected when both facility and nonfacility medical payments were available.

Medicaid discount and gap calculation

We arrayed each CPT code payment by state and then calculated the Medicaid difference (in dollars and as a percent) as defined by Medicaid (MCD) payment minus Medicare (MCR) payment (MCD − MCR = MCD discount or gap). This produced a Medicaid "discount" if the number was negative or a "gap" if the number was positive. Descriptive statistics were then performed on the 48 states in this analysis and selected examples of CPT codes with large Medicaid discounts are shown in Table 1. For each CPT code we displayed the maximum and minimum Medicaid discount or gap in both dollar amounts and percentages in Tables 2 and 3.

Medicaid discount and gap per unit of physician work

We purposely selected CPT codes that spanned the range from simple to complex procedures, for this analysis. But, that also means that there was a wide range of payments for those procedures. To best compare Medicaid payments within each state and across the nation, we had to convert that large range into a more meaningful metric. We therefore chose to express the dollars paid as a function of the RBRVS relative value of physician work for each CPT code. We determined the Medicare payment (adjusted for Geographic Practice Cost Index for that state) and then calculated the dollars paid per RVW. We repeated the same calculation for the Medicaid payment for that state, for each CPT procedure. We then calculated the difference between Medicaid and Medicare (in dollars and as a percent) by subtracting the Medicare payment per RVW from the Medicaid payment per RVW (MCD \$/RVW − MCR \$/RVW = Medicaid discount or gap \$/RVW). This allowed us to understand how much is

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