

# Medicaid Reimbursement

**Medicaid Rates and Provider Participation:**

Considerations for South Dakota Policymakers

Prepared by the South Dakota State Medical Association

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# Medicaid Rates and Provider Participation: Considerations for South Dakota Policymakers

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*"To promote the art and science of medicine,  
protect and improve the health of the public,  
and provide leadership and advocacy in the  
field of quality health care."*

## Introduction

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On behalf of its 1,900 members, the South Dakota State Medical Association (SDSMA) offers its perspective on the important issue of Medicaid reimbursement rates, particularly physician reimbursement.

The SDSMA has long expressed the concern of South Dakota's medical community that the state's Medicaid payment methodology results in payments that are substantially less than the actual cost of providing medical services to our Medicaid patients. For many states, including South Dakota, to stretch and efficiently use limited funding to ensure reasonable access to Medicaid beneficiaries and encourage provider participation results in a constant balancing act. As state policymakers struggle with the budget and Medicaid spending for acute and long-term services, some have sought to reduce or limit the growth of reimbursements as a cost-containment strategy.

However, this approach is counterproductive because reducing or limiting reimbursement rates inevitably contributes to access problems. Although many physicians continue to see Medicaid patients, an increasing number of physicians are less willing to take on new Medicaid patients and prefer patients covered by other types of insurance or payers that reimburse at higher levels. Reimbursement levels and access are inextricably linked, and as practice costs steadily rise at twice the rate of general inflation, further eliminating or postponing reasonable growth in provider reimbursement will only cause greater access problems across South Dakota and the United States.

The access problem is further complicated by our unique health care workforce recruitment and retention challenges. South Dakota is currently facing a shortage of physicians and will continue to struggle with physician recruitment and retention, especially in primary care, due to its demographics, lower payer reimbursement policies and other practice issues.

Medicaid is the largest children's health program in the country, and it is also the primary source of health care for low-income families, the elderly and the disabled. As an organization of physicians, the SDSMA is concerned that the continuing trend of inadequate payment in government health care programs will directly threaten access to quality health care for thousands of South Dakotans.

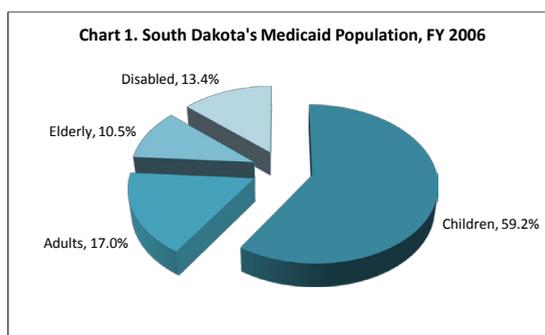


## South Dakota's Medicaid Population

According to the Kaiser Family Foundation's "State Health Facts," South Dakota's Medicaid enrollment as a percent of total population is 15 percent.<sup>1</sup> In FY 2007, South Dakota averaged 100,393 individuals (one in seven of the state's population) on Medicaid each month and served over 128,000 unduplicated recipients in the Medicaid program over the course of the year. At the end of FY 2007, South Dakota spent \$219 million in general funds on Medicaid, receiving \$420 million in matching federal funds (37.45 percent state, 62.55 percent federal).

South Dakota and its neighboring states all have a lower percentage of Medicaid enrollees as a percent of their total population compared to the U.S. average of 20 percent: Iowa, 15 percent; Minnesota, 15 percent; Montana, 12 percent; Nebraska, 14 percent; North Dakota, 11 percent; and Wyoming, 16 percent. Of these states, only Iowa, at 48.7 percent, has a lower percentage of children in its Medicaid population than the national average of 49.7 percent. South Dakota's Medicaid proportion of children is over 10 percentage points higher than the national average at 59.2 percent.

Of the remaining enrollees in FY 2006, adults accounted for 17.0 percent of the Medicaid population, with elderly at 10.5 percent and disabled at 13.4 percent (Chart 1).



Source: Kaiser Family Foundation "State Health Facts"

## What SD Physicians are Saying ...

"South Dakota is in the top percentile of states as far as having good outcomes for medical care. We are near the bottom in medical costs per patient ... about half as much per patient ... versus the most expensive states. Our reimbursement rates are much lower and our outcomes are much better. Medicare and Medicaid should reimburse based on outcomes or at least reimburse quality care here as much as is reimbursed in the high reimbursement states such as Florida, Texas and California."

"As a federally qualified health center (FQHC) we accept all Medicaid patients, but they have difficult situations and are more complex and occasionally more needy than other patients."

Source: SDSMA Physician Survey, June 2009

"I wish that I didn't have to worry if my patients can pay or not. Poor Medicaid reimbursement forces doctors to stop seeing or limiting their Medicaid patients. It forces physicians into developing 'boutique' clinics that care only for patients who can pay the best reimbursement."

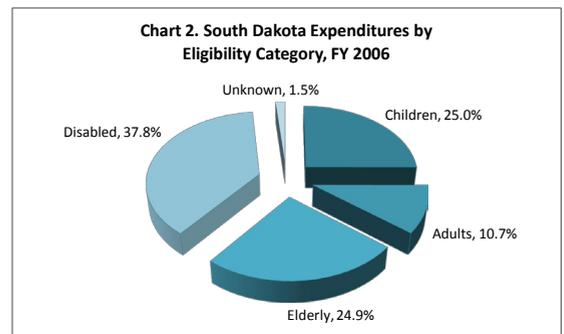
"The cost of providing care for Medicaid should be spread throughout the population. The health care provider is already giving the care at a level that not only does not reimburse the care giver; the reimbursement is less than the overhead cost. If reimbursement is not upgraded, care givers will have to reduce the number of Medicaid patients they provide care for."

"Who will take care of [Medicaid patients] if payment reform and the primary care crisis is not solved?"

Further, three of the top five poorest counties in the nation are located in South Dakota. According to the most recent U.S. Census data, more than 72,000 American Indian residents live in the state, and 55 percent are on Medicaid. Eighty percent of American Indian children have their health care paid for by Medicaid.

In FY 2006, Medicaid payment distributions for South Dakota by enrollment group were as follows (Chart 2):

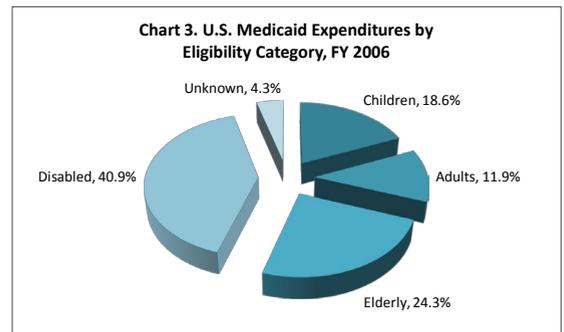
• Children	25.0 percent (\$2,145 per enrollee)
• Adults	10.7 (\$3,209)
• Elderly	24.3 (\$12,066)
• Disabled	37.8 (\$14,296)
• Unknown	2.2 (\$5,072)



Source: Kaiser Family Foundation "State Health Facts"

The U.S. average for the same eligibility categories in FY 2006 is as follows (Chart 3):

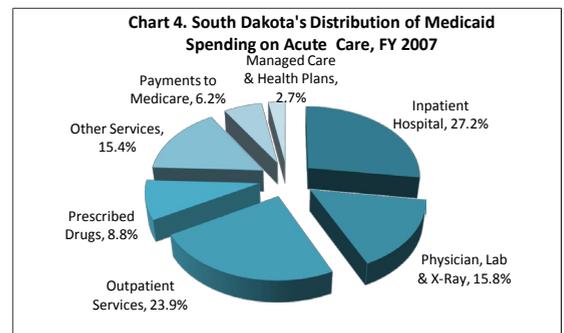
• Children	18.6 percent (\$1,708 per enrollee)
• Adults	11.9 (\$2,142)
• Elderly	24.3 (\$10,691)
• Disabled	40.9 (\$12,874)
• Unknown	4.3 (NA)



Source: Kaiser Family Foundation "State Health Facts"

In South Dakota, acute care accounted for 57.9 percent, or \$360 million, of Medicaid's total spending in FY 2007, followed by long-term care at 41.9 percent and disproportionate share hospital payments at 0.2 percent. South Dakota's acute-care spending is detailed in Chart 4.

Nationwide, acute care accounted for 60.9 percent of the total distribution of Medicaid spending by service, followed by long-term care at 34.1 percent and disproportionate share hospital payments at 5.0 percent.



Source: Kaiser Family Foundation "State Health Facts"

## Medicaid Reimbursement and its Impact on Physician Participation and Access to Care

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As indicated, Medicaid is undeniably an integral part of our state's health care system and is used by thousands of South Dakotans who need it most – the disabled, the poor, the elderly and the young. Physicians do their part in providing access to quality medical care for the state's Medicaid beneficiaries while receiving reimbursement rates that are often less than the cost of providing that care. According to fee data collected over the past 15 years by the American Medical Association (AMA), on average, state governments have not improved payments for Medicaid patients relative to those of other major public payers, and surveys suggest that physicians are less likely to accept new Medicaid patients than other insured patients.<sup>2</sup>

Despite increases in Medicaid payment rates and increasing beneficiary enrollment, the proportion of U.S. physicians accepting Medicaid patients has decreased over the past decade, according to a national study by the Center for Studying Health System Change (HSC).<sup>3</sup> From 2004 to 2005, 14.6 percent of physicians in the United States reported they received no revenue from Medicaid, an increase from 12.9 percent in 1997. There has also been an increase in the percentage of physicians not accepting new Medicaid patients. As a result, the care of Medicaid patients is becoming increasingly concentrated among a smaller number of physicians who tend to practice in large groups, hospitals and community health centers.<sup>3</sup> A similar trend exists in South Dakota and further suggests that reimbursement and access to care are linked.

In a June 2009 SDSMA survey of its physician members, 90.8 percent of those surveyed stated that Medicaid does not pay enough to cover their overhead costs.<sup>4</sup> The bottom line is that an overwhelming majority of physicians lose money on Medicaid patients. This phenomenon ultimately leads physicians into cost-shifting their losses to the private sector, driving up health care costs across the board.

In the same SDSMA survey, 30.3 percent of those surveyed indicated that due to current reimbursement levels they have stopped accepting new Medicaid patients and only continue to see existing Medicaid patients; an additional 2.5 percent have stopped accepting Medicaid patients altogether.<sup>4</sup>

When compared to other payers (non-Medicaid), 63.9 percent of physicians surveyed said they accept all other new patients (including Medicare), and an additional 31.1 percent indicated they accept some new patients.<sup>4</sup> These numbers illustrate an alarming disparity that has a direct impact on access to care.

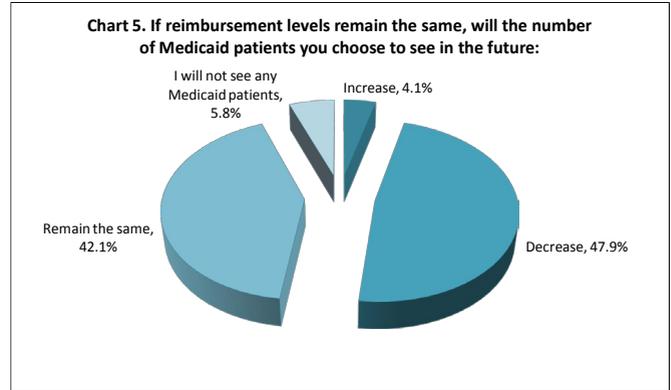
Further, when asked what number of Medicaid patients they would see if reimbursement levels remained constant in future years, 47.9 percent indicated they would decrease their Medicaid patient load, and 5.8 percent said

they would not see any Medicaid patients. Only 4.1 percent said they would increase their Medicaid patient load (Chart 5).<sup>4</sup> These troubling statistics may be exacerbated by South Dakota’s FY 2009 budget, which contains no discretionary provider inflationary update.

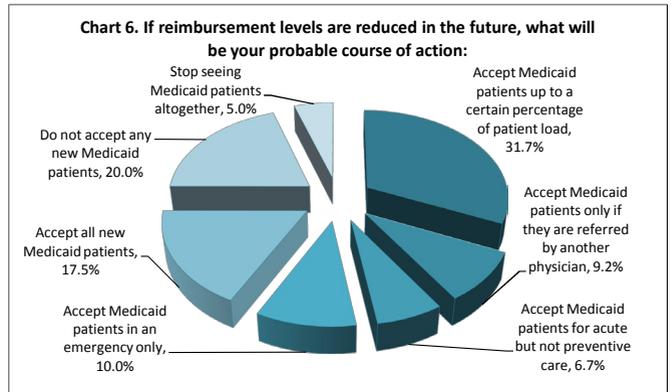
When asked what their probable course of action would be if Medicaid reimbursement levels are reduced in future years, only 17.5 percent of physicians surveyed indicated they would accept “all new Medicaid patients.” Conversely, the remaining 82.5 percent surveyed stated they will limit their Medicaid patient load or stop seeing Medicaid patients entirely (Chart 6).<sup>4</sup>

With limited access to providers, too many Medicaid patients do not get the care they need. According to the American Medical Association’s (AMA) Physician Consortium for Performance Improvement, adults in the United States currently do not receive almost half of the clinical services from which they would likely benefit. Any reduction in access to care by failing to support an already underfunded program will only increase this number and add to the total cost of care.

Beyond new members, many current Medicaid beneficiaries find that their access to doctors is limited. In 2007, approximately 20 percent of the U.S. population reported not getting or delaying needed medical care at some point in the previous 12 months, up significantly from 14 percent in 2003. That same year, more than 23 million people reported going without needed care and approximately 36 million people delayed seeking care, for a total of 59 million people reporting access problems, according to findings from HSC’s nationally representative 2007 Health Tracking Household Survey.<sup>5</sup> Many Medicaid patients who delay needed medical care end up seeking it in the most expensive place – the hospital emergency room – which ultimately drives up the overall cost of care. For example, in 2006, more than one-third of all ambulatory visits for people on Medicaid in the United States went to a hospital emergency room or outpatient department, compared to just 14 percent of visits by people with private insurance.<sup>6</sup>



Source: SDSMA Physician Survey, June 2009



Source: SDSMA Physician Survey, June 2009

## Medicare's Impact on Medicaid

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 a 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.

In Medicare, there is substantial geographic disparity in patient services and physician reimbursement levels which has an increasingly negative impact on patient care and access in South Dakota. Table 1 compares South Dakota's Medicaid fees as a percentage of Medicare fees to other states in the Midwest for certain services. When compared to its neighbors, South Dakota's Medicaid fees (95 percent of Medicare fees for all services) are the lowest in the region. Although Medicaid payment rates increased modestly relative to Medicare rates between 1998 and 2003, they are still substantially lower than what private insurance pays and fail to cover provider costs.

Region	All Services	Primary Care	Obstetric Care	Other Services
South Dakota	0.95	0.85	1.09	1.05
Iowa	0.96	0.89	1.08	0.99
Nebraska	1.01	0.82	1.19	1.24
North Dakota	1.02	1.01	10.3	1.02
Montana	1.03	0.96	1.19	1.24
Wyoming	1.43	1.17	2.13	1.23

According to a recent study, the Medicaid to Medicare fee index for all services combined ranges from a low of 0.37 to a high of 1.43. And while Medicaid physician fees increased 15.1 percent nationwide from 2003 to 2008, or at an average annual rate of increase of 2.6 percent,

over the same period of time the consumer price index increased 20.3 percent, an annual rate of 3.4 percent. In real terms, Medicaid physician fees are declining about 1 percent annually relative to general inflation and 2 percent annually relative to medical care services inflation.<sup>2</sup>

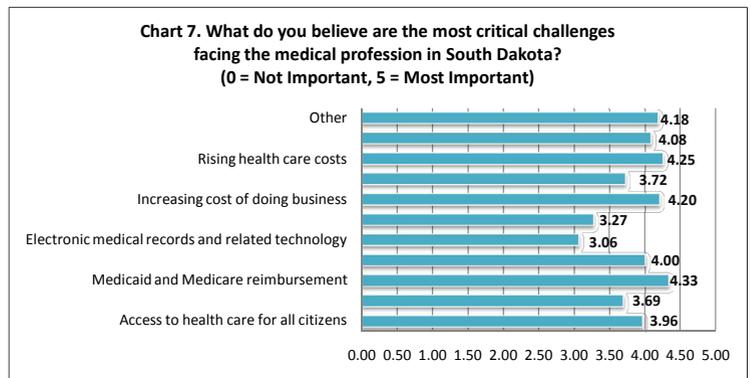
Source: Kaiser Family Foundation "State Health Facts"

Many physicians still see Medicaid patients even as the gap between inflation and reimbursement continues to widen, but, as illustrated, a growing trend among physicians is to limit not only their number of Medicaid patients, but also the time they have available for caring for patients on Medicaid. In times of tight finances, state officials turn to factors under their control to contain 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 fails as a long-term Medicaid policy. Without sufficient reimbursement for Medicaid services, provider participation and access to care decline, the state's Medicaid program will become increasingly inefficient, and as a result, Medicaid beneficiaries seek treatment in expensive emergency room settings for primary care services. The resulting inefficiency in health care delivery ends up increasing costs to local taxpayers or to those who are privately insured. Underfunding temporarily postpones the expenditures needed to sustain reasonable reimbursement levels and will only require large appropriations to "catch up" with more reasonable rate levels in the future.

## The “Cost” of Care

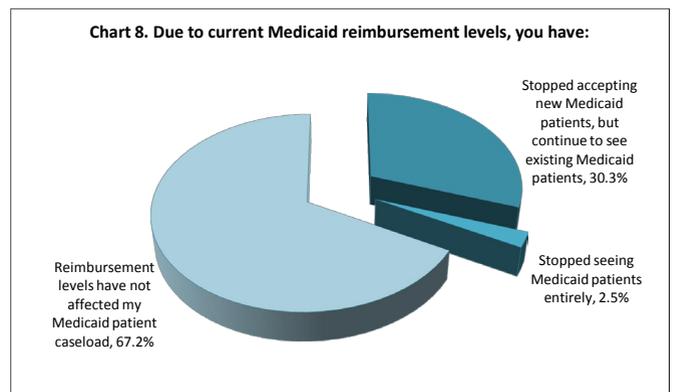
Physicians are ethically bound to support access to medical care for all people, and the SDSMA has been very involved in efforts to ensure the long-term sustainability of the Medicaid program in South Dakota. Medicaid physician reimbursement levels undoubtedly have a dramatic impact on a physician’s bottom line, but what is often lost in the shuffle is how the business side of medicine can contradict a physician’s ethical obligation of providing care. How a physician is able to juxtapose operating an efficient business with accepting all comers often leads to difficult questions and undesirable consequences.

“If you end up seeing patients that cost you money to see, and you have no other ability to make up for that ... then you have to decide if you’re going to continue to see more Medicaid patients,” said Tom Huber, MD, president-elect of the SDSMA in a March 2009 interview for KELO-TV. “If taking care of more people under the Medicaid program means my business no longer survives, then I’m doing a disservice to all the other patients, and that’s the dilemma that physicians are facing.”<sup>7</sup> Dr. Huber’s sentiments are echoed by comments made by physicians in the recent SDSMA survey (see sidebars).



Source: SDSMA Physician Survey, June 2009

When SDSMA members were asked to rate the most critical challenges facing the medical profession in South Dakota, Medicaid and Medicare reimbursement received the highest rating (4.33 out of 5), signifying they view it as the most important issue facing their practices. Reimbursement was closely followed by rising health care costs (4.25) and the increased cost of doing business (4.20). Access to health care for all citizens received a 3.96 rating, well below the other cost-driven responses (Chart 7).<sup>4</sup> These ratings clearly illustrate how rising cost factors into the practice of medicine and reimbursement levels threaten access to care. Additionally, when asked what impact current Medicaid reimbursement levels have had on their practice, 30.3 percent of SDSMA physicians surveyed indicated they have stopped accepting new Medicaid patients (Chart 8).<sup>4</sup>



Source: SDSMA Physician Survey, June 2009

The problem is further compounded by the fact that when compared to the rest of the country, South Dakota, at 15 percent, has an above-average proportion of Medicare patients. And, at 14 practicing physicians per 1,000 beneficiaries, South Dakota has a below-average ratio of physicians to Medicare beneficiaries. Also, 42 percent of South Dakota's practicing physicians are over 50, an age at which studies have shown many physicians consider reducing their patient care activities.<sup>8</sup>

These are important statistics to keep in mind when discussing the dilemma physicians across the state face as they contemplate taking more public-payer beneficiaries. Medicaid pays doctors only 56 percent of private coverage and hospitals receive 67 percent. Because many Medicaid beneficiaries tend to seek care from primary care physicians, these specialty groups, including family medicine, internal medicine, and pediatrics (Medicaid only), are often overburdened by beneficiaries of both Medicare and Medicaid, forcing them to reduce the number of these types of patients they see at the cost of keeping their business alive. According to a 2004 to 2005 study by the American Academy of Pediatrics, South Dakota Medicaid pays less than 61 percent of the Medicare value for over one-third of the most common pediatric services, which results in fewer pediatricians participating in Medicaid and further threatening access to quality health care for children within the state.<sup>9</sup>

## What SD Physicians are Saying ...

"I am providing quality care to my patients at times at a loss due to [Medicaid] reimbursement."

"The increasing numbers on Medicaid without increases in reimbursement will force physicians to stop seeing Medicaid patients."

"Medicaid pays us about \$25 for \$100 in charges. You can't keep a clinic open at that rate if we see more and more Medicaid patients."

"It's hard for doctors who want to see patients to turn them away because of political issues. Makes it tough in rural areas because these patients are often our neighbors."

"Reimbursement is really the only thing I worry about [regarding Medicaid]. I can't keep giving away services and keep the lights on at the same time."

"I cannot afford to have my schedule completely filled by Medicaid patients. The reimbursement is not sufficient to cover operating costs if I saw a higher percentage of Medicaid patients."

"[Medicaid] reimbursement is below the cost of doing business."

"Negative reimbursement IS the primary reason for not accepting any more Medicaid patients."

"In an emergency department, because of EMTALA (Emergency Medical Treatment and Active Labor Act), we need to see all Medicaid patients that present for care. If Medicaid reimbursement for office physicians does not stay sufficient, then the patients will not be seen in the office and forced to use emergency rooms more often."

Source: SDSMA Physician Survey, June 2009

## Increasing the Federal Match

Although some states have initiated provider taxes in various forms as a means of generating extra revenues, the SDSMA is opposed to the implementation of a selective revenue tax on physicians and other health care providers. The SDSMA also opposes the use of provider taxes or fees to fund health care programs or to accomplish health system reform. The cost of taxes which apply to medical services should not be borne by physicians, but through adequate broad-based taxes for the appropriate funding of Medicaid and other government health care programs.<sup>10</sup>

Physician taxes are highly inefficient and have only complicated matters in states in which they exist. For example, in Minnesota where a broad-based health care provider tax has been in effect for over 10 years, health care premiums have skyrocketed due to the 2 percent tariff. The unintended consequence of these increased premiums has been an increase in the number of uninsured citizens, the very people the tax was purportedly created to help.<sup>11</sup>

When asked if they believed a provider tax was necessary to boost Medicaid funding in South Dakota, 95.1 percent of SDSMA physicians surveyed indicated “No.”<sup>14</sup> In comments that followed this survey question (see sidebar), the overwhelming response was that physicians believe a provider tax would be a penalty, especially given the disproportionate number of Medicare patients seen in South Dakota and the fact that many South Dakota physicians already provide significant amounts of charity care, also known as uncompensated care.

An AMA survey in 2001 determined that 64.5 percent of physicians nationwide provide charity care (over 361,000 physicians). On average these physicians provide 7.5 hours of charity care per week totaling \$54,468 per physician each year (\$19.7 billion annually). In South Dakota, it’s estimated that \$13.3 million of charity care (roughly \$7,350 per licensed physician in South Dakota) is provided each year.<sup>12</sup> Pediatricians are the least likely to provide charity care (fewer children are uninsured), and levels of charity care are highest among physician in solo or group practices and those who are full or part owners of their own practice. Constraints from payers have already created financial pressures that may be limiting physicians’ ability to provide charity care, as is the physician movement toward larger practice arrangements and less ownership.

### What SD Physicians are Saying ...

“Providers are already subsidizing the [Medicaid] program.”

“It’s adding insult to injury if you tax me for giving charity care, basically.”

“A provider tax would drive physicians away from seeing Medicaid patients at all; thus serving as a barrier to access of care for a very high-risk population.”

“Why should physicians already accepting reduced payment be expected to further fund the program?”

“A provider tax would ultimately make it cost providers even more to see a group of patients that is already causing us to lose money. That would basically be punishing us for seeing these patients, and I feel will cause providers to limit their Medicaid load even more or stop seeing these patients. In the long run I think this would hurt the program because more patients will have difficulty accessing quality care, causing the patients to get sicker and, ultimately, cost the system more to care for even sicker patients.”

Source: SDSMA Physician Survey, June 2009

## Conclusion

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The SDSMA is dedicated to protecting the health care interests of patients and enhancing the effectiveness of medical care throughout South Dakota. Its mission is to promote the art and science of medicine, protect and improve the health of the public, and provide leadership and advocacy in the field of quality health care. In South Dakota, 128,000 unduplicated individuals were covered by Medicaid in FY 2007. Nearly one in eight persons are covered by Medicaid or SCHIP in any given month, and one in three persons under 19 are covered by Medicaid or SCHIP. Fifty percent of children born in South Dakota are on Medicaid in the first year of life.<sup>1</sup>

While Medicaid funding has slowly increased over the years, it is significantly less than the inflationary rate at which the cost of providing care has grown. Physicians in South Dakota and across the United States have already begun to reduce their Medicaid patient load, and the failure to update Medicaid physician reimbursement will ultimately lead to a disparity in access to care for those on Medicaid compared to the privately insured. Currently, 30.0 percent of the state's physicians are not accepting any additional or new Medicaid patients, and 47.9 percent have stated they will be forced to decrease the amount of Medicaid patients they see in the future if reimbursement levels fail to receive sufficient updates. More concerning is the fact that any reduction of current levels will result in 82.5 percent of South Dakota's physicians limiting or refusing to see Medicaid patients entirely.<sup>4</sup>

Reimbursement levels and access to care are inextricably linked, causing an ethical dilemma for many physicians who took an oath to provide care to those who need it most. Seeing more patients who rely on underfunded government programs to grant them access to care will ultimately lead to a reduction in care, whether it's due to a pediatric office closing its doors to new patients or because a rural physician can no longer afford to stay in business.

Medicaid is undeniably an integral part of South Dakota's health care program, and the SDSMA looks forward to working with the South Dakota State Legislature in addressing the need for equitable payment for Medicaid medical services.



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