South Carolina Department of Health and Human Services 2010 Fee Schedule Comparison

Purpose: To compare Medicaid's physician reimbursements to those of the Employee Insurance Program (EIP) and Medicare.

Methodology: In order to accurately measure the relationship between the Medicaid, EIP, and Medicare fee schedules, a methodology was developed that reflects frequency of a given procedure as well as the allowance for the procedure. To elaborate, if an allowance has been established for a procedure that has low frequency and is "above market" in terms of fee allowance, the financial impact is not as pronounced as a procedure that has high volume and is "above market" with respect to reimbursement.

The first step in the analysis was to build a file that listed for each procedure code, the established allowance for the Medicaid, EIP, and Medicare programs. For 2010, a number of revisions have been made to the Medicaid, EIP and Medicare physician reimbursement systems. Some of the highlights are:

1) Medicaid has moved from physician reimbursement at 86% of the 2008 South Carolina Medicare allowance with a fully implemented site of service differential to 86% of 2009 South Carolina Medicare with a fully implemented site of service differential. Enrolled pediatric subspecialists are reimbursed at 120% of 2009 Medicare for neonatal intensive care (NICU) services and evaluation and management (E and M) services, and all other services are at 100% of 2009 Medicare. Last year, enrolled pediatric subspecialists were reimbursed at 120% of 2008 Medicare for NICU and E and M services and 100% of 2008 Medicare for all other services. The site of service differential approach establishes different reimbursements for services that can be safely performed in a non-facility setting. The goal of a site of service differential is to incent physicians to perform services in a non-facility setting by establishing an allowance for a specific service that is lower in a facility setting. Because the program typically incurs both facility and professional claims for services performed in a facility setting, the program will save claim expense for every service that is shifted to the non-facility setting. SC DHHS utilized the non facility and facility allowance relativity defined by CMS in the RBRVS methodology.
2) EIP has established allowances that are relative to the South Carolina 2009 Medicare allowances (both facility and non facility). Relativity generally ranges from 100% to 150% of Medicare. Clinical lab is reimbursed using Blue Cross and Blue Shield of South Carolina's laboratory network

allowances. The focus of the 2010 update was on E and M services – greater than 99.5% of the SHP update was focused on this type of service. Overall, the impact of the EIP fee schedule update in 2010 is a .2% increase in unit cost reimbursement over 2009 levels.

3) For 2010, Medicare has adjusted its conversion factor from 36.0666 to 36.0846 (an increase of .0499%). This update was the result of an intervention by Congress that cancelled an approximately 21.2% decrease in the RBRVS conversion factor. CMS has also adjusted a number of relative weights in the 2010 package as well as made other budget neutrality adjustments. Because of the other adjustments to the system, the impact of the conversion factor update varies based on procedure mix.

Once the combined fee file for the study period was built, a procedure specific summary of frequencies for the Medicaid program was compiled. The time period for this summary was services incurred from July 1, 2008 to June 30, 2009. Only final status claims are included in the analysis; correction and adjustment records are ignored.

The next step of the process was to combine the compiled fees with the Medicaid frequency file. Please note that an individual procedure code must meet the following criteria to be included in the analysis:

1) The procedure had Medicaid frequency during the study period.
2) EIP has established an allowance.
3) Medicaid has established an allowance.
4) Medicare has established an allowance.

The following record is an example from the analysis file.

				State Health Plan		South Carolina Medicare		Average South Carolina Medicaid	
CPT4 Procedure Code	Procedure Description	Non Facility Units	Facility Units	Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
99213	OFFICE/OUTPATIENT VISIT, EST	555,822	56,771	58	43	61.09	45.39	50.42	37.39

The analysis file contained 3,802 such records.

Analysis and Discussion: To complete the analysis, the frequency for each procedure was multiplied times the allowance for each program. The sum of these products is the fee schedule relativity for that schedule that takes into account the frequency of procedures.

To summarize, based upon the frequency of procedures during the time period, and the fee allowances currently in place:

- The Medicaid allowance is worth 77.46% (in aggregate) of the EIP fee schedule.
- The Medicaid allowance is worth 90.74% (in aggregate) of the Medicare fee schedule.

The current relativity is consistent with the update implemented on July 1, 2009 that included restoration of maternity allowances to 2008 levels. The following table summarizes the historical Medicaid to Medicare relativity:

- 2009 – 87.04%
- 2008 – 90.94%
- 2007 – 90.06%
- 2006 – 89.90%
- 2005 – 75.15%
- 2004 – 74.23%
- 2003 – 72.19%

The following table summarizes the top 10 Medicaid procedures:

CPT4 Procedure Code	Procedure Description	Non Facility Units	Facility Units	SHP Non Facility	SHP Facility	Medicare Non Facility	Medicare Facility	DHHS Non Facility	DHHS Facility
99213	OFFICE/OUTPATIENT VISIT, EST	555,822	56,771	58.00	43.00	61.09	45.39	50.42	37.39
99214	OFFICE/OUTPATIENT VISIT, EST	266,428	19,612	88.00	67.00	91.66	70.08	75.98	57.84
99283	EMERGENCY DEPT VISIT	0	140,717	77.00	77.00	57.91	57.91	51.00	51.00
99284	EMERGENCY DEPT VISIT	0	85,515	120.00	120.00	108.83	108.83	95.72	95.72
99285	EMERGENCY DEPT VISIT	1	39,513	188.00	188.00	160.77	160.77	142.58	142.58
59409	OBSTETRICAL CARE	63	12,111	1,032.00	1,032.00	667.62	667.62	1,200.00	1,200.00
99232	SUBSEQUENT HOSPITAL CARE	28	153,930	65.00	65.00	64.74	64.74	55.97	55.97
92507	SPEECH/HEARING THERAPY	307,756	1,850	60.00	37.00	58.83	24.83	49.00	21.47
59514	CESAREAN DELIVERY ONLY	0	5,872	1,032.00	1,032.00	791.97	791.97	1,200.00	1,200.00
99469	SUBSEQUENT INPATIENT NEONATAL CRITICAL CARE	0	5,330	455.00	455.00	364.70	364.70	345.43	345.43

The following table summarizes the top 10 Berenson-Eggers Type of Service (BETOS) categories. The excess relativity to Medicare in the "Major procedure – Other" category is a function of the Medicaid allowances for obstetric procedures – Medicare allowance for these procedures are not generally considered appropriate. The excess relativity in the "Hospital visit – critical care" is driven by Medicaid's allowances for NICU care for newborn children, another category of service that is not high volume in the Medicare program.

				Medicaid Relativity	
Type of Service	Medicaid Value	Medicare Value	SHP Value	Medicare	SHP
Office visits - established	58,336,649	69,965,329	67,315,274	83.38%	86.66%
Emergency room visit	21,669,800	24,777,398	29,497,954	87.46%	73.46%
Major procedure - Other	27,169,585	19,013,825	27,367,735	142.89%	99.28%
Hospital visit - subsequent	18,968,772	21,547,546	21,584,225	88.03%	87.88%
Hospital visit - critical care	8,528,541	7,992,695	9,713,653	106.70%	87.80%
Specialist - other	19,436,555	23,179,044	24,459,340	83.85%	79.46%
Minor procedures - other (Medicare fee schedule)	5,126,630	5,845,212	8,090,169	87.71%	63.37%
Echography/ultrasonography - abdomen/pelvis	6,332,744	7,169,150	11,243,605	88.33%	56.32%
Ambulatory procedures - other	3,993,575	4,651,178	7,464,849	85.86%	53.50%
Office visits - new	7,901,968	9,546,768	9,097,634	82.77%	86.86%