Joint Legislative Audit and Review Commission

The Virginia General Assembly

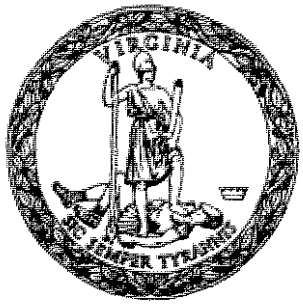
Medicaid-Financed Physician and Pharmacy Services in Virginia

A Report in a Series
on the Virginia Medicaid Program

REPORT OF THE
JOINT LEGISLATIVE
AUDIT AND REVIEW COMMISSION ON

Medicaid-Financed Physician and Pharmacy Services in Virginia

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA



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Preface

Senate Joint Resolution (SJR) 180 of the 1991 Session of the General Assembly directed the Joint Legislative Audit and Review Commission (JLARC) to conduct a comprehensive study of the Virginia Medicaid program. This report is one in a series of reports which addresses issues outlined in SJR 180. The focus of this report is on the provision of Medicaid physician and pharmacy services. The report also assesses related utilization review activities and other cost control activities.

Over the past ten years, Medicaid expenditures for physician and pharmacy services have steadily grown, with dramatic increases occurring in the late 1980s and early 1990s. Much of these recent increases have been the result of deliberate program expansions at the federal and State level, particularly those targeted at indigent pregnant women and children. These expansions have transformed the Medicaid program into a de facto national health care program for many indigent persons.

Although expenditures have grown, the Medicaid program employs a conservative reimbursement methodology for physician services. Recent reimbursement increases for obstetric and pediatric services have been successful in maintaining physician participation in the Medicaid program. However, additional steps are necessary to enhance physician participation and improve Medicaid recipient access to care.

The growth in pharmacy expenditures appears to be slowing due to the implementation of a federally-mandated drug rebate program. However, additional alternatives exist to further curtail the growth in these expenditures. This report contains a number of recommendations concerning cost control options for the future.

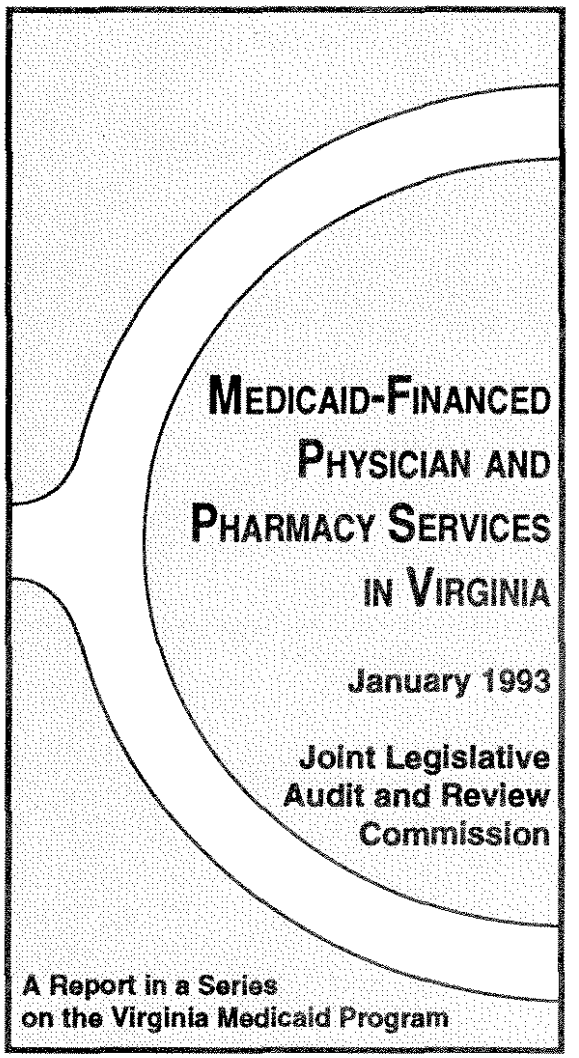
Utilization review activities conducted by the Department of Medical Assistance Services to control fraud and abuse in the Medicaid program meet federal minimum requirements. Nevertheless, several steps could be implemented to further strengthen these activities.

On behalf of JLARC staff, I would like to thank the director and staff of the Department of Medical Assistance Services for their cooperation and assistance during the course of this review. In addition, I would also like to thank the various physician and pharmacy professional associations for their assistance.

Philip A. Leone
Director

January 15, 1993

JLARC Report Summary



The Virginia Medicaid program is a joint federal-state program authorized under Title XIX of the Social Security Act. It is the largest of the State's health care programs for indigent persons. Total program expenditures for medical care were about $1.2 billion in FY 1991, representing a 30 percent increase from the previous fiscal year. In FY 1992, expenditures continued to grow, increasing by 16 percent to about $1.4 billion. The number of persons receiving Medicaid services has also increased significantly. In FY 1991, the number of recipients grew by 17 percent to 428,650. Growth continued in FY 1992, when the number of recipients grew about 16 percent to 495,516.

The 1991 General Assembly passed Senate Joint Resolution (SJR) 180 in response to concerns about rapidly escalating costs of the Medicaid program. The resolution directed the Joint Legislative Audit and Review Commission (JLARC) to conduct a comprehensive review of the Virginia Medicaid program.

This report is the one in a series on the Virginia Medicaid program. It presents an analysis of Medicaid-financed physician and pharmacy services. It also overviews other ambulatory care services provided through the program. In addition, the report provides an assessment of Medicaid efforts to contain program costs for services through two specific mechanisms: (1) post-payment review of program expenditures and (2) activities to pursue third-party liability for services provided through the program.

Medicaid reimbursement for ambulatory care services (excluding hospital outpatient services) in FY 1991 represented about one-quarter ($280 million) of total Medicaid expenditures for medical care. Of this $280 million, 80 percent or about $225 million was spent on physician and pharmacy services.

In recent years, Medicaid expenditures for physician and pharmacy services have increased dramatically. These increases have been largely the result of growth in the number of program recipients due to recent federal mandates to expand Medicaid eligibility. The U.S. Congress has incrementally extended Medicaid coverage to larger numbers of uninsured citizens by linking eligibility for certain categories of individuals to the federal poverty income level. Consequently, the Medicaid program has become a *de*

facto national health care program for many indigent persons.

Despite these large increases in recipients and their attendant costs, coverage through the Medicaid program is cost effective. In FY 1991, the Medicaid program spent, on average, $688 per recipient to provide reimbursement for ambulatory care services. The average cost per recipient to provide Medicaid reimbursement for physician and pharmacy services was $406 and $322, respectively.

The Medicaid Program Has Experienced Rapid Increases in Expenditures for Physician Services

Medicaid expenditures for physician services have more than quadrupled over the past ten fiscal years to $168 million in FY 1992. The increases in expenditures for physician services have outpaced increases in total Medicaid expenditures for medical care and annual rates of inflation. Most of the growth in expenditures for physician services, however, coincided with program changes implemented between FY 1989 and FY 1991.

For example, much of the recent growth in physician expenditures is due to federally-mandated eligibility expansions, particularly those targeted at increasing Medicaid enrollment of indigent pregnant women and indigent children. In addition, recent reimbursement rate increases account for a portion of the growth in expenditures for physician services.

The Medicaid Program Employs a Conservative Reimbursement Methodology for Physician Services

States have broad discretion in determining fee levels and payment methodologies for physician services. Federal regulations for physician reimbursement require that payment be consistent with principles of efficiency, economy, and quality of care. The Virginia Medicaid program employs a conservative reimbursement methodology for physician services. Recent increases in Medicaid physician reimbursement rates were necessary to maintain physician participation in the Medicaid program.

The Virginia Medicaid program reimburses physician services on a fee-for-service basis, according to a fee schedule. This reimbursement is based on charges from a past claims year. Consequently, reimbursement may not keep pace with inflation in physician practice costs and charges for services.

Medicaid reimbursement of physician services is generally lower than reimbursement by other third party payers. Studies conducted by the U.S. Physician Payment Review Commission and responses to a 1992 JLARC survey of Medicaid-enrolled physicians support this conclusion. In addition, physician associations reported that other third party payers generally reimburse between 60 and 80 percent of charges or more.

Patient Cost-Sharing Does Not Appear to Meet Its Intended Goal

Physician reimbursement is further reduced relative to actual charges because many providers cannot collect patient cost-sharing amounts. Virginia requires some Medicaid beneficiaries to share the costs of their care by making a copayment for services. Theoretically, a copayment should discourage unnecessary utilization by Medicaid recipients, thereby reducing program expenditures for physician services. However, providers cannot deny services if a recipient does not pay the copayment, even though their reimbursement is reduced by the copayment amount.

In FY 1991, the total amount of reimbursement reductions due to required copayments for physician services was about $56,000. Although some physicians responding to the JLARC survey support the concept of copayments to control utilization,

these copayments do not appear to be effective in controlling recipient utilization. About one-third of the physicians who responded to the JLARC survey indicated that they do not generally collect copayments from their Medicaid patients, because the recipients are unwilling or unable to pay their share.

Recommendation. *The General Assembly may wish to consider abolishing the copayment requirement for physician services.*

Addressing Physician Concerns Regarding Recipient Education May Maintain and Improve Physician Participation

Low Medicaid reimbursement has a negative effect on physician participation in the program; however, other factors such as recipient behavior also appear to negatively influence participation rates by physicians. Physician concerns about recipient behavior point to the need for recipient education through the Medicaid program on patient responsibilities. This is especially important as Virginia implements statewide managed care for Medicaid recipients.

Recommendation. *The Department of Medical Assistance Services should design and implement a recipient education program on patient responsibilities and appropriate utilization. This program should receive high priority so that it may be implemented in conjunction with expansion of the managed care program statewide.*

Further Expansion of Medicaid Managed Care Could Enhance Physician Participation and Improve Recipient Access

Virginia has implemented a managed care program called "Medallion" which currently operates in four pilot localities. Recipients participating in Medallion can only access certain services through an assigned primary care physician. The General Assembly directed that the Medallion program be expanded statewide during FY 1993.

Even though average costs for other ambulatory adult recipients such as aged, blind, and disabled recipients are relatively high, the Medallion program will only cover recipients who are classified as ADC-related, indigent pregnant women, or indigent children. Inclusion of these other adults in the Medallion program could help address what may be an access problem for aged and disabled recipients.

Currently, local health department clinics are not required to serve elderly and disabled patients. Also, physicians who practice general internal medicine (those who are likely to treat these patients) reported lower participation rates than other physicians who responded to the JLARC survey. Inclusion of these recipients in the Medallion program could encourage greater physician participation among these physicians because they would receive greater reimbursement, without a rate increase, through the monthly Medallion case management fee.

Recommendation. *The General Assembly may wish to consider directing the Department of Medical Assistance Services to expand the Medallion program to include all ambulatory recipients. This expansion should be undertaken in 1994 after the program, as currently defined, has been implemented statewide and additional waiver authority has been obtained.*

Expenditures for Pharmacy Services Have Increased Rapidly

Like physician services, expenditures for Medicaid pharmacy services have been growing at a faster rate than total Medicaid expenditures for medical care and annual rates of inflation. In FY 1991 alone, pharmacy expenditures increased by 34 percent to almost $103 million. Between FY 1989 and FY 1991, average pharmacy costs per recipient and per claim increased by 15 and

20 percent, respectively. In comparison, during this same period the rate of inflation was 11 percent for all goods and services and 20 percent for prescription drug prices.

Also similar to physician services, much of the growth in pharmacy expenditures has taken place in conjunction with growth in recipients due to federally-mandated program expansions between FY 1989 and FY 1991. The largest increases in recipients who received pharmacy services were in the indigent pregnant women and indigent children eligibility categories. Pharmacy expenditures for these two groups increased by rates much higher than rates of growth for other eligibility categories.

Recent Growth in Pharmacy Expenditures May Be Slowing

Examination of FY 1992 data indicates that the recent growth rate in pharmacy expenditures is slowing. This appears to be related, in part, to the implementation of a prescription drug rebate program required by federal legislation. In FY 1992, the Virginia Medicaid program received almost $16 million in drug rebates for drugs dispensed to program recipients since January 1, 1991.

Nevertheless, the Virginia Medicaid program may not be receiving the entire savings to which the program is entitled. Assessment of Department of Medical Assistance Services (DMAS) data revealed that for FY 1991 and FY 1992, Virginia received about 22 percent less in total rebates than was invoiced due to disputes with pharmaceutical manufacturers. According to staff at the Office of the Inspector General within the U.S. Department of Health and Human Services, this is consistent with experiences of other states.

At this time, complete resolution of these disputes appears to be dependent on additional action from HCFA. The Office of the Inspector General is currently completing reports for action in this area. In the meantime, DMAS has adopted an internal policy to facilitate the dispute resolution process and track the accounts receivable for the disputed rebate amounts.

The State Has Options for Modifying Pharmacy Reimbursement

The current reimbursement system for Medicaid pharmacy services is based on a fee-for-service, retrospective methodology which contains several expenditure controls. Provisions in the Omnibus Budget Reconciliation Act of 1990 do not allow the federal government or states to lower their current reimbursement for pharmacy providers or the upper limits imposed on Medicaid payments for drugs until January 1, 1995. Nevertheless, some options do exist for modifying pharmacy reimbursement to allow the Medicaid program to more prudently purchase pharmacy services.

Recommendation. *The Department of Medical Assistance Services should begin planning for pharmacy reimbursement changes to be implemented January 1, 1995. Consideration should be given to revising the calculation used to establish the estimated acquisition costs of drug products and the dispensing fees for pharmacy providers because the estimation currently used by DMAS was derived from data which systematically excluded certain providers' acquisition costs.*

Recommendation. *The Department of Medical Assistance Services should pursue obtaining a waiver from the U.S. Department of Health and Human Services to provide pharmacy services to recipients through selected pharmacies chosen through a competitive process. If assessment of this arrangement indicates that the Medicaid program can obtain cost efficiencies without jeopardizing recipient access to pharmacy services, the department should implement this type of contractual arrangement for the provision of pharmacy services.*

Recommendation. *The Department of Medical Assistance Services should ex-*

plore the impact of imposing limits on reimbursement for pharmacy services in the Medicaid program in conjunction with the implementation of the prior authorization program for high-cost drugs. These limits should be developed with the assistance of the prior authorization program's advisory panel.

Recommendation. *The Department of Medical Assistance Services should explore the feasibility of expanding pharmacy coverage to include reimbursement for limited over-the-counter drugs in the Medicaid program for specific recipients.*

Medicaid Utilization Review Activities to Control Fraud and Abuse Meet Minimum Requirements But Could Be Improved

After payments have been made by the Medicaid program, DMAS staff analyze claims data as one means of controlling program expenditures. This "post-payment utilization review" function is done to determine if recipients or providers have developed patterns indicative of excessive use, medically unnecessary use, or unsound billing practices. Although DMAS post-payment utilization review activities meet federal minimum requirements, more could be done to achieve additional cost savings. To address these concerns, the following recommendations are made:

Recommendation. *The Department of Medical Assistance Services should consider expanding staff resources for provider reviews to attain additional cost savings. In addition, the Department should maintain and use data from past provider review cases to select providers for review.*

Recommendation. *The Department of Medical Assistance Services should place high priority on recipient fraud activities to ensure the Division of Program Compliance maintains adequate staff to detect and control recipient fraud and make additional monetary recoveries. DMAS should track the impact of this function, including the amount of program costs avoided, and assess if the current level of staffing is adequate to perform this function.*

Recommendation. *The Department of Medical Assistance Services should strengthen its drug diversion activities by entering into a new interagency agreement with the Department of State Police to conduct drug diversion investigations on behalf of DMAS. The department should continue to support these investigations by providing referrals and any necessary information or records to conduct them, including regularly produced reports from the Medicaid Abusable Drug Audit System.*

The State Police should be allocated additional staff who are dedicated to Medicaid drug diversion investigation. To the extent possible, federal financial participation through the Medicaid program should be used to fund these investigations.

Development of a New Third-Party Liability System Should Include Evaluative Components to Assess Cost Effectiveness

Federal law requires that Medicaid be the payer of last resort. Consequently, any other parties which have a liability to pay for services for Medicaid recipients must be pursued. During FY 1992, DMAS estimates its third-party liability (TPL) activities saved at least $95 million.

DMAS is in compliance with federal regulations affecting State TPL operations. DMAS is in the process of acquiring a new TPL system which will automate many of the manual tasks performed by TPL staff. The new system will allow TPL staff to select cases for research based on their cost-effectiveness, conduct in-house data matches with insurance companies and State agencies to identify other resources, and pursue more TPL cases.

The new TPL system meets most of the criteria established for a model TPL system.

However, as the new system is developed, there are additional evaluative components that DMAS should consider to better assess the cost effectiveness of certain TPL activities.

Recommendation. *As development of the third-party liability system begins, the Department of Medical Assistance Services should consider incorporating additional TPL practices that other states have found to be successful. For example, other data matches, TPL training and evaluation of social service workers, and estate liability functions could be included in the design of the new system.*

Recommendation. *When the new third-party liability system is operational, the Department of Medical Assistance Services should undertake tests, such as adding or deleting trauma codes, to identify the most cost-effective third-party liability cases to pursue.*

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I. Introduction

The Virginia Medicaid program is a joint federal-state program authorized under Title XIX of the Social Security Act. It is the largest of the State's health care programs for indigent persons. Total program expenditures for medical care were about $1.2 billion in FY 1991, representing a 30 percent increase from the previous fiscal year. In FY 1992, expenditures continued to grow, increasing by 16 percent to about $1.4 billion. The number of persons receiving Medicaid services has also increased significantly. In FY 1991, the number of recipients grew by 17 percent to 428,650. Growth continued in FY 1992, when the number of recipients grew about 16 percent to 495,516.

The increases in program recipients have played a significant role in the increases in program expenditures. Recipient increases are largely the result of federal mandates to expand Medicaid eligibility. The U.S. Congress has extended Medicaid coverage to larger numbers of uninsured citizens by linking eligibility for certain categories of individuals to the federal poverty income level. Consequently, the Medicaid program has become a *de facto* national health care program for many indigent persons. These mandated eligibility expansions have made it increasingly difficult for states to control growth in program costs.

Concerns by the General Assembly about Medicaid program costs resulted in passage of Senate Joint Resolution (SJR) 180 in 1991. SJR 180 directed the Joint Legislative Audit and Review Commission (JLARC) to comprehensively review the Virginia Medicaid program. The review includes an assessment of the extent to which federal mandates have been implemented in a cost-effective way and explores options for controlling program costs.

This report is one in a series on the Virginia Medicaid program. Previous JLARC reports provided an overview of the Medicaid program, assessed the Medicaid forecast and budget process, examined the provision of hospital and long-term care, and assessed Medicaid requirements for asset transfers and estate recoveries. This report reviews physician and pharmacy services provided by the program to eligible indigent persons. These two services account for a majority of Medicaid spending for ambulatory care services. It also provides a brief overview of ambulatory care services. Finally, the report includes an assessment of Medicaid efforts to contain program costs for services through two specific mechanisms: (1) post-payment review of program expenditures and (2) activities to pursue third-party liability for services provided through the program.

In FY 1991, claims data indicate that the Medicaid program spent about $280 million to provide reimbursement of claims for ambulatory care services on behalf of 406,716 persons. Overall, Medicaid coverage of these services is cost effective. Despite the large increases in expenditures, the State's costs are relatively low on a per-recipient basis. On average, the Medicaid program spent $688 per recipient to provide ambulatory care services. And, for many recipients this cost was much lower. For example, the cost

to provide these services to children, who comprise the largest group of program recipients (49 percent), averaged $345 per child in FY 1991. In addition, approximately 50 percent of these program expenditures are funded by the federal government.

OVERVIEW OF AMBULATORY CARE SERVICES PROVIDED THROUGH THE VIRGINIA MEDICAID PROGRAM

State Medicaid programs must provide certain federally-mandated ambulatory care services. States may choose to provide additional ambulatory care services for which they receive matching federal Medicaid funding. Most covered services must be provided to all individuals who meet eligibility criteria for Medicaid. However, states are required to provide a greater complement of services to certain individuals who receive Medicaid such as, pregnant women and children.

For this review, ambulatory care services are defined as those which are generally provided on an outpatient basis and are preventive in nature or for acute illnesses. Ambulatory care services covered by the Virginia Medicaid program include:

- physician services
- pharmacy services (primarily prescription drugs)
- services provided by other practitioners (such as mental health clinic services, podiatry services, and psychological services)
- diagnostic laboratory and X-ray services
- transportation services
- dental services
- early and periodic screening, diagnostic, and treatment (EPSDT) services.

Typically, hospital outpatient services are considered ambulatory in nature; however, these services were excluded from this review because they were assessed in a 1992 JLARC report titled *Medicaid-Financed Hospital Services in Virginia.*

The Department of Medical Assistance Services (DMAS) has responsibility for administering the Medicaid program in Virginia. The Medicaid program functions as a third party payer of medical services for eligible individuals. As such, it reimburses health care professionals and facilities for covered services provided to those enrolled in the program. It also makes insurance-type payments to providers on behalf of qualified Medicare beneficiaries (QMBs) to ensure their continued Medicare coverage.

Based on claims data, about $280 million was spent for Medicaid reimbursement of ambulatory care services in Virginia in FY 1991. About 80 percent of this amount, or $225 million, was spent to provide physician and pharmacy services to eligible indigent persons. These expenditures do not include amounts which the Medicaid program must pay to ensure continued Medicare coverage for impoverished QMBs. In FY 1991, the Medicaid program spent an additional $56 million on payments to Medicare for coinsurance, deductible amounts, and copayments on behalf of these persons.

Medicaid Eligibility and Recipient Health Status

In order to receive ambulatory care services through the Medicaid program, an indigent person must meet certain eligibility criteria. In Virginia, local social service departments are responsible for determining eligibility and enrolling individuals as beneficiaries in the program. Beneficiaries receive a Medicaid card each month, which they present to Medicaid providers prior to obtaining covered health care services. (Beneficiaries who obtain covered services are referred to as recipients.)

Medicaid Eligibility Categories. An individual can be determined eligible for Medicaid only if he or she fits into one of several eligibility categories. All state Medicaid programs are required to cover indigent persons who are entitled to benefits due to their participation in federally-supported public assistance programs. These include:

- aged (age 65 and older), blind, or disabled individuals (including children) who receive Supplemental Security Income (SSI) assistance
- families with dependent children who receive Aid to Families with Dependent Children (ADC) assistance.

Several federal initiatives recently expanded eligibility in these traditional categories. For example:

- The Family Support Act of 1988 expanded coverage for ADC-eligible two-parent families during periods of unemployment and mandated 12 months of extended Medicaid coverage for families that lose ADC eligibility due to increased earnings.
- The Medicare Catastrophic Coverage Act of 1988 enacted new criteria for determining the eligibility of institutionalized individuals who have a spouse living in the community.
- The Deficit Reduction Act of 1984 gradually increased the Supplemental Security Income standard to a threshold of $2,000, thereby increasing the number of recipients eligible in the aged, blind, and disabled categories.

- The Immigration Reform and Control Act of 1986 required Medicaid to cover certain amnesty aliens as of July 1, 1988.

In addition, a U.S. Supreme Court decision handed down in February 1990 changed the definition of "disabled" for children qualifying for the Medicaid program; the decision in *Sullivan vs. Zebley* expanded eligibility for these children.

The U.S. Congress also created new categories of eligibility in order to finance pregnancy-related and pediatric services for low-income women and children through the Medicaid program. Coverage of these new "indigent" classifications has been phased-in — initially as options, then as federal mandates. Eligibility requirements are less restrictive and more straightforward than for traditional coverage since they are tied directly to federal poverty income levels. Furthermore, the federal government now requires state Medicaid programs to pay the costs associated with ensuring Medicare coverage for certain impoverished Medicare beneficiaries.

These expansions have weakened the link between Medicaid eligibility and eligibility for government cash assistance programs. Increasingly, federal policy-makers have used the Medicaid program as a vehicle for providing health care to growing numbers of poor, uninsured individuals. However, it is important to recognize that Medicaid coverage of many of these newly expanded groups is cost effective, particularly for indigent pregnant women and children.

The Virginia Medicaid program will continue to be impacted by eligibility expansions as the program phases in coverage of children up to age 18 with incomes at or below 100 percent of the federal poverty income level. As of July 1, 1992, the Medicaid program covers children up to age 13 at 100 percent of the federal poverty income level. DMAS projects that based on FY 1991 program figures, 29,000 more children will be eligible for Medicaid services in FY 1993 and FY 1994 due to these expansions and will enroll in the program.

If utilization patterns for eligible indigent children mirror those for all Medicaid-eligible children in FY 1991, about 81 percent of the newly enrolled children could actually receive Medicaid-reimbursed services. Assuming the services they receive are ambulatory care services, enrollment of these additional indigent children could increase Medicaid ambulatory care expenditures by about $12 million (based on average costs per indigent child in FY 1991). This estimate does not account for inflation or changes in utilization.

Medicaid Eligibility Classes. Individuals seeking eligibility are classified as either categorically needy or medically needy according to their level of need. Most categorically needy individuals participate in other public assistance programs, typically ADC or SSI. However, indigent pregnant women and indigent children have recently been added to this class. Federal statute requires that most categorically needy individuals be covered by Medicaid.

The Virginia Medicaid program also provides coverage to those who are classified as medically needy. Persons classified as medically needy have profiles similar to the categorically needy. However, medically needy persons have countable incomes or resources which exceed the limits set for persons eligible as categorically needy. Most medically needy individuals must reduce their countable resources and/or "spend down" excess income by sustaining medical expenses in order to qualify for Medicaid coverage. Virginia elected to provide medically needy coverage (which is optional) in 1970. Additional information on beneficiary eligibility categories and classes can be found in the JLARC report *Review of the Virginia Medicaid Program*, 1992.

Recipient Health Status. Recipients of ambulatory care services can also be defined by their health status. As Figure 1 illustrates, ambulatory care services are primarily provided to eligible adults and children who are *ambulatory*, that is, they are generally mobile, not bedridden, and are not receiving long-term care services. However, ambulatory care services are also provided to adults and children who are in Medicaid long-term care programs. These *long-term care* recipients may be institutionalized, or in a special program receiving community-based care or home health care on a long-term basis. Due to their health care needs, these recipients often have higher levels of service than other recipients. More specific information on the cost of Medicaid services for long-term care recipients was covered in the JLARC report *Medicaid-Financed Long-Term Care Services in Virginia*, 1992.

Covered Ambulatory Care Services

As mentioned earlier, the Virginia Medicaid program covers a variety of ambulatory care services. Some of these services, such as physician services, are mandatory for state Medicaid programs to provide. However, Virginia has chosen to provide services beyond those specified by federal statute. For example, the State has chosen to provide pharmacy services to Medicaid eligible persons.

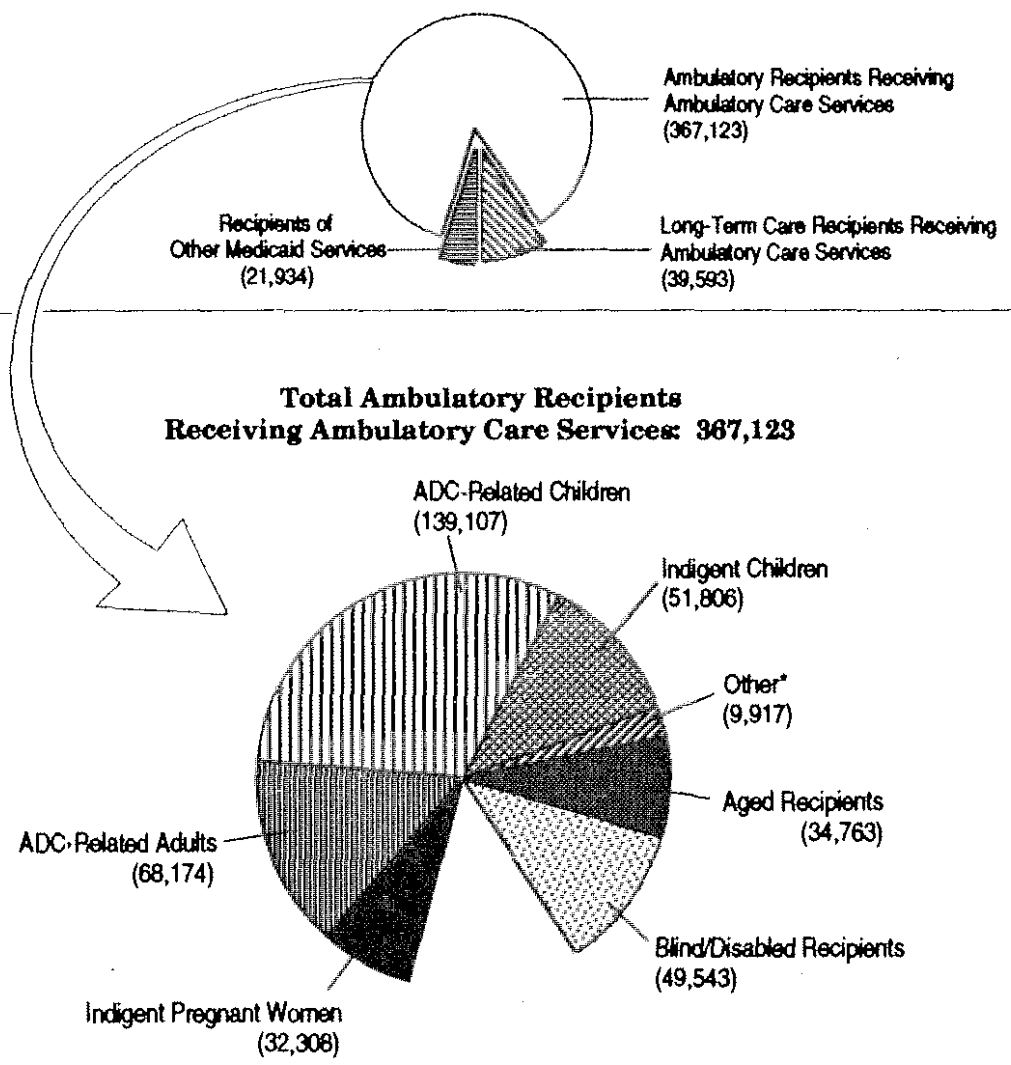
Mandatory Ambulatory Care Services. The Medicaid program is required to provide the following services to all Medicaid recipients:

- physician services
- diagnostic laboratory and X-ray services
- early and periodic screening, diagnostic, and treatment services
- transportation services
- certain other practitioner services such as rural health clinic services, nurse midwife services, and family planning services and supplies.

These services are provided to categorically needy recipients as well as medically needy recipients, and must be comparable in amount, duration, and scope of coverage.

Figure 1

Recipients of Ambulatory Care Services, FY 1991



*Other includes children in foster care, subsidized adoption (who are not ADC-related under Title IV-E), and corrections; and refugees.

Note: Total number of ambulatory recipients is lower than the sum of the individual categories of ambulatory recipients due to recipient changes in eligibility status. Many recipients were enrolled in more than one category during the year.

Source: JLARC staff analysis of Department of Medical Assistance Services Medicaid claims, SAS datasets, FY 1991.

Physician services reviewed in this report refer primarily to medical and surgical procedures rendered by physicians and local health department clinics. They do not include services provided in federally qualified health centers, rural health clinics, or EPSDT services provided by physicians. For discussion purposes, these services are separated from physician services. Physician services described and assessed in this review also do not include those services and attendant payments made to physicians for Medicare coinsurance, deductible amounts, and copayments on behalf of QMBs. These were excluded for those QMBs who actually receive Medicare services, which are only partially paid for by Medicaid, not Medicaid-reimbursed services.

Diagnostic laboratory and X-ray services are professional and technical laboratory and radiological services, provided by independent laboratories. These services do not include laboratory and X-ray services provided in hospitals, either in an inpatient or outpatient setting, or those provided in physicians' offices. However, they are ordered by physicians or other licensed practitioners within the scope of their practice, as defined by State law.

Early and periodic screening, diagnostic, and treatment services (EPSDT) provide scheduled medical screenings for recipients younger than age 21. The object of these services is to identify any health problems in children early so that medical services can be provided to resolve the problems. EPSDT services are provided according to established schedules based on the child's age. State Medicaid programs are required to provide children with all services that have been identified as medically necessary during an EPSDT screening, regardless of whether the service is covered under a state's Medicaid plan.

EPSDT services are generally provided by physicians; however, they are described separately because claims for these services are tracked separately from claims for other types of physician services. The federal government has established goals for ensuring that enrolled children receive EPSDT services. By tracking these claims separately, the Medicaid program is able to monitor compliance with federal goals for delivering EPSDT services.

States are required to assure that recipients have necessary transportation to and from providers. Transportation services include ambulance services, buses, commercial taxicabs, special project vehicles, registered drivers, and commercial air carriers. Recently, DMAS increased enrollment of registered drivers, the most cost-effective form of transportation.

Rural health clinic services, nurse midwife services, family planning services, and federally qualified health centers are included in this review as part of other practitioner services. In terms of total ambulatory care services provided through the Medicaid program, these services account for smaller portions of services and expenditures.

Optional Ambulatory Care Services. Similar to most other states, the Virginia Medicaid program provides coverage for a number of optional ambulatory care

services. Optional services covered in the Commonwealth include pharmacy services, dental services, and additional services provided by other practitioners.

Currently, all states provide pharmacy services to Medicaid recipients even though they are considered optional. Pharmacy services in Virginia include prescription drugs, and some over-the-counter drugs and pharmaceutical supplies for certain eligible persons. For example, Medicaid pays for specific types of over-the-counter drugs for recipients who are institutionalized in nursing facilities.

Dental services are primarily provided to Medicaid recipients who are children. Covered dental services include preventive and restorative services such as root canals and permanent crowns. Dental services for adult recipients are limited to oral surgery for medically-related diagnoses.

Several additional optional services are covered by the Virginia Medicaid program. For example, psychiatric services such as medical psychotherapy and psychological testing are covered when they are provided by private psychiatrists, licensed clinical psychologists, certified hospital outpatient departments, and community mental health clinics. Podiatry services include medical and surgical treatment of disease, injury, or defects of the foot, but do not include amputation. In addition, although certain vision services are covered for all recipients, eyeglasses and other lenses are only provided to children.

Limitations on Ambulatory Care Services

Expenditures for ambulatory care services are limited in two ways. First, the Medicaid program can limit the amount, duration, and scope of services for which reimbursement is made. For example, preventative and restorative dental services are limited to children younger than age 21 and exclude several procedures. Coverage of physician services excludes cosmetic surgery and most transplant surgery.

Second, cost-sharing requirements are imposed for certain recipients and for specific services. Cost-sharing, often referred to as a copayment, is designed to add the cost of service into the recipient's decision to seek service. However, if the recipient is unable to pay the copayment when one is due, providers are not reimbursed by Medicaid for the uncollected copayment amount.

Copayments are not required of the following types of Medicaid recipients or for the following types of services:

- children younger than age 21
- pregnant women, when services are related to their pregnancy
- individuals receiving long-term care services or hospice services
- emergency services
- family planning services and supplies.

During the 1992 General Assembly, DMAS was directed to increase recipient copayments to the maximum amounts allowed by federal regulation. As a result, copayments were added for categorically needy recipients of physician services, and copayment amounts for certain physician services were increased from $1 per visit to $3 per visit.

The copayment amount for rehabilitation services was also increased to $3 beginning July 1, 1992. Copayments for other services such as home health services, and inpatient hospital services, were also increased. Table 1 shows current copayment amounts required by the Medicaid program for ambulatory care services.

Table 1

Cost-Sharing Requirements for Ambulatory Care Services

Ambulatory Care Service	Copayment Amount
Physician Services	
office visit	$1.00
clinic visit	1.00
other physician visit	3.00
Pharmacy Services	
prescription drugs (per prescription or refill)	1.00
Eye Examinations	1.00
Rehabilitation Services	
per visit	3.00

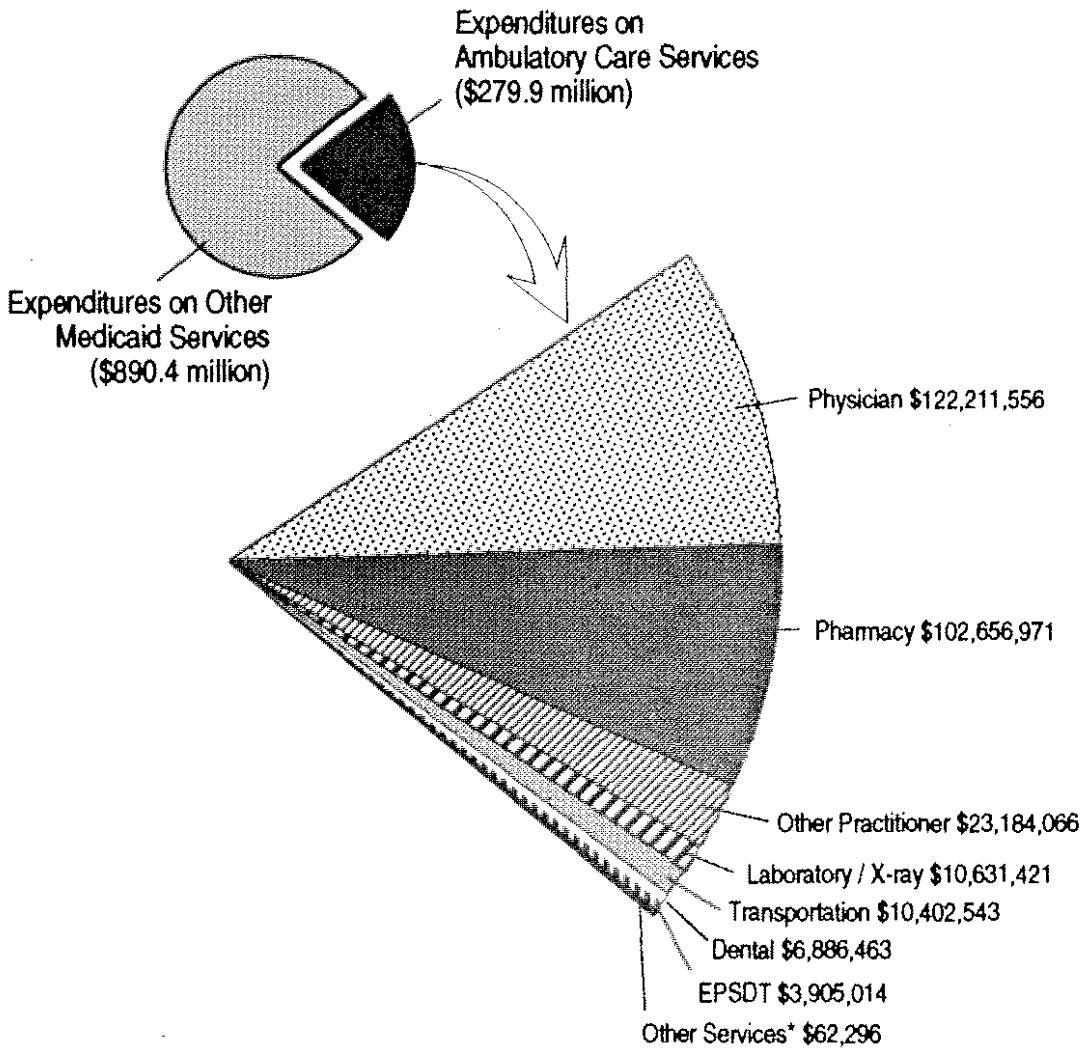
Source: Department of Medical Assistance Services, Medicaid memo to all providers participating in the Virginia Medical Assistance Program from Bruce U. Kozlowski, Director, June 1, 1992.

MEDICAID EXPENDITURES FOR AMBULATORY CARE SERVICES IN VIRGINIA

In FY 1991, ambulatory care services accounted for about one-quarter of total Medicaid expenditures for medical care. Based on claims data for that year, expenditures for ambulatory care services totaled nearly $280 million. The two largest expenditure categories for ambulatory care services were physician and pharmacy services (Figure 2). The combined expenditures for these two services accounted for almost $225 million, or 80 percent, of total ambulatory care expenditures. The remaining 20 percent (approximately $55 million) in ambulatory care expenditures was for Medicaid reimbursement of the following services: services provided by other practitioners, diagnostic laboratory and X-ray services, transportation services, dental services, and EPSDT services.

Figure 2

Expenditures for Ambulatory Care Services, FY 1991



*Other services include claims by out-of-state providers for physician, pharmacy, and independent laboratory services.

Source: JLARC staff analysis of Department of Medical Assistance Services Medicaid claims, SAS datasets, FY 1991.

The Medicaid program has experienced significant growth in expenditures for ambulatory care services. Since FY 1987, total expenditures on ambulatory care services have increased by 197 percent. Much of the growth is the result of Medicaid eligibility expansions. Because physician and pharmacy services comprise a large portion of ambulatory care services, large increases in these expenditures have had a significant

impact on overall increases in total ambulatory care expenditures. However, expenditures for other ambulatory care services have also experienced large increases. In addition, recent State efforts to maximize the use of Medicaid funding to pay for services that had previously been financed solely with State general funds have contributed to expenditure growth.

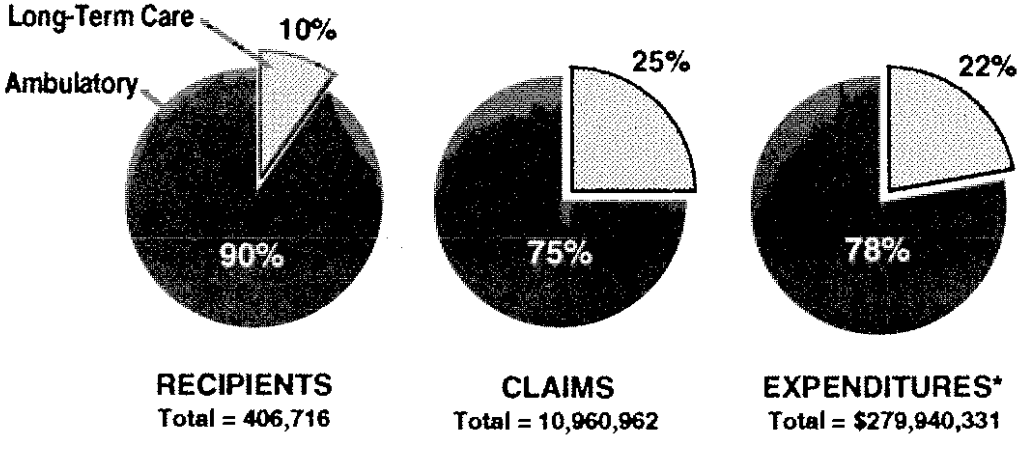
Most Expenditures for Ambulatory Care Services Are for Ambulatory Recipients

Expenditures for ambulatory care services were analyzed using Medicaid claims data from FY 1991. Figure 3 illustrates the total recipients, claims, and expenditures for ambulatory care services by recipient health status. Ambulatory recipients comprised about 90 percent of the total number of recipients in FY 1991. However, they were responsible for 75 percent of all claims and about 78 percent of the total expenditures.

As a group, long-term care recipients incur a proportionally higher number of claims and attendant expenditures for ambulatory care services. Although they comprised 10 percent of all recipients of ambulatory care services in FY 1991, they accounted for 25 percent of all claims and 22 percent of total expenditures for ambulatory care. Because they incur proportionally higher number of claims, the average cost per long-term care recipient is much higher than it is per ambulatory recipient. In FY 1991, the average cost of ambulatory care services per long-term care recipient was $1,546 versus $596 per ambulatory recipient.

Figure 3

Ambulatory and Long-Term Care Recipients, Claims, and Expenditures for All Ambulatory Care Services, FY 1991



Source: JLARC staff analysis of Department of Medical Assistance Services Medicaid claims, SAS datasets, FY 1991.

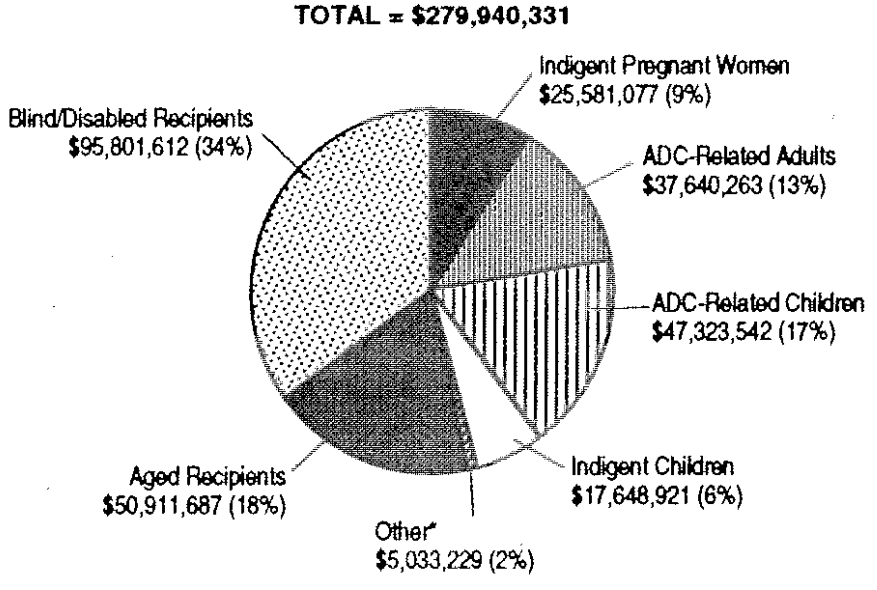
Expenditures for Ambulatory Care Services Vary by Eligibility Category

Expenditures for ambulatory care services vary considerably among Medicaid recipients, depending on their category of eligibility. Examination of FY 1991 claims data revealed that the majority of ambulatory care expenditures are for claims paid on behalf of persons eligible as blind and disabled. Figure 4 illustrates the breakdown of FY 1991 expenditures for ambulatory care services by recipient eligibility category. Approximately 34 percent of all expenditures for ambulatory care services in FY 1991 were for these recipients. It is not surprising that blind and disabled recipients account for most ambulatory care expenditures because blind and disabled recipients have higher average costs per recipient.

The next largest group of recipients, in terms of overall expenditures for ambulatory care services, were ADC-related recipients. They accounted for about 30 percent of total ambulatory care expenditures in FY 1991. The ADC-related, indigent pregnant women, and indigent children categories have much lower average costs per recipient.

Figure 4

Ambulatory Care Service Expenditures by Recipient Eligibility Category, FY 1991



*Other includes children in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities; and refugees.

Source: JLARC staff analysis of Department of Medical Assistance Services Medicaid claims, SAS datasets, FY 1991.

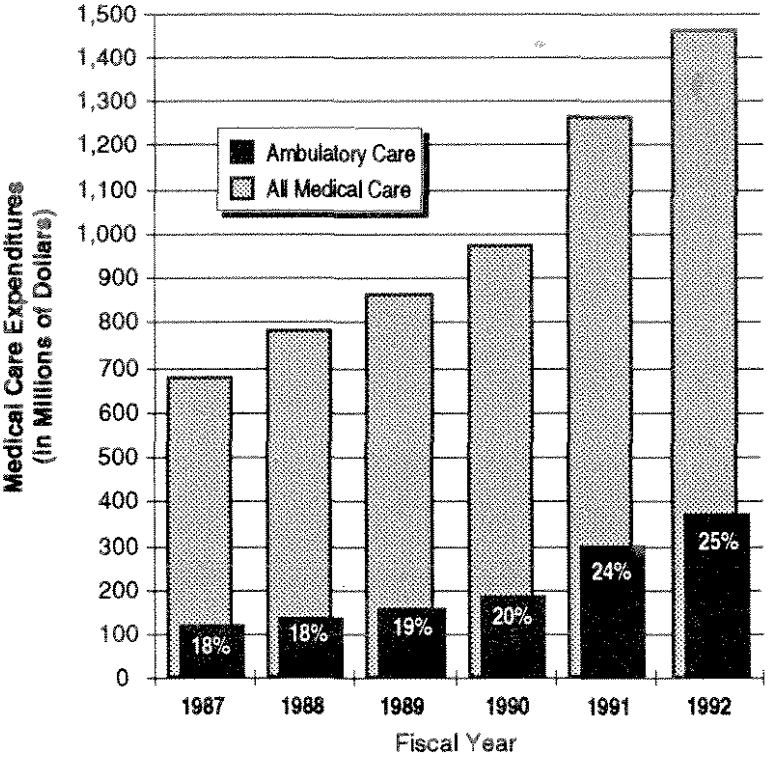
Recent Growth in Ambulatory Care Expenditures Primarily Reflects Federally-Mandated Eligibility Expansions

According to data from DMAS unaudited financial statements, total ambulatory care expenditures have more than doubled in the past five fiscal years. During the same period, expenditures for ambulatory care services have grown as a percentage of all Medicaid expenditures for medical care from about 18 to 25 percent (Figure 5). The greatest growth in ambulatory care expenditures occurred between FY 1990 and FY 1991.

Much of this growth reflects the increases in Medicaid recipients brought about by Medicaid policies to expand eligibility. In the absence of a national health care policy, a piecemeal approach to providing health care to poor, uninsured individuals, particularly children, through the Medicaid program has evolved. This has resulted in the shifting of more costs to the State to fund services for these individuals. To a lesser extent, increases are due to State policies to maximize use of Medicaid funding for certain services.

Figure 5

Ambulatory Care Expenditures as a Proportion of All Medical Care Expenditures

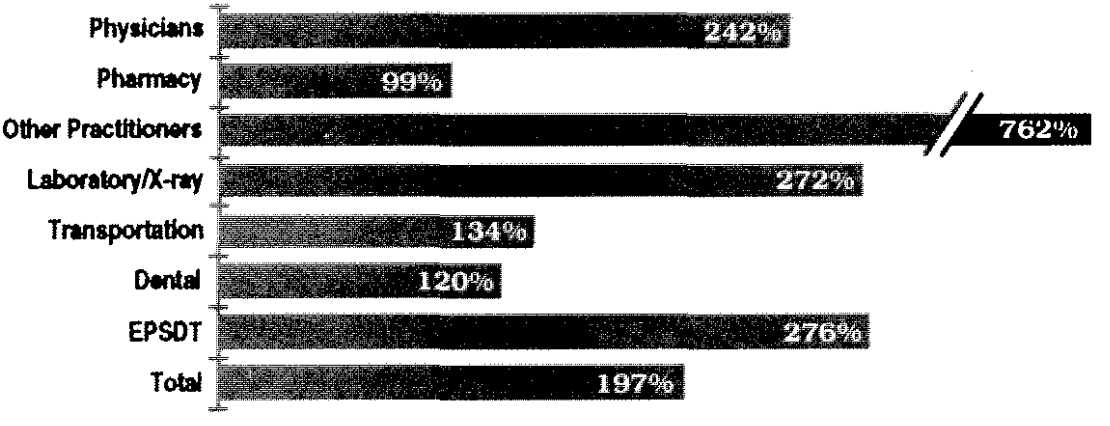


Source: Department of Medical Assistance Services, CARS Medical Expenditures for "64" Report, FY 1991 and FY 1992; and DMAS internal expenditure report, FY 1987 - FY 1991, derived from unaudited financial statements.

The amount of expenditure growth also varies by the type of ambulatory care service (Figure 6). Most growth has occurred in expenditures for other practitioner services. This is explained, in part, by the inclusion of expenditures for mental health and mental retardation clinic services in this service category. In FY 1991, Virginia began covering these services through the Medicaid program. Previously they had been funded solely with State general funds. Expenditures for these services alone have grown by 100 percent from $19 million in FY 1991 to almost $38 million in FY 1992.

Figure 6

Percent Growth in Ambulatory Care Expenditures by Type of Service, FY 1987 - FY 1992



Notes: Physicians include services provided by federally qualified health centers and some payments on behalf of QMBs. Other practitioners include local health department clinics, mental health clinics, rural health clinics, prenatal nutrition, and case management services.

Source: Department of Medical Assistance Services, CARS Medical Expenditures for "64" Report, FY 1991 and FY 1992; and DMAS internal expenditure reports, FY 1987 - FY 1991, derived from unaudited financial statements.

JLARC REVIEW

Increasing gaps in health care coverage experienced by the general population have fueled concerns about citizens' access to basic health care. This has led to increased reliance on the Medicaid program as a vehicle for expanding health care to cover larger numbers of the poor on both a national and state basis. Dramatic growth in the costs of providing this expanded coverage through the Medicaid program has resulted in additional scrutiny of state Medicaid programs for ways in which program costs can be contained, while preserving essential health care services.

This JLARC review of Medicaid-financed physician and pharmacy services is a result of legislative concerns about the growth of Virginia's Medicaid program. The Commission on Health Care for All Virginians (now the Joint Commission on Health Care) sponsored SJR 180, directing JLARC to review the Medicaid program and assess whether Virginia has implemented the program in the most cost-effective and efficient manner. Numerous research activities were undertaken as part of this assessment.

Study Issues

Senate Joint Resolution 180 outlines specific issue areas to be addressed in the JLARC review of the Medicaid program. Research activities were designed to address the following items in the mandate:

- assess the cost savings and health policy implications of limiting the scope or duration of optional services or adjusting recipients' contributions to care
- examine the State's interpretation of federal requirements to determine if they have been implemented in the most effective and least costly manner
- determine the effectiveness of current utilization review procedures in controlling costs and explore additional options
- evaluate reimbursement methods to determine if they adequately encourage cost effective delivery of services
- determine the sufficiency of reimbursement rates to provide quality care at the lowest required cost
- explore the costs of alternative administrative methods for implementing program requirements and options.

These issues were examined in relation to Medicaid-financed physician and pharmacy services. Two earlier reports examined the relationship of these issues to the provision of Medicaid-financed hospital care and long-term care services.

Research Activities

A number of research activities were undertaken to assess the issues surrounding the provision of Medicaid-financed ambulatory care services and cost savings opportunities. These included analysis of Medicaid claims data for ambulatory care services; a survey of physicians enrolled as providers in the Virginia Medicaid program; structured interviews with staff of DMAS, other State agencies, and provider associations; document reviews; file reviews; and site visits. Where possible, secondary data sources were used to conduct analyses.

Analysis of Medicaid Claims Data. Medicaid claims data were collected to assess the cost of providing ambulatory care services to Medicaid recipients and to assess utilization by Medicaid recipients. Claims data from FY 1991 were analyzed for ambulatory care services, particularly physician and pharmacy services, that were reimbursed by the Medicaid program. However, additional years of claims data were obtained for physician and pharmacy services to provide more detail on changes in services, reimbursement, and costs over the past several years.

Survey of Physicians Enrolled as Medicaid Providers. To assess physician participation and the adequacy of current Medicaid reimbursement for physician services, JLARC staff conducted a survey of physicians. The survey was mailed to a stratified sample of 662 physicians who were enrolled in the Virginia Medicaid program in June 1992. Physicians were stratified according to their specialty and the amount of reimbursement received since January 1990. Although not stratified by geographic location, the sample was reviewed to ensure adequate geographic representation of enrolled physicians, including those practicing in neighboring states who provide services to Virginia Medicaid recipients. Forty-four percent of the surveys (293 surveys) were returned and used in this assessment. Response rates varied by physician specialty and payment level.

Structured Interviews. The study team conducted structured interviews with staff in the following State agencies: Medical Assistance Services, the Attorney General's Office, and the State Police. In addition, private providers, provider organizations, and representatives from Blue Cross/Blue Shield of Virginia were interviewed. Site visits were made as part of the structured interviews to two physician offices and one local health department.

During these interviews, JLARC staff collected information on all aspects of the Medicaid program including program funding, recipients, providers, services, reimbursement, utilization review, administration of the program, and potential cost containment measures. JLARC staff also discussed administrative aspects of the program with physicians and their office staff, particularly billing procedures. Leaders of several organizations representing physicians were interviewed to learn about provider perceptions of Medicaid services, program administration, and reimbursement.

Document Reviews. Numerous documents pertaining to the Medicaid program and relevant health care issues were collected and reviewed. Topics of interest included the current health care environment, Medicaid program costs, the nature of physician and pharmacy services and reimbursement, and cost containment opportunities as a result of post-payment utilization review and third-party liability operations. A comprehensive list of these documents has not been included in this report. However, documents that provided important information on the Medicaid program included:

- *The State Plan for the Medical Assistance Program Under Title XIX of the Social Security Act,* DMAS

- Medicaid manuals, published by the U.S. Health Care Financing Administration (HCFA)

- successful practices guides, published by HCFA

- provider manuals, published by DMAS

- *Code of Federal Regulations* Parts 430 to 435

- *Code of Virginia*, Sections 20-88.01, 32.1-313, and 63.1 et seq.

In addition, several other reports and research articles were reviewed to gather information for this report. Congressional budget conference reports pertaining to past legislative mandates for the Medicaid program were collected, as well as the Omnibus Budget Reconciliation Acts of 1986, 1987, 1989, and 1990. A number of reports issued by the U.S. General Accounting Office on the Medicaid program were also reviewed. State budget documents and DMAS unaudited financial statements were also assessed for fiscal years 1982 to 1992.

File Reviews. To assess the performance of DMAS staff engaged in post-payment utilization review activities, more than 300 randomly-selected case files were reviewed. JLARC staff selected files documenting individual cases reviewing providers, recipient medical management, and recipients suspected of fraud. JLARC staff also assessed DMAS efforts to recover: (1) overpayments made to abusive and fraudulent providers and (2) funds spent on behalf of abusive and fraudulent recipients.

Secondary Data Analyses. Data from a variety of sources were also analyzed. Secondary data analyses were conducted to assess: (1) the amount of claims and expenditures for all ambulatory care services and (2) caseloads and case outcomes for post-payment utilization review activities. Analysis of FY 1991 expenditures were based on data obtained from claims files for practitioner services, pharmacy services, diagnostic laboratory and X-ray services, transportation services, dental services, and EPSDT services.

However, to assess expenditure trends over the last ten years, it was necessary to use unaudited financial statements maintained by DMAS. Because services accounted for in these statements are combined differently for federal reporting requirements, some discrepancies exist between totals reported in these statements and totals reported from the claims data. In addition, the unaudited financial statements include year-end adjustments due to cost settlements between providers and DMAS, recoveries, and other manual adjustments.

While some service categories are defined somewhat differently between the unaudited financial statements and the claims data, for purposes of describing overall expenditure trends, the distinction does not appear significant. Differences primarily affect physician services and services provided by other practitioners. For example,

physician services reported in the unaudited financial statements include procedures rendered by physicians, federally qualified health centers, and claims submitted by Medicare physicians for QMBs (for whom Medicaid pays premiums, deductible amounts, and copayments). In describing FY 1991 physician expenditures, physician claims and claims for physician services provided in local health departments were used since they account for the greatest expenditures for these services. Federally qualified health centers are described as other practitioners in this review.

Report Organization

This chapter has presented a brief introduction to the Medicaid program and the current program costs for ambulatory care services in Virginia. The next chapter provides information on the cost, utilization, and reimbursement system for physician services. Chapter III presents details on the provision of pharmacy services and pharmacy reimbursement. Opportunities for Medicaid cost savings through post-payment utilization review and pursuit of Medicaid third party liability are discussed in the final chapter.

II. Financing of Medicaid Physician Services

Since FY 1987, expenditures for physician services in the Virginia Medicaid program have been increasing more rapidly than total expenditures for medical care services. In FY 1991, physician services eclipsed pharmacy services to become the fourth largest expenditure category for the Medicaid program. Previously, they had ranked in the top five or six expenditure categories.

Despite rapidly increasing expenditures for physician services, the Virginia Medicaid program appears to be a prudent purchaser of physician services. Much of the growth in physician expenditures is related to federal mandates which expanded eligibility for Medicaid coverage — thereby dramatically increasing the number of beneficiaries receiving physician services. Consequently, Virginia has relatively few options for controlling physician expenditures since most of the services are provided to recipients in mandatory eligibility classifications.

Further, reimbursement must be maintained at a level which will ensure physician participation in the program. To that end, Virginia implemented three reimbursement rate increases for physician services within a five-year period. However, Medicaid reimbursement for many procedures is still low compared to other third-party payers. Physicians report that, for certain procedures, reimbursement is below actual practice costs and well below charges.

Although current reimbursement rates appear to be sufficient to maintain physician participation, reimbursement for physicians will need to be monitored to ensure that physicians are not forced to choose between the financial viability of their practices and participation in the program. Some physicians were forced to make this choice before the recent rate increases were implemented. They could be placed in a similar position if the gap between charges and reimbursement is allowed to grow too large.

However, Virginia could do more to contain costs by more aggressively educating recipients on appropriate utilization of services and their responsibilities as patients. Although recipient education is an appropriate function of the Medicaid program, the Department of Medical Assistance Services (DMAS) does not currently have a program in place. As the managed care program is implemented statewide, its success in enhancing recipient access to care and in controlling inappropriate utilization will depend in large part on the education of recipients.

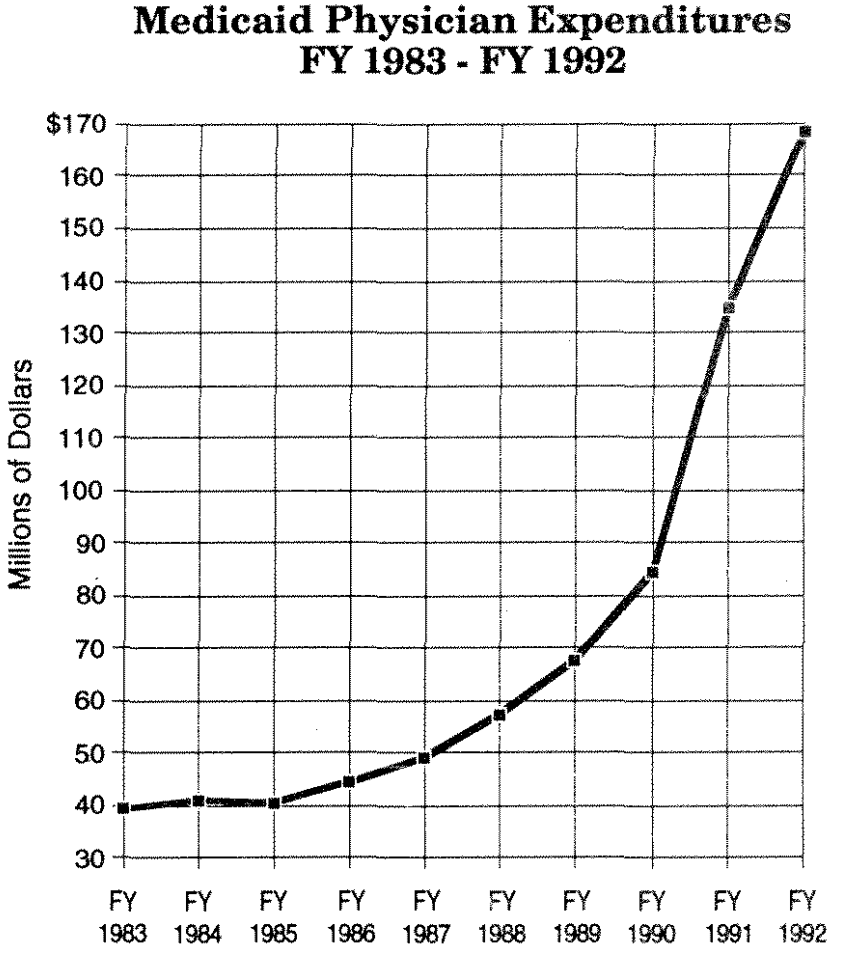
This discussion of physician services is limited to medical and surgical procedures rendered by physicians and local health department clinics. (Specific limitations on covered physician services are included in Appendix B.) The discussion does not include physicians who do not treat Medicaid beneficiaries but do treat qualified Medicare beneficiaries, whose Medicare copayments and deductible amounts are paid for

by the Medicaid program. However, some trend data are based on Medicaid program financial statements which classify physician services differently.

EXPENDITURE GROWTH IN MEDICAID PHYSICIAN SERVICES

In recent years Medicaid expenditures for physician services have increased dramatically. Medicaid expenditures for physician services were relatively stable during the early 1980s, at about $40 million each year. However, implementation of eligibility expansions and reimbursement rate increases in the latter half of the decade caused considerable growth in these expenditures. Between FY 1983 and FY 1992, Medicaid expenditures for physician services more than quadrupled, from approximately $40 million to $168 million (Figure 7).

Figure 7



Source: Department of Medical Assistance Services, CARS Medical Expenditures for "64" Report, FY 1991 and FY 1992; and DMAS internal expenditure reports, FY 1982 - FY 1991, derived from unaudited financial statements.

The current distribution of Medicaid physician services is a result of recent growth trends. Clearly, Medicaid policies which placed greater emphasis on coverage for children are responsible for the current distribution of physician services and their attendant expenditures. However, other factors, such as inflation related to the reimbursement rate increases, have also contributed to the growth in physician expenditures.

Current Distribution of Medicaid Physician Services

Along with the tremendous growth in physician expenditures, the distribution of these services has shifted. Eligibility expansions have increased the number and proportion of recipients (an unduplicated count of the actual number of beneficiaries who have had at least one physician service paid on their behalf) who are classified as children. Since most of these children are considered ambulatory, the balance between ambulatory and long-term care recipients has also shifted.

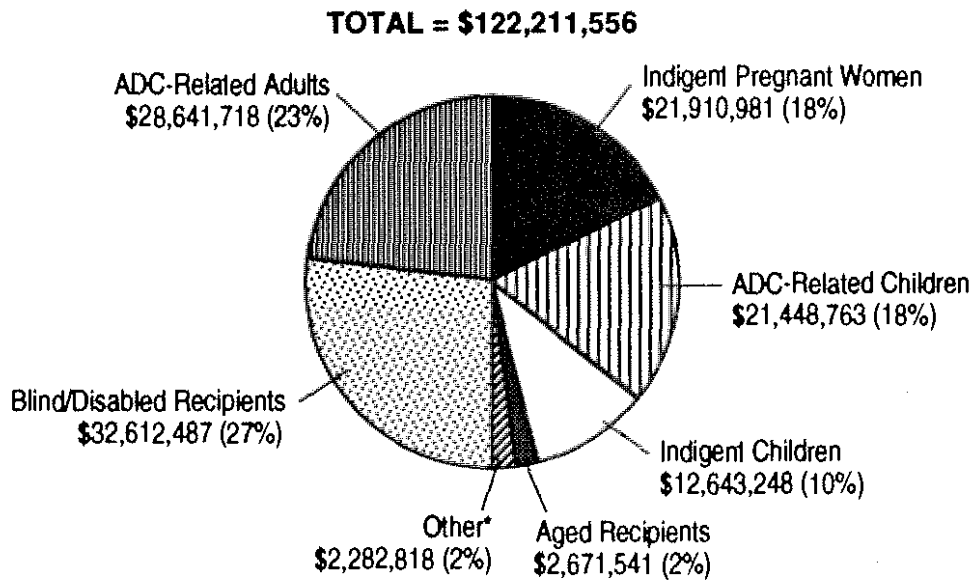
More Children Receive Physician Services than Adults, But Expenditures Are Greater for Adults. More children than adults receive physician services through Medicaid. In FY 1991, most recipients (168,242) of physician services were classified as children. However, they had fewer claims than recipients in other eligibility categories and, consequently, lower total expenditures. As Figure 8 illustrates, expenditures for children classified as ADC-related, indigent, and "other" only accounted for about 30 percent of total physician expenditures. Additional information on expenditures for physician services by eligibility category and class is included in Appendix C.

Long-Term Care Recipients Account for a Disproportionate Share of Physician Medicaid Expenditures. Physician service claims for FY 1991 were assessed against a recipient-level, long-term care database for the same year. Long-term care recipients include recipients who were institutionalized or in a special care program at any time during the year. Almost all physician services are provided to Medicaid recipients who are considered ambulatory, that is, those not receiving long-term care services (Figure 9). Less than five percent of the recipients during FY 1991 were among the long-term care population. However, the long-term care population represented almost ten percent of all claims and accounted for 12 percent of all expenditures for physician services that same year.

Obviously, there is a tremendous difference in utilization between the ambulatory and long-term care populations. On average, each ambulatory recipient had almost ten claims whereas each long-term care recipient had almost 24 claims. The average cost per claim was also greater for the long-term care population at $49 versus $38 for the ambulatory population. Consequently, the average expenditure for each recipient was more than three times greater for long-term care recipients than for ambulatory recipients — $1,162 versus $374. Additional information on ambulatory and long-term care recipient costs for physician services is included in Appendix C.

Figure 8

Medicaid Physician Expenditures by Recipient Eligibility Category, FY 1991



*Other includes children in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities; and refugees.

Note: The total for physician expenditures is derived directly from Department of Medical Assistance Services practitioner claims, SAS dataset. This total is lower than the amount reported in the CARS Medical Expenditures for "64" Report, FY 1991, due to differences in the way physician services are defined and year-end adjustments.

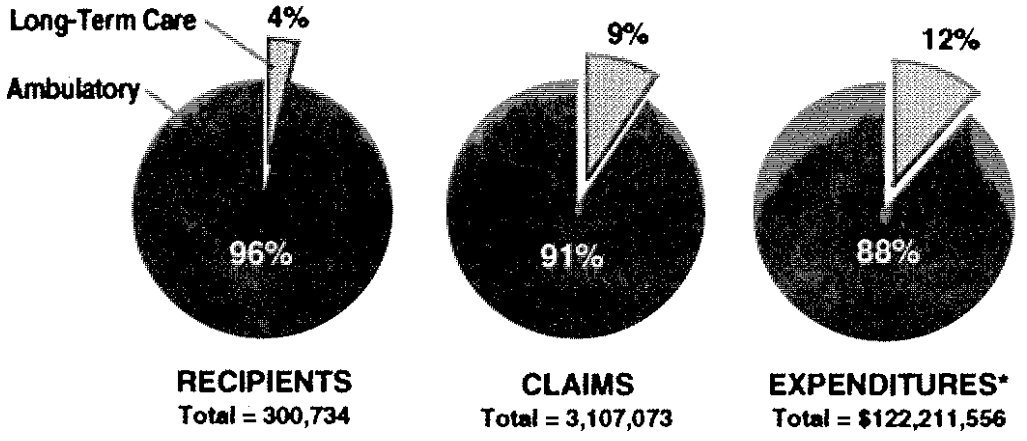
Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS dataset, FY 1991.

Physician Services Rendered in Offices Are Less Expensive than Those Provided in Hospitals. Although the place of treatment for physician services varies, most are rendered in practitioners' offices, including local health department clinics. Services rendered in offices are much less expensive than those rendered in other sites. For example, 62 percent of the physician services reimbursed in FY 1991 were rendered in offices. However, they accounted for only 32 percent of physician expenditures. Services rendered on an inpatient or outpatient basis (including the emergency room) at a hospital accounted for 36 percent of all physician claims but approximately 67 percent of expenditures. Services rendered in all other sites accounted for almost two percent of claims and about one percent of expenditures.

Almost all (92 percent) physician services were rendered by physicians enrolled as providers in the Medicaid program. Local health department clinics provided about eight percent of services and out-of-state physicians who were not enrolled in the program provided less than one percent.

Figure 9

Ambulatory and Long-Term Care Recipients, Claims, and Expenditures for Physician Services, FY 1991



*The total for physician expenditures is derived directly from Department of Medical Assistance Services practitioner claims, SAS dataset. This total is lower than the amount reported in the CARS Medical Expenditures for "64" Report, FY 1991, due to differences in the way physician services are defined and year-end adjustments.

Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS dataset, FY 1991.

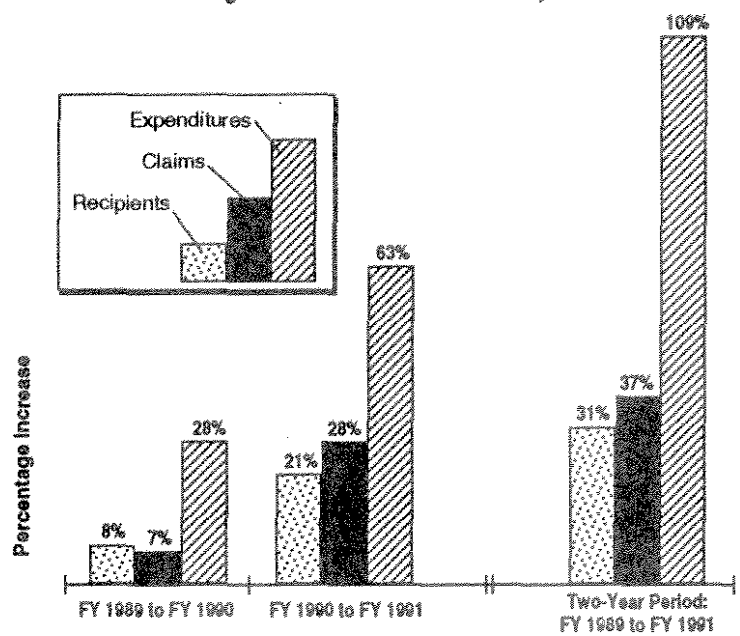
Recent Trends in Expenditures for Medicaid Physician Services

For the past several years, Medicaid expenditures for physician services have been growing at a faster rate than the total Medicaid budget — and faster than annual rates of inflation. Most of the growth in expenditures for physician services coincided with program changes implemented between FY 1989 and FY 1991, however. As Figure 10 illustrates, the number of Medicaid recipients grew by about 31 percent, while the expenditures for their care more than doubled during this period. Clearly then, the average cost per recipient has increased, particularly for certain eligibility classifications.

Physician Expenditures Have Steadily Increased as a Percentage of the Total Medicaid Budget. For several years, expenditures for physician services have steadily increased as a percentage of overall Medicaid expenditures for medical services. For example, in FY 1987 physician services represented slightly more than seven percent of total medical care expenditures, but by FY 1992, they consumed more than 11 percent of the budget. As shown in Figure 11, the annual rate of increase in Medicaid expenditures for physician services has outpaced the rate of increase in total medical care expenditures for several years. The rates of increase in FY 1990 and FY 1991 Medicaid expenditures for physician services were almost double those for total medical care in the same years.

Figure 10

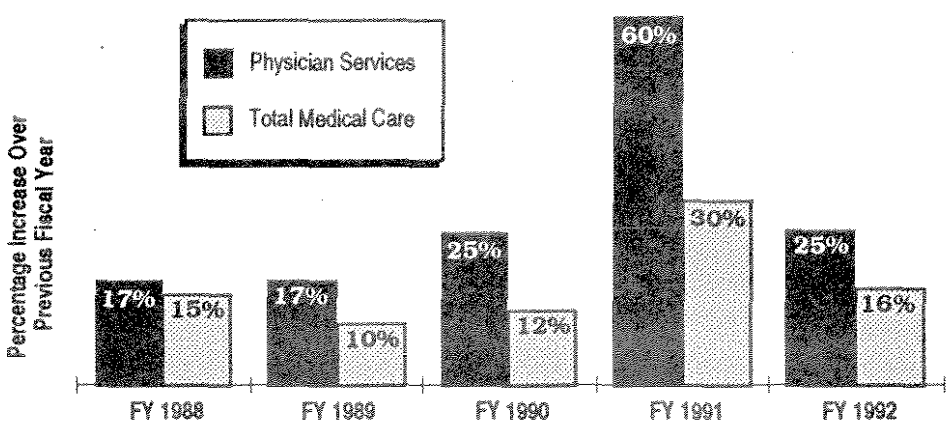
Percent Growth in Recipients, Claims, and Expenditures for Medicaid Physician Services, FY 1989 - FY 1991



Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS datasets, FY 1989 and FY 1991.

Figure 11

Percent Growth in Medicaid Physician Expenditures Compared to Total Medical Care Expenditures FY 1987 - FY 1992

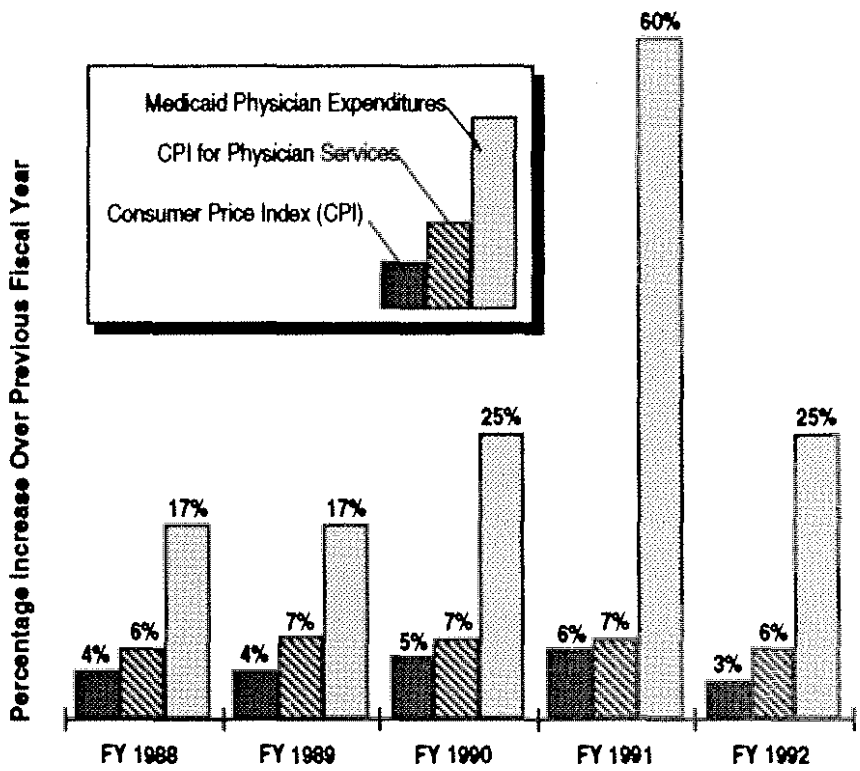


Source: Department of Medical Assistance Services, CARS Medical Expenditures for "64" Report, FY 1991 and FY 1992, and DMAS internal expenditure report, FY 1982 - FY 1991, derived from unaudited financial statements.

Increases in Physician Expenditures Have Outpaced Increases in Annual Rates of Inflation. The annual rates of increase in expenditures for physician services within the Virginia Medicaid program also exceeded annual rates of inflation for all goods and services as well as inflation in the physician services component of the consumer price index (CPI). As Figure 12 illustrates, the rate of increase in Medicaid expenditures for physician services was substantially higher than increases in inflation for the past five fiscal years. In FY 1991, the rate of increase in Medicaid physician expenditures was more than eight times greater than the rate of increase in the CPI for physician services.

Figure 12

Comparison of Annual Rates of Increase in Medicaid Physician Expenditures to Annual Inflation Rates, FY 1987 - FY 1992



Note: Inflation rates from the consumer price index reflect index changes from December to December; therefore, inflation rates from the calendar year ending during the midpoint of each fiscal year were used for comparison. For example, CPI inflation rates used for the FY 1992 comparison were rates reflecting changes in December 1991 over the previous December 1990.

Source: JLARC staff analysis of CPI Detailed Report, December 1991, U.S. Department of Labor, Bureau of Labor Statistics; Department of Medical Assistance Services, CARS Medical Expenditures for "64" Reports, FY 1991 - FY 1992; and DMAS internal expenditure reports, FY 1982 - FY 1991, derived from unaudited financial statements.

Average Costs for Physician Services Have Increased Dramatically. To better assess growth in these expenditures, JLARC staff examined claims for physician services made in FY 1989, FY 1990, and FY 1991 on a per-recipient and per-claim basis (Figure 13). The greatest growth was in average physician service costs per recipient. The average cost per recipient increased by more than 59 percent between FY 1989 and FY 1991 from $255 to $406 per recipient. The average cost per claim increased by almost 52 percent, from $26 to $39. Although the average number of physician claims per recipient declined slightly in FY 1990, utilization increased in FY 1991.

Growth in Average Costs Per Recipient Has Been Greatest Among Recipients in Adult Eligibility Categories. Average costs per recipient rose more sharply for adult eligibility categories than for other recipients. For example, the greatest rate of increase in average costs per recipient was for ADC-related adult recipients, whose average cost per recipient almost doubled from $244 to $462 (Figure 14). Recipients eligible as indigent pregnant women and aged also had high rates of increase — at 63 percent each. In contrast, the average cost per recipient for ADC-related children increased by only 19 percent, the smallest rate of increase among all categories.

The higher average costs for adult recipients are not surprising since their utilization of services was greater than that for children. Adult recipients, averaged as few as ten claims each or as many as 20, depending on their eligibility category. However, recipients in the children eligibility categories had, on average, fewer than nine claims each.

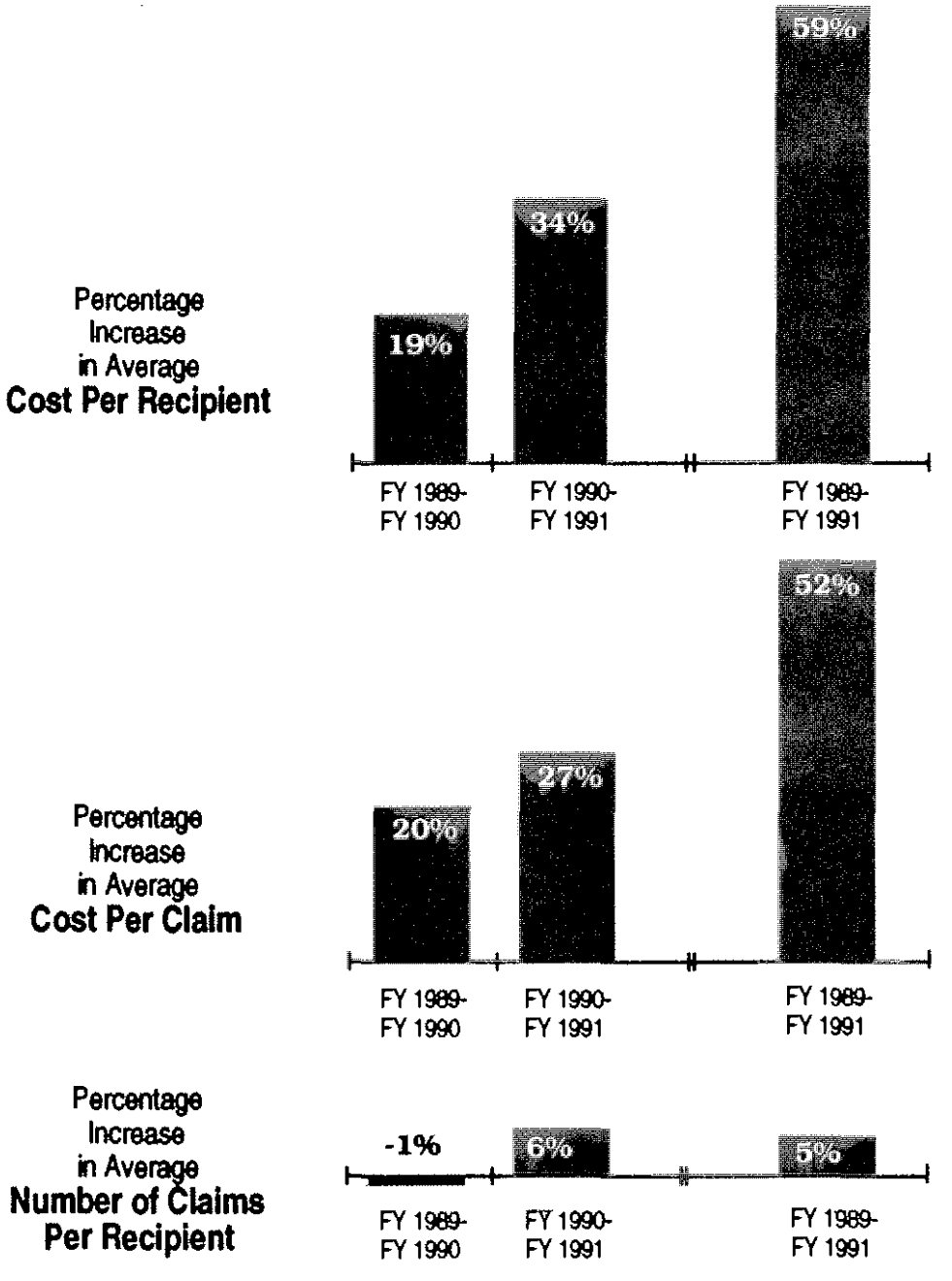
Average Costs for Optional Recipients Are Growing More Rapidly than for Mandatory Recipients, But Still Represent a Small Portion of Total Expenditures. Average costs also differed by eligibility class. There was greater growth in the costs for recipients classified as medically needy than for recipients classified as categorically needy. However, claims paid on behalf of medically needy recipients, whose coverage through Medicaid is optional, represented less than five percent of total physician expenditures each year. (See Appendix C for more information on average costs for physician services by recipient eligibility category and class.)

Factors Related to Increased Medicaid Physician Expenditures

Much of the growth in physician expenditures is related to federal eligibility expansions targeted at indigent pregnant women and indigent children. In addition, increases in reimbursement rates and the effect of inflation on those rates help explain a large portion of increased expenditures. By projecting expenditures forward from the baseline year of FY 1989, JLARC staff estimated the percentage of increase in actual expenditures for FY 1991 due to changes in the number of recipients, the number of claims, and inflation related to reimbursement rate increases. Appendix D contains additional information on the methodology used to make these estimates.

Figure 13

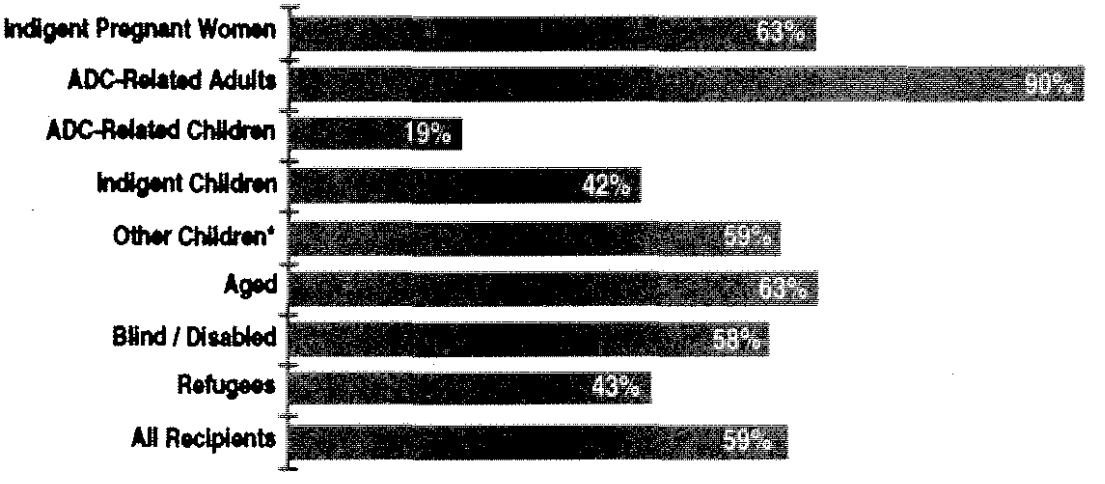
Percent Growth in Average Physician Expenditures FY 1989 - FY 1991



Source: JLARC staff analysis of Department of Medical Assistance Services physician claims, SAS datasets, FY 1989 - FY 1991.

Figure 14

Percent Growth in Average Costs per Recipient for Medicaid Physician Services by Eligibility Category FY 1989 - FY 1991



*Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

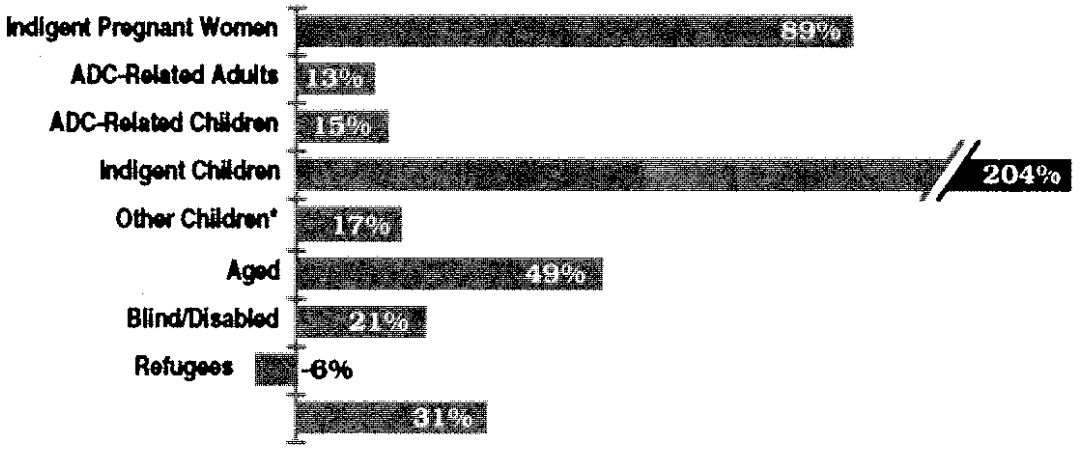
Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS datasets, FY 1989 - FY 1991.

Expansions in Eligibility Significantly Increased the Number of Recipients of Physician Services, the Number of Claims, and Related Expenditures. As discussed in Chapter I, recent federal mandates related to eligibility have significantly increased enrollment of beneficiaries in the Medicaid program and the number of recipients of services. Although the number of recipients of physician services increased in all eligibility categories except refugees between FY 1989 and FY 1991, the greatest growth occurred in the new indigent categories (Figure 15). During this period, the number of indigent pregnant women increased by 89 percent and the number of indigent children recipients increased by more than 200 percent. As Figure 16 illustrates, growth in expenditures was also greatest in these two eligibility categories.

Examination of claims data revealed that changes in the total number of recipients who had Medicaid physician services paid on their behalf between FY 1989 and FY 1991 accounted for about 28 percent of the growth in expenditures over the same period. However, when changes in the mix of recipients are included, a greater percentage of growth in physician expenditures is explained. Approximately 32 percent of the growth is attributable to the combined effect of changes in the total number and mix of recipients. The combined effect accounts for the effect that the two factors have individually and on each other. For example, one of the recipient categories with the

Figure 15

Percent Growth in Medicaid Recipients of Physician Services, by Eligibility Category FY 1989 - FY 1991



*Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Note: Total number of recipients is lower than the sum of the individual categories of recipients due to changes in eligibility status. Many recipients may be enrolled in more than one category in any given fiscal year.

Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS datasets, FY 1989 - FY 1991.

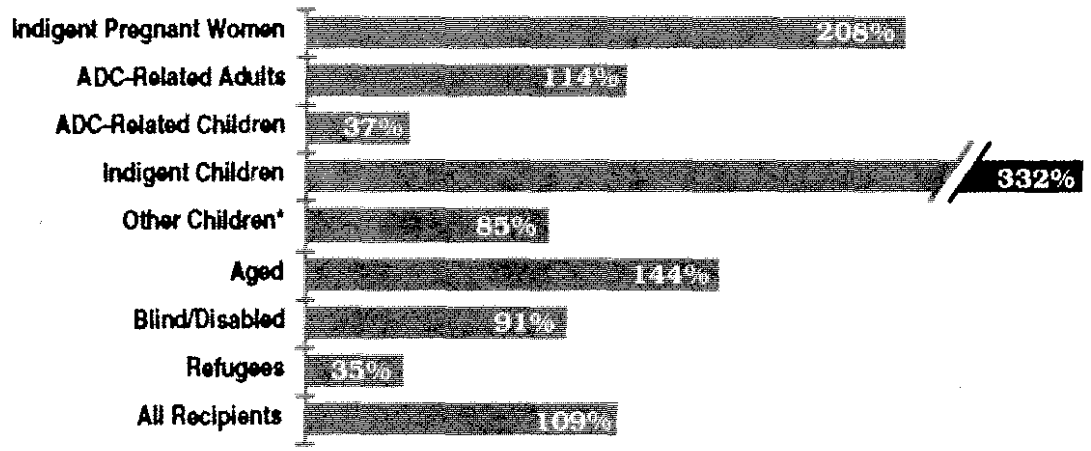
greatest growth, indigent pregnant women, is also one of the categories with the highest cost per recipient. Therefore, increases in the number of pregnant women receiving Medicaid physician services would have a greater impact on the growth of physician expenditures than increases of persons in other eligibility categories.

The federally-mandated eligibility expansions also significantly increased the number of physician service claims since the greatest growth was for services rendered to recipients in the indigent children and indigent pregnant women categories. The number of claims for indigent children and indigent pregnant women increased by 222 percent and 141 percent, respectively, from FY 1989 to FY 1991.

Inflation Related to a Recent Increase in Physician Reimbursement Rates Accounts for a Large Portion of the Remaining Growth in Expenditures for Physician Services. When reimbursement rates are maintained at the same level for several years, as occurred during the early 1980s, inflation does not affect expenditures. This is one reason that reimbursement for physician services remained fairly constant during that period. But when a reimbursement rate increase is implemented, inflation rates for the entire period between reimbursement rate increases will have a cumulative effect on expenditures for physician services. This is what occurred in the latter half of the decade.

Figure 16

Percent Growth in Medicaid Physician Expenditures by Recipient Eligibility Category, FY 1989 - FY 1991



*Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS datasets, FY 1989 - FY 1991.

One reimbursement rate increase was implemented during the period for which claims data were examined (FY 1989 to FY 1991). In January 1990, Virginia increased reimbursement rates for all physician services to the 15th percentile of ranked charges for the 1989 claims year. Funding for this increase in FY 1990 totaled $12 million in general and non-general fund appropriations. Prior to that change, physician reimbursement rates had been based on charges from 1986 or an earlier claims year.

Inflation in the cost of physician services between 1986 and 1989 is accounted for in the charges used to rebase the reimbursement rate increase. This inflation is responsible for almost 21 percent of the $63.6 million increase in physician expenditures between FY 1989 and FY 1991. However, a much greater percentage of the growth in expenditures, approximately 60 percent, is explained by the combined effect of inflation and changes in the number and mix of recipients. Not surprising, an even greater percentage of the increase in physician expenditures, almost 73 percent, can be attributed to the combined effect of inflation in physician service costs and changes in the number and mix of claims by recipient eligibility category.

THE REIMBURSEMENT SYSTEM FOR PHYSICIAN SERVICES

States have broad discretion in determining fee levels and payment methodologies for physician services. Federal regulations require that payment be consistent with efficiency, economy, and quality of care. However, payment must also be sufficient to ensure that services are available to Medicaid beneficiaries at least to the same extent as to the general population.

Virginia reimburses physician services on a fee-for-service basis, according to a fee schedule. This is the predominant method used by other state Medicaid programs for physician reimbursement. However, Virginia reimbursement rates are based on charges from a past claims year. These rates can remain at the same level for several years — only changing by legislative appropriation. Consequently, the reimbursement rates do not keep pace with inflation in physician charges and practice costs.

When reimbursement is maintained at the same level for several years, physicians may have to make choices between maintaining the financial viability of their practices and participating in the program. The ability of many physicians to continue treating Medicaid patients is contingent upon receiving reimbursement sufficient to cover most of their costs. As physicians limit their acceptance of Medicaid patients, access problems develop.

It is important to maintain and enhance the amount of Medicaid care provided in physicians' offices. Provision of medically necessary care may be much more cost effective if obtained at a practitioner's office than at a hospital outpatient department or emergency room.

Physician Reimbursement Erodes over Time Relative to Charges and Practice Costs

Medicaid reimbursement in Virginia generally does not compare favorably with the amount paid by many other third-party payers. In fact, some physicians state that they lose money every time they treat a Medicaid patient. Although current reimbursement rates generally appear to meet physician costs, there is great variation depending on the type of service rendered, the place of treatment, and the physician's specialty. In addition, because reimbursement is based on charges from a past claims year, the gap between reimbursement paid by the Medicaid program and physician costs may become larger each year.

Reimbursement rates have been increased three times in the last five years (Exhibit 1). The maximum payment level for each service is determined on the basis of ranked charges from a previous claims year. Although charges may increase each year, payment does not necessarily increase. For example, physicians and local health department clinics are currently reimbursed up to the 15th percentile of ranked charges

Exhibit 1

Reimbursement Rate Increases for Physician Services during Last Five Years

Effective Date of Reimbursement Rate Increase	Procedures to Which Increase Applies	Percentile Ranking for Maximum Payment	Base Year for Ranked Charges
January 1, 1988	Primary Care	25th Percentile	1986
January 1, 1990	All	15th Percentile	1989
October 1, 1991	Obstetric and Pediatric Care*	25th Percentile	1990

*Pediatric care is defined as medical and surgical procedures rendered to recipients younger than age 21.

Source: Department of Medical Assistance Services, Division of Client Services, April 6, 1992.

from the 1989 claims year. For pediatric services (defined as medical and surgical procedures rendered to recipients younger than age 21) and certain obstetric services, reimbursement is set at the 25th percentile of ranked charges from the 1990 claims year.

The percentile ranking serves as the maximum payment level for a particular procedure. Providers whose charges are at or below the maximum payment level are reimbursed 100 percent of their charges. However, when provider charges are higher than the maximum payment level for a procedure, the provider is only reimbursed the maximum payment level. For example:

> *Assessment of claims data for August 1991 indicated that one physician billed the program $8.40 for a limited office visit by an established adult patient. Since this was less than the maximum payment level for that service, the physician was paid $8.40 — the amount of the charge. However, most physicians charged more than the maximum payment level for the same service. The average physician charge for a limited office visit by an established adult patient during August 1991 was $31.60. Physicians who charged this amount were paid only $20.00, the maximum payment level for an established patient limited office visit.*

When providers charge similar fees, there is less variation in the percentiles for the ranked charges. For example, 35 charges for ultrasonic guidance for amniocentesis during calendar year 1990 were ranked. Charges at the fifth through tenth percentiles were the same — $30. At the 15th percentile, charges were $63 and at the 20th, 25th, and 50th percentiles, charges were $75.

Medicaid Reimbursement in Virginia Is Generally Lower than Reimbursement by Other Payers. It is difficult to compare Medicaid reimbursement in Virginia to reimbursement by other third-party payers because reimbursement data for commercial payers are considered proprietary information. However, there are several indications that Medicaid reimbursement is generally lower than that of other payers.

The Physician Payment Review Commission (PPRC) of the U.S. Congress has compared Medicaid reimbursement across states to reimbursement by Medicare and some commercial insurers. A review of their data indicates that Virginia has been more generous in reimbursement than some states but has been considerably less generous than others (Table 2). For example, reimbursement for obstetric procedures in Virginia was lower than most neighboring states in FY 1989. However, Virginia's reimbursement has increased since then to $1,200 for total care with a vaginal delivery and to $1,441 for a cesarean-section delivery.

Information on physician charges is available through the Medicaid claims database. Although some third-party payers reimburse 100 percent of charges, most

Table 2

Comparison of Reimbursement Rates for Certain Obstetric Procedures Paid by the Virginia Medicaid Program to Rates Paid by Neighboring State Programs during FY 1989

	Obstetric Procedures			
	Total Care Vaginal Delivery	Vaginal Delivery	Total Care C-Section Delivery	C-Section Delivery
District of Columbia	N/A	600	N/A	775
Kentucky	N/A	581	N/A	595
Maryland	N/A	895	N/A	948
North Carolina	925	550	1,025	650
Pennsylvania	N/A	313	N/A	459
South Carolina	N/A	700	N/A	800
Tennessee	725	363	925	650
Virginia	**$625**	**$450**	**$820**	**$645**
West Virginia	600	330	913	630
National Median	$738	$440	$903	$638

Note: N/A indicates the data were not available from these states.

Source: Physician Payment Review Commission, *Physician Payment Under Medicaid*, 1991.

reimburse only a certain portion. Physician associations reported that the percentage reimbursed is generally between 60 and 80 percent of charges or more. However, even with the rate increases, the Virginia Medicaid program typically reimburses a much lower percentage of charges. For example:

> *The Medicaid program reimbursed physicians, on average, approximately 39 percent of their charges for services rendered during the six months prior to the January 1, 1990, rate increase. For services rendered during the six months after this increase, physicians were reimbursed almost 59 percent of their charges, on average.*

In addition, a JLARC survey of physicians enrolled as providers in the Virginia Medicaid program asked physicians whether reimbursement by the Medicaid program compares favorably with the amount paid by other third-party payers. Few physicians agreed that Medicaid reimbursement was comparable, and those who did were the physicians most affected by the recent fee increases. Family practitioners, obstetrician/gynecologists, and general pediatricians were much more likely to agree that reimbursement was comparable than were physicians with other specialties. Physicians practicing internal medicine were more likely to disagree.

Modeling Physician Reimbursement in the Virginia Medicaid Program After Medicare Reimbursement Does Not Appear Feasible at the Present Time. Physician reimbursement has been studied at the national level for several years. In 1986, the U.S. Congress established the Physician Payment Review Commission (PPRC) to study physician payment under the Medicare program. Later, through the Omnibus Budget Reconciliation Act of 1989, PPRC was directed to study physician payment under state Medicaid programs. And in 1990, PPRC was given permanent responsibility for consideration of policies related to access to care and the level of Medicaid payments to physicians.

The Physician Payment Review Commission has established several goals for Medicaid payment policy (Exhibit 2). These goals will be used as the framework for reforms in physician payment at the federal level. They also provide a valuable starting point for any changes to be made at the State level. For example, raising reimbursement for Medicaid to Medicare levels would address some physician inequities but would be very costly for the State. Virginia's reimbursement has been considerably lower than that for Medicare.

The Physician Payment Review Commission supports a long-term goal of raising Medicaid fee reimbursement to Medicare levels. PPRC estimated that raising FY 1989 reimbursement for physician services to the Medicare level in Virginia would have increased expenditures by 75 percent, at a cost of almost $40 million for that year alone.

While this goal may be desirable in the long-term, given current budget constraints, it is not feasible at the present time. Furthermore, it is not clear how much it would cost the State to model reimbursement after Medicare reimbursement now. The

Exhibit 2

Goals Established by the Physician Payment Review Commission for Medicaid Physician Payment Reform

- *Enhance Medicaid Beneficiary Access to Medical Care*
  - in physicians' offices
  - for services such as prenatal care, obstetric services, and other primary care
- *Maintain or Improve Quality of Care*
  - through improvement in key health status indicators
    -- infant mortality
    -- the rate of low birthweight births
- *Address Inequities Among Physicians*
  - by not placing physicians who treat Medicaid beneficiaries at a substantial economic disadvantage relative to their peers
  - by not forcing physicians to make trade-offs between service to low-income communities and the viability of their practices
- *Constrain Expenditure Growth*
  - by recognizing the need for fiscal responsibility
  - by recognizing the competing demands placed on federal and state tax dollars
  - by exploring methods that encourage more appropriate and cost-effective care
- *Strive for Administrative Simplicity*
  - so that the method of payment is easy to understand and to administer
  - so that short-term reforms are orderly and consistent with long-term goals
- *Maintain Flexibility*
  - to accommodate diverse needs of the distinct populations served by state Medicaid programs
  - to accommodate needs which are unique to each state
- *Treat Beneficiaries Equitably*
  - by recognizing their rights
    -- to receive appropriate medical services of high quality
    -- to be treated with dignity

Source: Physician Payment Review Commission, *Physician Payment Under Medicaid,* 1991.

Medicare program has recently been reformed so that payments are now made according to resource-based relative value scales.

Although the effects of this reform are not yet clear, similar reform may hold some promise for future changes in Virginia's Medicaid program. The Department of Medical Assistance Services has already begun to assess the impacts of implementing reforms similar to those implemented at the national level for Medicare and in the Maine Medicaid program. DMAS staff are determining whether the procedures defined as "overvalued" in the Medicare program also appear to be overvalued in the Virginia Medicaid program.

Another across-the-board increase does not appear feasible either. However, 65 percent of physicians responding to the JLARC survey reported that increases in reimbursement would encourage them to accept more Medicaid recipients as patients in their practices. Although many physicians did not specify the level of increase needed, there was support for raising fees to Medicare levels or to levels of other third-party payers. Approximately two-thirds of these respondents rated increasing reimbursement the most important change that could be made, and 80 percent rated it among the top three changes.

Patient Cost-Sharing Often Functions as a Means of Reducing Physician Reimbursement. Physician reimbursement is further reduced relative to actual charges because many providers cannot collect patient cost-sharing amounts. Virginia requires some beneficiaries to share the costs of their care as a form of utilization control. However, providers may not deny services if a recipient cannot pay the copayment. When a copayment is due, reimbursement to the provider is automatically reduced by the amount of the copayment. Consequently, when a copayment cannot be collected, the physician loses an additional $1 or $3 in reimbursement depending on the type of service provided. Moreover, the intended effect of the copayment, controlling utilization, is lost.

Approximately one-third of physicians responding to the JLARC survey of physicians reported that they do not generally collect copayments from their Medicaid patients who are required to make them. Although a small portion of these respondents were physicians whose patients have no copayment requirements (because they are children, receive maternity care, or receive family planning services), most reported they could not collect the copayment for other reasons.

The predominant reason for non-collection was the recipient's inability or refusal to pay. Physicians generally differentiated between inability and unwillingness to pay in their survey responses. For example, physicians commented:

> These patients are poor and they know that they cannot be refused service because of their inability/refusal to pay the copay[ment]. In essence, the copay[ment] acts as a Medicaid payment cut to the physician.

* * *

> Patients are not willing to pay and there is no reason to have a scene in the office for a dollar.
>
> * * *
>
> Most patients believe they don't have to pay. In addition, the copayments are so small it is hardly worth the trouble of billing.
>
> * * *
>
> Most patients on Medicaid [are] unable to make [the] copayment. [I] accept Medicaid payment as full payment.
>
> * * *
>
> [Collecting copayments is] too much trouble and almost no one can afford to pay.
>
> * * *
>
> [I do] not [require copayment in my practice] if they cannot afford one and insistence on their paying would limit their access to care.

Many physicians also indicated that it is not worth the billing costs to attempt to collect the copayment amount due. For example, one physician wrote, "The copayment is so low that it costs more to process than I receive to cover the overhead." Consequently, physicians indicated that they often write off the amount of the copayment. Alternatively, they carry the copayment amount due on their books and continue collection attempts, often at a much greater expense than would be covered by the amount due.

Although some physicians supported the concept of copayments as a means of utilization control, these copayments do not appear to be effective in controlling Medicaid recipient utilization because physicians cannot refuse to treat patients who do not pay the copayment amount. Instead, as some physicians have pointed out, copayments often act as a reduction in physician reimbursement. The total amount of reimbursement reductions due to required copayments for physician services was about $55,996 in FY 1991 and about $49,000 in FY 1992. Although there is no information on the amount of copayments actually collected by physicians, physician responses to the survey suggest that a fairly large percentage was not or could not be collected.

Physician reimbursement will be reduced by larger amounts in FY 1993 and beyond. Effective July 1, 1992, copayment requirements were extended to a larger group of beneficiaries and the amount was increased from $1 to $3 for physician services rendered in a hospital setting. The difficulties in collecting the copayment amounts may be exacerbated by these changes especially if additional recipients are unable to pay the copayment amount.

Recommendation (1). **The General Assembly may wish to consider abolishing the copayment requirement for physician services.**

Maintaining Physician Participation in the Medicaid Program

It is important to maintain — and improve — physician participation in the Medicaid program. Doing so will not only enhance recipient access by providing more caregiver options, but may also lower total program expenditures. The literature suggests that reimbursement levels for physicians do not appear to affect whether beneficiaries seek and obtain care, but do affect the site of care. Increasing reimbursement rates may also divert recipients who use alternative sources of care, which may be more expensive, into physician care.

Improving physician participation was a stated goal of the recent reimbursement rate increases in Virginia. Although participation appears to have improved, this improvement is not necessarily due to the rate increases. However, participation probably would have deteriorated if rates had remained at the same level and the gap between charges and reimbursement had continued to increase. Physicians participate in Medicaid for reasons other than reimbursement, but reimbursement must be sufficient to allow physicians to maintain their financial viability. Other concerns about the Medicaid program could exacerbate low reimbursement and deteriorate current participation levels.

Low Reimbursement May Be the Primary Reason for Non-Participation by Physicians. Physicians who are enrolled as Medicaid providers appear to have a strong sense of professional commitment to their patients. Seventy percent of all physicians who responded to the JLARC survey indicated that they participate because they believe it is an ethical obligation of the profession. However, many physicians also wanted to be reimbursed for services rendered to poor patients that would have been charity care otherwise.

Even though physicians believe they have an obligation to participate, reimbursement must be sufficient to cover most or all of their practice costs so that they can maintain their financial viability. Low reimbursement has a negative effect on participation — physicians are more likely to limit participation or cancel it altogether when reimbursement is too low.

Some physicians commented on the need to limit the number of Medicaid patients in their practices because of low reimbursement. For example:

> I currently receive no reimbursement for preventive care services rendered to Virginia Medicaid patients. I am currently severely limiting new Virginia Medicaid patients because of very poor reimbursement. Especially compared to Tennessee Medicaid reimbursement. I cannot afford to pay rent or employee salary at rates provided by Virginia's Medicaid for office visits.

* * *

> I believe your reimbursement [rates] for certain services are awful e.g. fetal echocardiogram: [CPT code number] 76825, our charge is $800, you are paying [a] shameful [rate], below my supplies for the procedure.

* * *

> Our main concern (and those not seeing Medicaid patients) is the need to keep charges and reimbursement current. What was current last year may not be this year, and reimbursement should be adjusted yearly. Otherwise, the state does as well generally as most private insurers.

Physicians who had cancelled their enrollment agreements at some time in the past (but had subsequently reenrolled as Medicaid providers) cited low Medicaid reimbursement as the primary reason for cancellation of enrollment in the program. For example:

> *One physician reported cancelling his participation agreement with Medicaid because payments were below the cost of running his practice. Even though this physician reported still losing money when seeing Medicaid patients, he later reenrolled as a provider to help patients. According to the physician, none of the other 25 gynecologists in his town accepted Medicaid.*

Physician dissatisfaction with reimbursement is not surprising since reimbursement was increased only once (by five percent in 1981) between 1969 and 1986. Over this same period, however, charges for office visits increased by 150 percent — so that by 1986, Medicaid reimbursement was not even covering overhead expenses. Moreover, the reimbursement increases in 1986 and 1988 did not benefit all physicians since they were targeted to particular services.

Reimbursement Increases Did Little to Enhance Participation of Enrolled Physicians But May Have Helped Maintain the Same Level of Participation. Physicians were asked to compare the number of Medicaid patients in their practices after each of the two most recent reimbursement rate increases to the number in their practices before the increases. After both increases, many physicians responding (41 percent for the January 1990 rate increase and 48 percent for the October 1991 rate increase) reported that the number of Medicaid patients in their practices remained about the same.

However, those whose practices had an increase in Medicaid patients generally did not attribute any changes in their level of participation in the program to concurrent increases in the reimbursement rate. For example, most of the 102 physicians who responded that the number of Medicaid patients in their practices increased after the

January 1990 reimbursement rate increase attributed the increase to changes in the community. Nevertheless, some did attribute the increase in Medicaid patients, at least in part, to the new reimbursement rate. Specifically:

- 74 reported that the number of Medicaid patients in their practices increased because the number of Medicaid beneficiaries in the community increased
- 41 reported that the number of other physicians in the community to treat Medicaid patients decreased
- nine reported that Medicaid patients were helping establish the patient base in a new practice
- seven reported that the volume of other patients in their practice decreased
- 15 reported that January 1990 increase in reimbursement rates met a sufficient portion of actual practice costs to make a higher level of participation more cost effective
- 16 reported other reasons.

Physicians responses mirrored the above statistics for the October 1991 reimbursement rate increase. Although fewer physicians reported that the number of patients in their practices increased after that fee increase, their reasons for the increase in the number of Medicaid patients seen in their practices were similar. However, a smaller percentage of physicians attributed the increase to changes in the community.

Relatively few physicians reported decreases in the number of Medicaid patients seen after each of the two reimbursement rate increases. For cases in which this did occur, the predominant reason for the decrease in Medicaid patients given by these physicians was an increase in the volume of other patients in their practices.

The JLARC survey findings appear to confirm those in national and other state studies on physician reimbursement. The literature suggests that increasing reimbursement rates may positively affect physician participation in the program by increasing the number of physicians that accept Medicaid recipients as patients. However, increasing reimbursement does not necessarily enhance the number of Medicaid recipients accepted as patients by physicians already participating in the program. Factors which appear to be positively related to physician participation in Medicaid include competitive rates vis a vis those paid by other parties, the supply of physicians, the density of the Medicaid population, and being a foreign medical school graduate.

It also appears that many DMAS perceptions of physician participation are correct. Although DMAS staff have not assessed the impact of the reimbursement rate increases, several staff stated during interviews that they believe more physicians are participating in the program. In fact, assessment of the provider enrollment and claims databases indicates that more physicians participated after each of the two most recent

reimbursement rate increases than were participating prior to either of the increases. However, as the survey responses indicate, increased participation was not necessarily due to reimbursement rate increases.

Higher Medical Risks and More Disruptive Behavior Associated with Medicaid Recipients Exacerbate Physician Concerns About Low Reimbursement. A 1989 Medical Society of Virginia survey of physicians identified several negative behaviors or characteristics which physicians and the general public attribute to Medicaid recipients. Many of these perceptions were reaffirmed through discussions with medical society staff and responses to the JLARC survey of physicians. Physician concerns about Medicaid recipient behaviors pointed to the strong need for recipient education through the Medicaid program.

Most physicians validated commonly-held perceptions about certain risks associated with Medicaid patients, but did not agree with the categorization of Medicaid patients as being more likely to bring a medical malpractice suit than other patients. Physicians did concur that Medicaid patients are more likely to be medically high risk than other patients. In addition, they reported that Medicaid patients are more likely to exacerbate risks by not seeking routine or preventive care and allowing an acute condition to deteriorate to a level requiring more extensive treatment.

Medicaid patients are also more likely than other patients to disrupt a physician's practice in certain ways. For example, Medicaid patients do not adhere to appointment schedules in two ways. First, they may be more likely than other patients to show up without an appointment and demand to be seen immediately. Second, 62 percent of physicians responding to the survey reported that Medicaid patients are more likely to be late for or not keep their scheduled appointments than other patients. Several physicians commented on the disproportionate number of "no show" Medicaid patients; one physician estimated that 40 percent of his Medicaid scheduled appointments are no shows. Another stated that Medicaid patients are less likely to keep their appointments even when called to remind them.

One physician explained that accepting Medicaid patients results in lost opportunity costs — which are exacerbated by the high no-show rate for scheduled appointments. A physician can lose money (relative to the amount which could be collected from other patients) each time a Medicaid patient is treated because reimbursement for Medicaid patients is often at or below the break-even level for expenses. A physician loses even more money when Medicaid patients do not keep their appointments because the appointment time is lost to any other patient.

Physicians also commented on abuse of the Medicaid program by recipients through overutilization or inappropriate utilization of services. For example:

> These patients demand more and are constant emergency room users. Medicaid patients Feel like Constant Service is a Right so [they] misuse it.

* * *

Something must be done to return some of the responsibility of care to the patients. Sharing part of the cost should be part of this. Putting limits/restrictions on patients' eligibility/expenditures/access are necessary. Other groups do not have unlimited coverage/access and resent that Medicaid patients appear to have this very desirable privilege.

* * *

Medicaid patients need a "medical home" and should not be allowed to "doctor shop" so much. There is tremendous abuse of the system in that regard.

* * *

Medicaid patients are generally very frustrating to treat. The older Medicaid patient generally has multiple medical problems and ..... follow through on proposed treatment plans is erratic at best. I don't mind trying to deal with the problems, but frankly it is disturbing to spend enormous amounts of time and energy with these patients to get dirt cheap reimbursement for my services. I cannot pay office expenses with what I get on Medicaid patients.

I do not generally like to treat younger Medicaid patients. They frequently "doctor shop"...and seem to show little interest in developing a "doctor-patient contract."

I have some Medicaid patients who I have received inadequate compensation for but whom I keep because there is a good doctor-patient relationship and because I know that if I am not treating them they might get "bounced" around from one doctor to another and their medical care would suffer.

These examples, coupled with higher medical risks for Medicaid patients, illustrate the need for recipient education about patient responsibilities. The Department of Medical Assistance Services has begun to address the higher costs associated with inappropriate recipient utilization patterns. For example, reimbursement for non-emergency procedures performed in the emergency room is now reduced, saving almost $1.8 million in physician reimbursement during FY 1992. But rather than directly address inappropriate recipient utilization patterns, this type of reduced reimbursement penalizes providers. One physician commented that, "Reduction of reimbursement based on final diagnosis of patients seen in [the] E.R. is unfair."

Recipient utilization patterns are generally not controlled because of federal requirements that Medicaid beneficiaries have freedom of choice in selecting their

providers. Most can seek care whenever and wherever they want. However, 865 beneficiaries enrolled in the Virginia Medicaid program were restricted to a particular physician for their care through the recipient medical management program as of June 1, 1992. These recipients were placed in the program because they had been identified as overutilizing services. Approximately one-half of these restricted recipients are ADC-related and the other half are disabled. They must have referrals to visit other physicians, and routine care performed in the emergency room is not reimbursed.

The Medallion program, which is operating on a pilot basis in four localities, is similar to the recipient medical management program in that recipients must obtain their care through their assigned primary care physician or by referral. Its primary purpose, however, is to enhance recipient access rather than control recipients identified as overutilizing services. Nevertheless, implementation of the Medallion program statewide will help control "doctor shopping" among participating recipients. Medallion may be less successful at changing other recipient behaviors, such as not making or keeping appointments and not seeking care when needed, unless it contains an aggressive recipient education component.

Despite these two programs, the responsibility for controlling utilization primarily falls to the physician because the Medicaid enrollment process is not successful at educating recipients about appropriate utilization of physician services, including scheduling and keeping appointments. The current process for enrolling beneficiaries does not include a strong educational component. Observation of face-to-face eligibility determination meetings between social service eligibility workers and applicants confirmed that workers who make eligibility determinations do not routinely explain the rights and responsibilities of beneficiaries. Instead they rely on information in printed materials, which may or may not be provided to applicants. These meetings focus on whether the applicant meets the requirements for eligibility, not their coverage if approved. Further, because federal law requires that mail-in applications be accepted, some applicants never discuss details of the program with local social service staff.

Consequently, at the time of their enrollment, recipients may incorrectly believe that they are entitled to all physician services, even those not covered by the program or those obtained when they were not eligible for coverage. Physicians and their staff then have difficulty collecting payment for non-covered services from recipients.

Recommendation (2). **The Department of Medical Assistance Services should design a recipient education program on patient responsibilities and appropriate utilization which should be implemented at the time of enrollment through local social services departments. The department should provide guidance to the Department of Social Services in implementing recipient education. This should include training of local social service eligibility workers on techniques to educate recipients on service benefits and appropriate utilization. This program should receive priority so that it may be implemented in conjunction with expansion of the managed care program statewide.**

Further Expansion of the Medallion Program Could Enhance Physician Participation and Improve Recipient Access. As mentioned earlier, the Medallion program is currently operating on a pilot basis in four localities. It is targeted for statewide implementation during 1993. The Medallion program evolved from a 1990 General Assembly mandate that the Department of Medical Assistance Services test the feasibility of establishing a statewide managed care system for Medicaid recipients. Before implementing the managed care program on a pilot basis, Virginia had to request waiver authority and receive approval from the U.S. Health Care Financing Administration, the federal agency with oversight responsibility for state Medicaid programs. Additional waiver authority is required to expand the program statewide.

Recipients participating in Medallion can only access certain services through their assigned primary care physician (generally a physician whose specialty is family or general practice, pediatrics, internal medicine, or obstetrics and gynecology) who functions as a "gatekeeper." Primary care physicians either provide all non-emergency care directly to recipients or refer them to other providers as appropriate. These physicians coordinate hospital inpatient admissions and maintain a comprehensive, unified patient medical record for each recipient in their care. They must also ensure that 24-hour coverage is available to their patients.

DMAS has considered expanding the Medallion program to include all ambulatory recipients. However, even when implemented statewide, Medallion is currently designed to cover only those recipients who are classified as ADC-related, indigent pregnant women, or indigent children. Although average costs for ADC-related adults have grown dramatically, they are still lower than average costs for ambulatory adults classified as blind or disabled under Medicaid eligibility criteria. Further, the average costs for aged ambulatory recipients are greater than those for any of the children categories.

DMAS should place a high priority on expanding the Medallion program to include other ambulatory recipients — particularly those classified as aged, blind, and disabled since an access problem may be developing for these recipients. Adults may have fewer sources of care available to them than children and pregnant women for several reasons. First, local health department clinics are not required to serve elderly and disabled patients — and if they do, care is not available on a 24-hour basis. Second, because reimbursement rates for these patients are lower than those for pediatric and obstetric Medicaid patients, they may put a greater financial strain on practices of physicians who primarily treat these adults.

Third, physicians who practice general internal medicine — those most likely to treat these patients — reported lower participation rates than other physicians who responded to the survey. These physicians were more likely to restrict acceptance of new patients than any other specialty. For example, only 39 percent reported accepting new Medicaid patients without restriction and another 28 percent reported having limits on the number accepted. In contrast, 72 percent reported accepting new Medicare patients. However, 28 percent reported that they do not accept any new patients, regardless of

insurance status. Physicians practicing general internal medicine also expressed more concerns about the adequacy of reimbursement.

Including these recipients in the Medallion program would not only enhance access for them but could also ensure that their health care needs, which may be chronic, are more closely monitored. Moreover, it could encourage greater physician participation. Primary care physicians who manage their care would receive greater reimbursement, without a rate increase, through the monthly case management fee or bonus incentive.

Recommendation (3). **The General Assembly may wish to consider directing the Department of Medical Assistance Services to expand the Medallion program to include all ambulatory recipients. This expansion should be undertaken in 1994 after the program, as currently defined, has been implemented statewide and additional waiver authority has been obtained.**

III. Financing of Medicaid Pharmacy Services

Tremendous growth in Medicaid pharmacy expenditures has resulted in scrutiny at State and federal levels. In the Virginia Medicaid program, reimbursement for pharmacy services has more than quadrupled during the past ten years to a high of $126 million in FY 1992. Although a large portion of this growth reflects federally-mandated eligibility expansions, some of the increase in expenditures is due to inflation in the cost of prescription drugs.

Consequently, recent federal mandates have been directed at slowing the growth of Medicaid pharmacy expenditures. One of these federal mandates has already been implemented, but others will be phased-in over the next year. The federally-mandated drug rebate program, which was implemented in FY 1991, has achieved some success in reducing program expenditures. This program targets the source of prescription drug inflation by requiring pharmaceutical manufacturers to give the Medicaid program their "best price."

The Department of Medical Assistance Services (DMAS) is in the process of implementing a drug utilization review program and initiating prior authorization of certain high-cost medications to further control Medicaid pharmacy expenditures. DMAS staff are also beginning to explore other cost containment alternatives. It is important to note that Virginia's efforts to control pharmacy expenditures are limited to some extent by federal statute and regulations. For example, federal statute prohibits Virginia from lowering its reimbursement to pharmacy providers before January 1, 1995. Nevertheless, high priority should be given to assessing the feasibility and impact of implementing cost containment alternatives, due to the high cost of pharmacy services and the rapid growth in these expenditures.

Although coverage of pharmacy services is optional, all state Medicaid programs cover them. Research supports continued coverage of pharmacy services because drug therapy can be one of the most cost-effective forms of treatment for many medical conditions. Discontinuing coverage of pharmacy services could have negative effects on recipients' health status and could result in greater expenditures for other services — such as costly hospitalizations.

Coverage of pharmacy services through the Virginia Medicaid program has fewer limits than many other state Medicaid programs. Covered services include:

- prescription drugs
- certain over-the-counter (OTC) drugs for Medicaid recipients residing in nursing facilities
- insulin, syringes, and needles for diabetics

- diabetic test strips for Medicaid recipients younger than age 21
- family planning drugs and supplies
- medically necessary immunizations for children, if provided as part of early and periodic screening, diagnostic, and treatment (EPSDT) services.

The Medicaid program does impose limits on the type of pharmacy services covered, however. For example, the program does not cover the following:

- anorexiant drugs for weight loss
- DESI drugs (those deemed less than effective by the U.S. Food and Drug Administration)
- investigational/experimental drugs or drugs that have been recalled
- dietary or nutritional supplements that are not prescription drugs
- vaccines for routine immunizations (except those provided to children through EPSDT services)
- fertility drugs
- drugs used for cosmetic purposes solely or hair growth
- drugs whose manufacturer does not have a rebate agreement with the federal government.

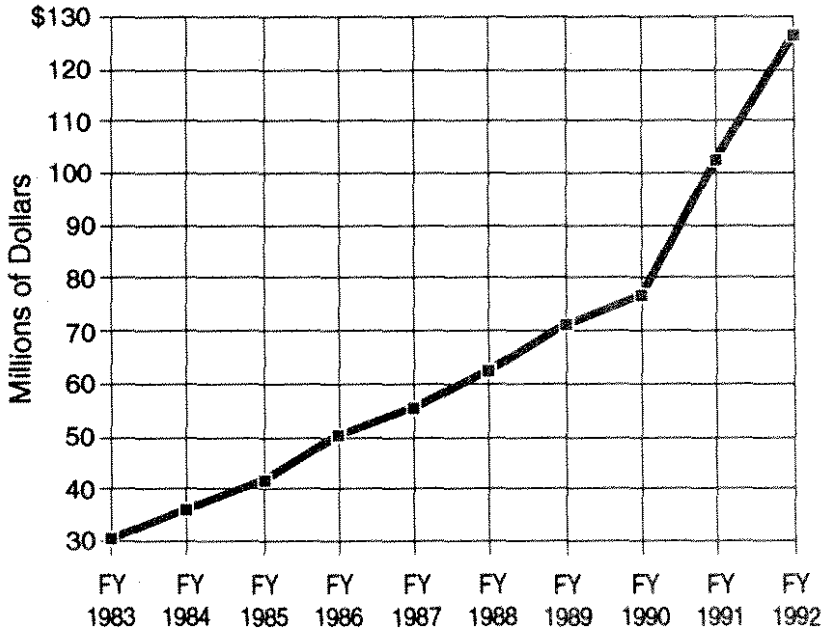
EXPENDITURE GROWTH IN MEDICAID PHARMACY SERVICES

Growth in pharmacy expenditures increased at a steady rate, averaging about 14 percent each year between FY 1983 and FY 1990 (Figure 17). However, in FY 1991 the growth rate accelerated as expenditures increased by 34 percent over the previous fiscal year. Much of this recent growth can be attributed to large increases in the number of persons eligible for and receiving Medicaid pharmacy services.

Analysis of claims data for fiscal years 1989 to 1991 indicates that increases in program recipients accounted for about 57 percent of the growth in program expenditures. When inflation in prescription drug prices for this time period is considered along with increases in recipients, about 87 percent of the growth in program expenditures is explained.

Figure 17

Medicaid Pharmacy Expenditures
FY 1983 - FY 1992



Note: Expenditure data for FY 1991 and FY 1992 do not reflect decreases due to drug rebate amounts received in FY 1992.

Source: Department of Medical Assistance Services, CARS Medical Expenditures for "64" Report, FY 1991 and FY 1992; and DMAS internal expenditure reports, FY 1982 - FY 1991, derived from unaudited financial statements.

Current Distribution of Medicaid Pharmacy Services

The Virginia Medicaid program expended almost $103 million in FY 1991 to provide pharmacy services for 318,422 recipients. Almost six million pharmacy claims were incurred by Medicaid beneficiaries who received these services. Most pharmacy expenditures were for claims paid on behalf of persons categorized as aged, blind, or disabled under Medicaid eligibility criteria. However, the program has experienced some shifting in the distribution of pharmacy services. Recent eligibility expansions directed at indigent pregnant women and indigent children have resulted in greater increases in pharmacy expenditures.

Most recipients of pharmacy services are ambulatory. Nevertheless, long-term care recipients incur a disproportionate amount of pharmacy claims and expenditures. This can be attributed to their higher utilization of pharmacy services. Often, persons in long-term care have higher needs for long-term maintenance drugs. In addition, the

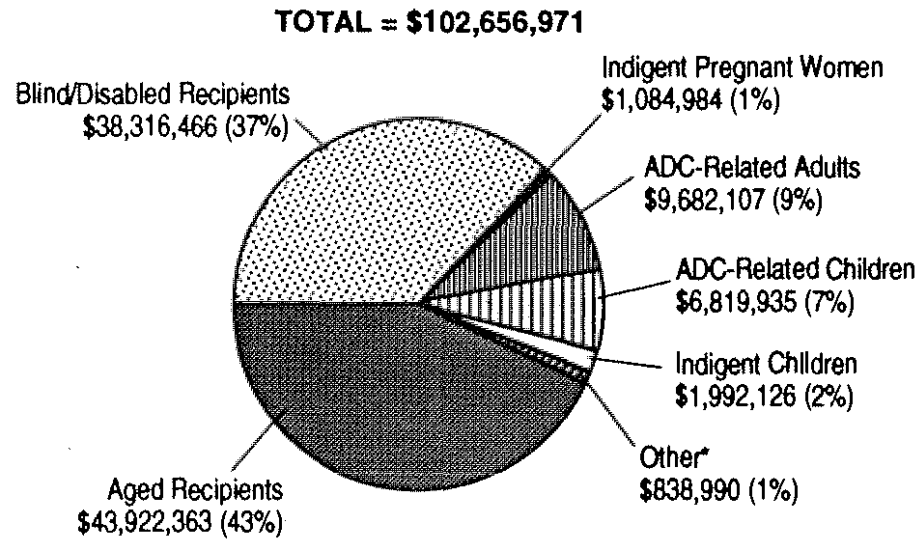
Medicaid program provides reimbursement for certain over-the-counter drugs for institutionalized long-term care recipients. This also contributes to the higher number of pharmacy claims for these recipients.

Most Pharmacy Expenditures Are for Claims Paid on Behalf of Aged, Blind, and Disabled Recipients. Analysis of FY 1991 claims data indicates that about 80 percent of Medicaid pharmacy expenditures in FY 1991 were for claims paid on behalf of aged, blind, and disabled recipients (Figure 18). These categories include both ambulatory and long-term care recipients. These recipients also accounted for about 76 percent of all pharmacy claims.

Several articles indicate that elderly and disabled recipients account for a majority of prescription drug expenditures in state Medicaid programs and that their utilization is increasing. For example, the national median rates of prescriptions per elderly and disabled recipients increased from 20 prescriptions in 1980 to almost 26 prescriptions in 1987. In Virginia, aged Medicaid recipients had an average of 44 pharmacy claims per recipient in FY 1991. Blind and disabled recipients had an average of 32 pharmacy claims per recipient.

Figure 18

Medicaid Pharmacy Expenditures by Recipient Eligibility Category, FY 1991



*Other includes children in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities; and refugees.

Source: JLARC staff analysis of Department of Medical Assistance Services pharmacy claims, SAS dataset, FY 1991.

Examination of pharmacy expenditures on a per-recipient basis also indicates that indigent pregnant women, indigent children, and children eligible for Medicaid through their affiliation with the ADC program incur the lowest costs for pharmacy services per recipient. In FY 1991, average costs per recipient for these eligibility categories ranged from about $58 to $70.

Average per-recipient costs were dramatically higher for aged, blind, and disabled recipients, ranging from about $600 to $750 per recipient. The higher costs for persons in these eligibility categories reflects: (1) the higher number of pharmacy claims they have and (2) the broader pharmacy coverage provided for institutionalized aged, blind, and disabled recipients.

Variation Exists in Pharmacy Costs by Recipient Eligibility Class. Additional analysis of Medicaid pharmacy claims in FY 1991 revealed that almost 79 percent of pharmacy expenditures were for claims submitted on behalf of categorically needy recipients. Therefore, even if Virginia had more restrictive eligibility criteria which excluded the medically needy population, due to recent federal required expansions in eligibility, Virginia would still have had pharmacy expenditures totaling close to $81 million.

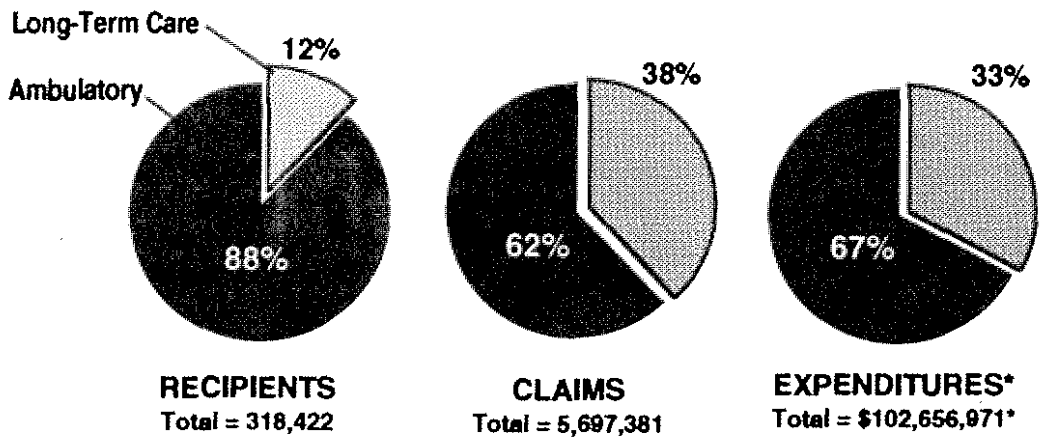
Long-Term Care Recipients Account for A Disproportionate Share of Pharmacy Expenditures. Most pharmacy expenditures are made on behalf of Medicaid recipients who are considered ambulatory, that is, those not receiving Medicaid long-term care services. However, long-term care recipients account for a disproportionate share of pharmacy claims and expenditures. In order to assess the expenditure differences between ambulatory and long-term care recipients, claims for pharmacy services in FY 1991 were assessed against a recipient-level, long-term care database for the same year. As noted in Chapter I, long-term care recipients include persons who received institutional Medicaid services or special long-term care services at any time during the year.

In FY 1991, ambulatory recipients comprised about 88 percent of the total number of recipients of Medicaid pharmacy services (Figure 19). These recipients were responsible for 62 percent of the total claims and accounted for 67 percent of total pharmacy expenditures. In contrast, about one-third of the total payments to pharmacy providers were made on behalf of Medicaid long-term care recipients, who made up only about 12 percent of the total number of recipients.

Analysis of average per-recipient expenditures for these two groups more clearly indicates that long-term care recipients consume a disproportionate amount of pharmacy expenditures. Average pharmacy expenditures per recipient are higher for long-term care recipients than ambulatory recipients. In FY 1991, Medicaid pharmacy payments for long-term care recipients averaged $908 per recipient compared to $244 per person for ambulatory recipients and $322 per recipient for all recipients. Long-term care recipients also incurred more pharmacy claims per recipient. During FY 1991, long-term care recipients averaged 57 claims per recipient compared to 13 claims per ambulatory recipient.

Figure 19

Ambulatory and Long-Term Care Recipients, Claims, and Expenditures for Pharmacy Services, FY 1991



*The total for pharmacy expenditures is derived directly from Department of Medical Assistance Services pharmacy claims, SAS dataset, FY 1991. This varies slightly from the amount reported in the CARS Medical Expenditures for "64" Report, FY 1991, due to cost settlements with providers and year-end adjustments.

Source: JLARC staff analysis of Department of Medical Assistance Services pharmacy claims, SAS dataset, FY 1991.

Interestingly, the costs per pharmacy claim are slightly lower for long-term care recipients than they are for ambulatory recipients ($16 per claim compared to $19 per claim, respectively). This may be due to the purchasing power of facilities for institutionalized recipients. They can potentially pay lower amounts for certain pharmacy products, especially if they are purchasing higher volumes. In addition, the Medicaid program covers over-the-counter medications for long-term care recipients which may be less expensive alternatives to certain prescription drugs provided for ambulatory recipients.

Recent Trends in Medicaid Pharmacy Expenditures

Expenditures for pharmacy services have continued to rank among the top five medical expenditure categories for the Medicaid program. However, compared to other Medicaid-reimbursed services such as physician services and hospital services, Medicaid expenditures for pharmacy services have been fairly consistent, as a percentage of the overall Medicaid budget for medical care services. In the past 10 fiscal years, pharmacy expenditures have averaged about eight percent of total medical care expenditures. However, for the past several years, Medicaid expenditures for pharmacy services (as measured by reimbursement amounts to pharmacy providers) have been growing at a faster rate than the total Medicaid budget for medical care and faster than annual rates of inflation.

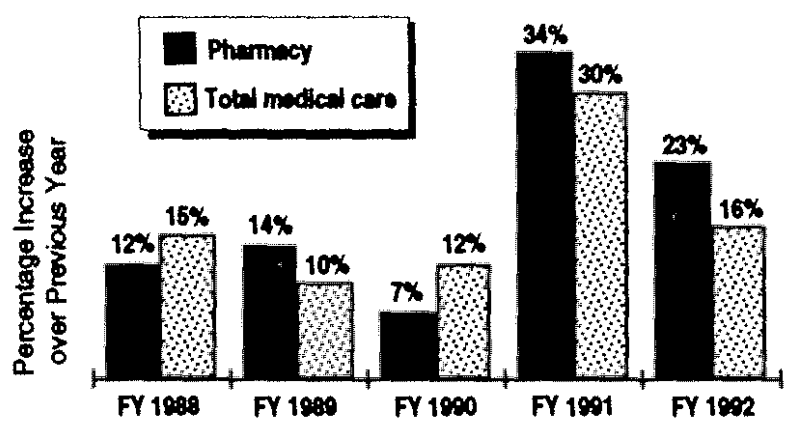
Much of the growth in expenditures for pharmacy services has coincided with program changes implemented between FY 1989 and FY 1991. The number of recipients grew about by about 25 percent, while expenditures for pharmacy services provided to them grew by about 44 percent. Not surprising, the average cost per recipient has increased, particularly for certain eligibility categories.

Pharmacy Expenditures Have Increased at Rates Higher than Total Medicaid Medical Care and Inflation. While Medicaid pharmacy expenditures have remained relatively constant as a percentage of the overall Medicaid budget for medical care services, pharmacy expenditures have outpaced the rates of growth in Medicaid medical care services and inflation. Figure 20 shows the growth in Medicaid pharmacy expenditures for each year from FY 1987 to FY 1992. In three of the last five fiscal years, pharmacy expenditures have increased at a rate higher than that of total Medicaid medical care expenditures.

Expenditures for pharmacy services have also consistently increased at rates higher than the rate of inflation for all goods and services as measured by the consumer price index (CPI) for urban consumers (Figure 21). The rate of increase in Medicaid pharmacy expenditures has also outpaced the rate of inflation for prescription drugs in four of the last five years. In FY 1991 alone, the increase in Medicaid pharmacy expenditures was more than three times the increase in the inflation rate for prescription drugs.

Figure 20

Growth in Medicaid Pharmacy Expenditures Compared to Total Medical Care Expenditures, FY 1987 - FY 1991

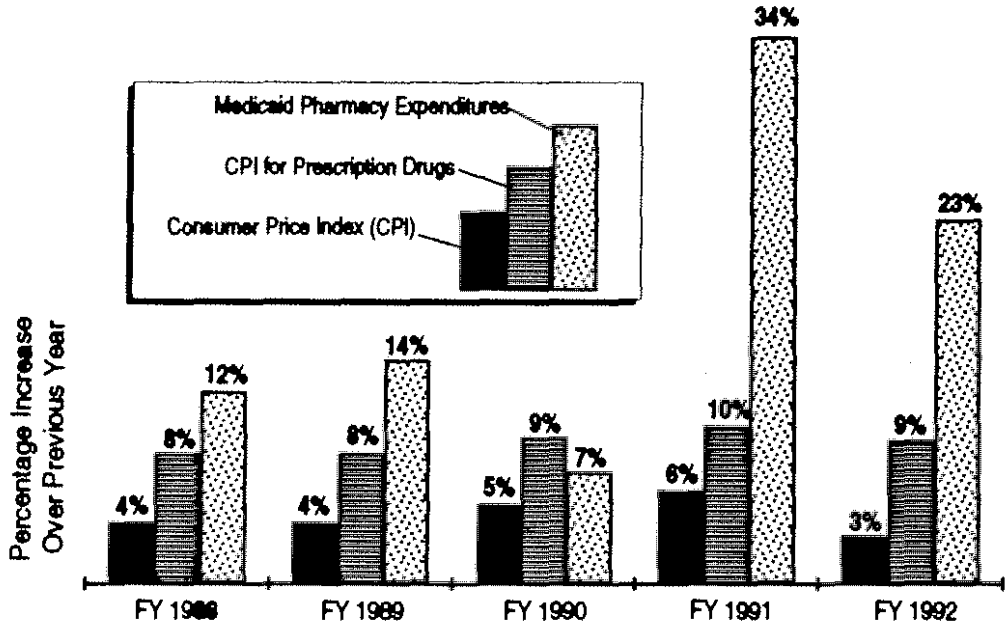


Note: Increases for pharmacy expenditures in FY 1991 and FY 1992 do not reflect drug rebate amounts received from pharmaceutical manufacturers in FY 1992.

Source: Department of Medical Assistance Services, CARS Medical Expenditures for "64" Report, FY 1991 - FY 1992; and DMAS internal expenditure report, FY 1982 - FY 1991, derived from unaudited financial statements.

Figure 21

Comparison of the Annual Rate of Increase in Medicaid Pharmacy Expenditures and Annual Inflation Rates, FY 1987 - FY 1992



Note: Inflation rates from the consumer price index reflect index changes from December to December; therefore, inflation rates from the calendar year ending during the midpoint of each fiscal year were used for comparison. For example, CPI inflation rates used for the FY 1992 comparison were rates reflecting changes in December 1991 over the previous December 1990.

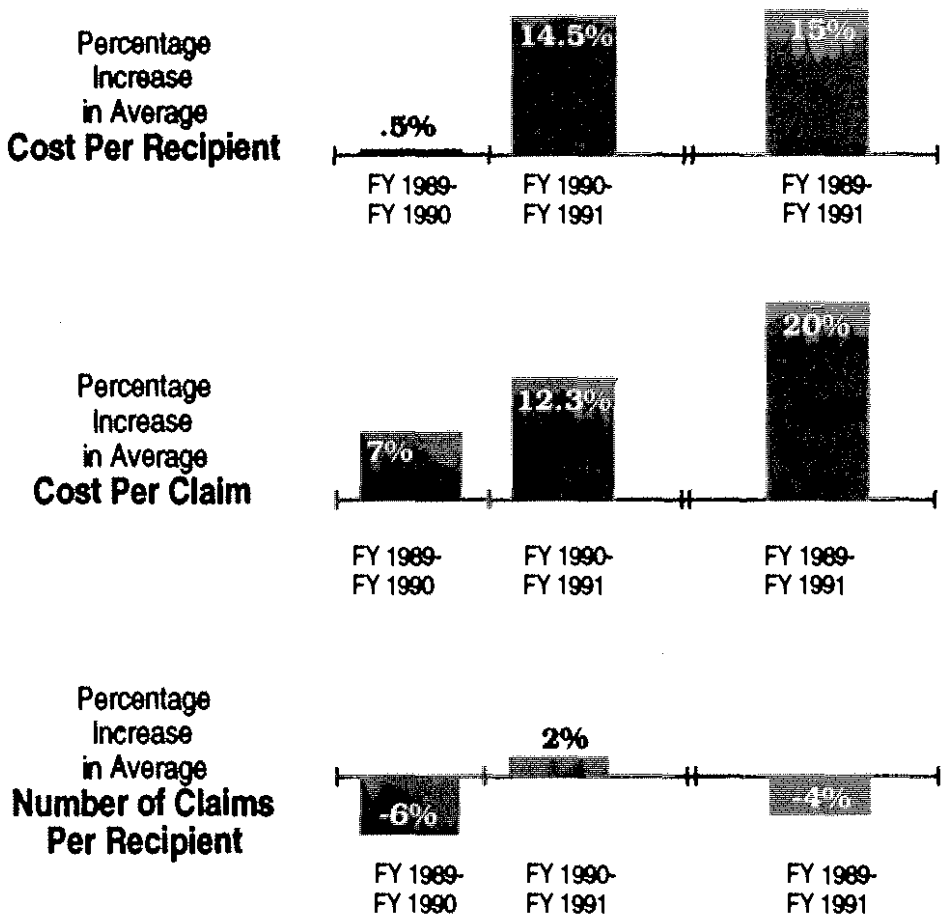
Source: CPI Detailed Report, December 1991, U.S. Dept. of Labor, Bureau of Labor Statistics; Department of Medical Assistance Services, CARS Medical Expenditures for "64" Report, FY 1991 - FY 1992; and DMAS internal expenditure reports, FY 1982 - FY 1991, derived from unaudited financial statements.

Average Costs for Pharmacy Services Have Also Increased. To better assess growth in pharmacy expenditures, claims were examined for FY 1989, FY 1990, and FY 1991 on a per-recipient and per-claim basis. As Figure 22 illustrates, pharmacy expenditures per recipient increased about 15 percent overall from FY 1989 to FY 1991 (from $280 per recipient to about $322 per recipient). The cost per claim increased by about 20 percent from $15 to $18 during this period. The number of pharmacy claims per recipient over this same period actually declined slightly by about four percent from about 19 to 18 claims per recipient. (See Appendix E for detailed information by recipient eligibility categories on expenditures per recipient and per claim for FY 1989 to FY 1991.)

Virginia Medicaid average per-recipient expenditures for pharmacy services are higher than average per recipient expenditures in most other states. In 1990, the Virginia Medicaid program ranked 11 out of 50 states in the average cost per recipient

Figure 22

Percent Growth in Average Pharmacy Expenditures FY 1989 - FY 1991



Source: JLARC staff analysis of Department of Medical Assistance Services pharmacy claims, SAS datasets, FY 1989 - FY 1991.

for prescription drugs. The national average cost per recipient for Medicaid prescribed drugs was $256 compared to $300 per recipient in Virginia in 1990. Average expenditures per recipient may be higher in the Commonwealth because the Virginia Medicaid program generally places fewer limits on pharmacy services than other states. Other states may limit the number of prescriptions dispensed to Medicaid recipients per month or refills allowed in a given period.

Factors Related to Increased Medicaid Costs for Pharmacy Services

In order to explore meaningful strategies to further control the increases in pharmacy expenditures, it is necessary to understand some of the underlying factors which are influencing the increases. Several factors appear related to the recent increases in Medicaid pharmacy expenditures. Clearly, increases in the number of persons receiving services through federally-mandated eligibility expansions have played a role in increasing pharmacy expenditures. In addition, increases in prescription drug prices help to explain some of the increases in pharmacy expenditures.

JLARC staff estimated the percentage of increase in actual expenditures for FY 1991 due to changes in the number of recipients, the number of claims, and inflation of prescription drug prices. This was accomplished by projecting expenditures forward from the baseline year of FY 1989. Appendix D contains more specific information on how these estimates were derived.

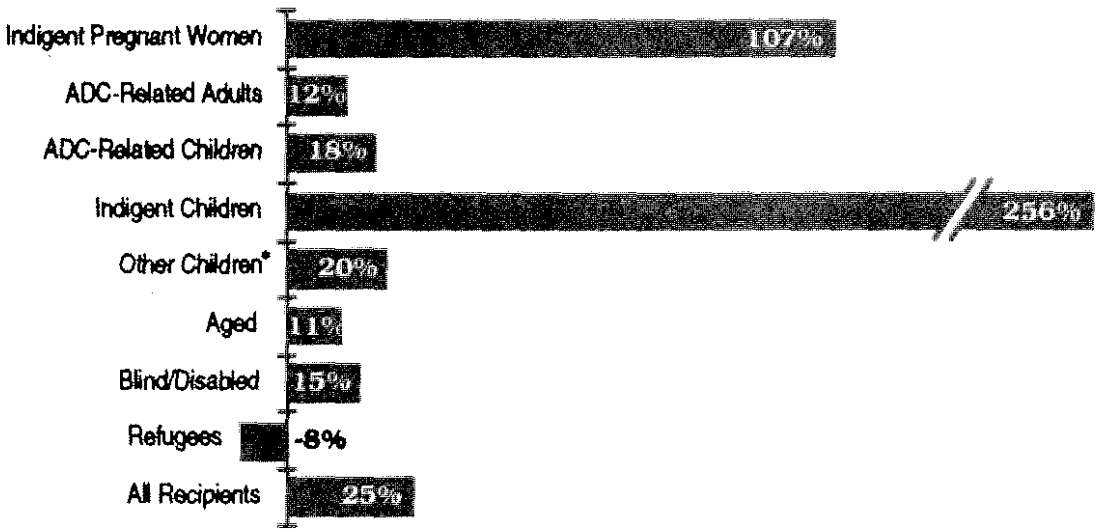
Expansions in Eligibility Significantly Increased the Number of Medicaid Recipients of Pharmacy Services, the Number of Claims, and Related Expenditures. As noted in Chapter I, federally-mandated program expansions in the past several years have resulted in significant growth in the enrollment of Medicaid beneficiaries and the number of recipients of services. As with physician services, the number of recipients of pharmacy services increased in all eligibility categories except refugees between FY 1989 and FY 1991 (Figure 23). Likewise, the greatest growth occurred in the new indigent categories in terms of numbers of recipients and expenditures. From FY 1989 to FY 1991, the number of indigent pregnant women recipients increased by 107 percent. The number of indigent children recipients of pharmacy services increased more than all other eligibility categories — 256 percent. In comparison, the total number of recipients increased by 25 percent between FY 1989 and FY 1991.

Similar to the increase in numbers of recipients, pharmacy expenditures for these two groups increased by rates much higher than rates of growth for other eligibility categories (Figure 24). Pharmacy expenditures for indigent pregnant women increased by more than 150 percent from FY 1989 to FY 1991, while overall pharmacy expenditures for indigent children increased by more than 400 percent. In contrast, the percentage increase in pharmacy expenditures for all recipients from FY 1989 to FY 1991 was about 44 percent. The large increases in pharmacy expenditures for these two indigent categories appear to be related to federally-mandated expansions in eligibility during this time period.

From FY 1989 to FY 1991, Medicaid spending for pharmacy services increased by almost $32 million from $71 million to almost $103 million. Analysis of the claims data for this period of time indicates that more than 57 percent of the growth in pharmacy expenditures was due to increases in the number of program recipients who obtained Medicaid pharmacy services. Accordingly, about $18 million of the almost $32 million in pharmacy expenditure increases during this period could be attributed to eligibility expansions.

Figure 23

Percent Growth in Medicaid Recipients of Pharmacy Services by Eligibility Category, FY 1989 - FY 1991



Note: Total number of recipients is lower than the sum of the individual categories of recipients due to changes in eligibility status. Many recipients may be enrolled in more than one category in any given fiscal year.

*Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

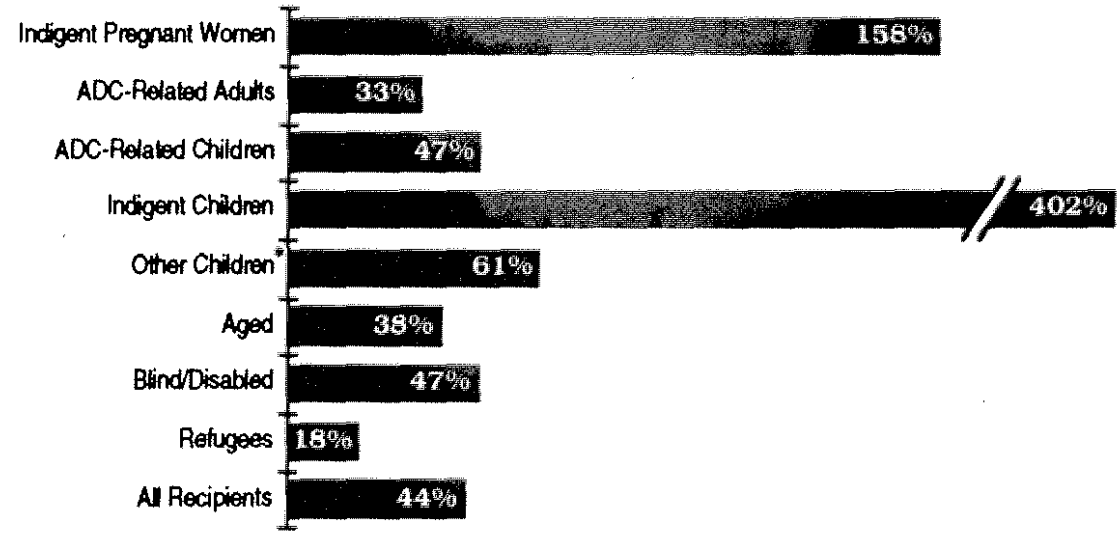
Source: JLARC staff analysis of Department of Medical Assistance Services pharmacy claims, SAS datasets, FY 1989 - FY 1991.

Eligibility expansions also significantly increased the number of pharmacy claims. Since the greatest growth was for services rendered to recipients in the indigent pregnant women and indigent children categories, it is not surprising that the total number of claims for these recipients also increased. Claims for indigent pregnant women and indigent children increased by 129 percent and 300 percent, respectively, from FY 1989 to FY 1991.

Increases in the number of claims explain less of the growth in expenditures than increases in the number of recipients. Approximately 46 percent of the growth in Medicaid pharmacy expenditures could be attributed to increases in pharmacy claims alone. This may be due to the fact that the two groups with the largest increases in total pharmacy claims account for a lower number of claims per recipient than many other recipient categories. However, it is important to note that increases in numbers of claims do account for increases in recipients as well as changes in their utilization of pharmacy services.

Figure 24

Percent Growth in Medicaid Pharmacy Expenditures by Eligibility Category, FY 1989 - FY 1991



*Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services pharmacy claims, SAS datasets, FY 1989 - FY 1991.

Prescription Drug Price Inflation Influences Increased Pharmacy Expenditures. While the Medicaid reimbursement system for pharmacy services does include limits for specific products and maximum payment levels for others, reimbursement amounts are still affected by inflation. Pharmacy reimbursement for multiple-source prescription drugs, as described in another section of this chapter, is subject to maximum cost controls set by the State and the U.S. Health Care Financing Administration (HCFA). (Multiple-source drugs have at least two sources of supply from either a pharmaceutical manufacturer or distributor and are also termed "generic" drugs.) However, the methodology used to set the limits for pharmacy reimbursement does account for changes in product costs over time.

Reimbursement for sole-source prescription drugs is based on: (1) a discount from the average wholesale price or (2) the pharmacy's usual and customary charge. (Sole-source drugs have only one source of supply, are generally still under patent, and are referred to as "brand name" drugs.) The average wholesale price would reflect changes due to prescription drug price inflation. In addition, the pharmacy's usual and customary charge would reflect inflation in drug product costs that have been passed on to pharmacy providers by wholesalers.

According to information obtained from DMAS, reimbursement for sole-source drugs accounted for almost 60 percent of total pharmacy ingredient expenditures (the majority of pharmacy expenditures) in FY 1991. Therefore, inflation in prescription drug prices is an important factor to be considered in overall increases in pharmacy expenditures.

During the past several years, the inflation rate for prescription drugs has outpaced inflation for all goods and services, as measured by the CPI for urban consumers. The rate of inflation for prescription drugs increased by about 20 percent between 1989 and 1991, compared to about 11 percent for all goods and services.

Analysis of the impact of prescription drug price inflation on pharmacy expenditures indicates that about 46 percent of the increase in expenditures from 1989 to 1991 could be attributed to prescription drug price inflation. Accordingly, of the almost $32 million increase in pharmacy expenditures from FY 1989 to FY 1991, about $14 million could be attributed to increases in prescription drug prices.

Influence of Utilization on Pharmacy Expenditures. It is difficult to estimate the precise impact that changes in the utilization of pharmacy services have had on the growth in pharmacy expenditures. Due to data limitations, it is not possible to determine which recipients became eligible for the first time due to eligibility expansions. In addition, recipients can and do change eligibility classifications from one period of eligibility to another. Consequently, utilization could not be distinguished between those already in the program and those who became newly eligible.

Overall, the average number of claims per recipient decreased by four percent from FY 1989 to FY 1991. Nevertheless, some data were available to indicate that utilization has increased for several eligibility categories. The average number of claims per recipient increased in five of nine eligibility categories from FY 1989 to FY 1991. However, it is difficult to determine whether these increases were due to changing health status of persons in these categories, increases in the number of recipients in these categories, or increases in the severity of illnesses. Claims data do not contain information on recipient health status or diagnosis of illness.

However, if the combined effect of recipient increases and inflation is calculated, it is possible to estimate the remaining impact of utilization and other factors on increased pharmacy expenditures. Holding everything else constant, increases in recipients and prescription drug price inflation together account for about 87 percent of the increase in pharmacy expenditures from FY 1989 to FY 1991. Therefore, it can be estimated that changes in utilization and other factors account for the remaining 13 percent of the almost $32 million increase in expenditures during this period.

Growth in Pharmacy Expenditures May Be Gradually Slowing

As noted earlier, Medicaid reimbursement for pharmacy services has more than quadrupled in the past ten fiscal years. Much of this growth appears to be related to the increase in recipients brought about by federally-mandated eligibility expansions and

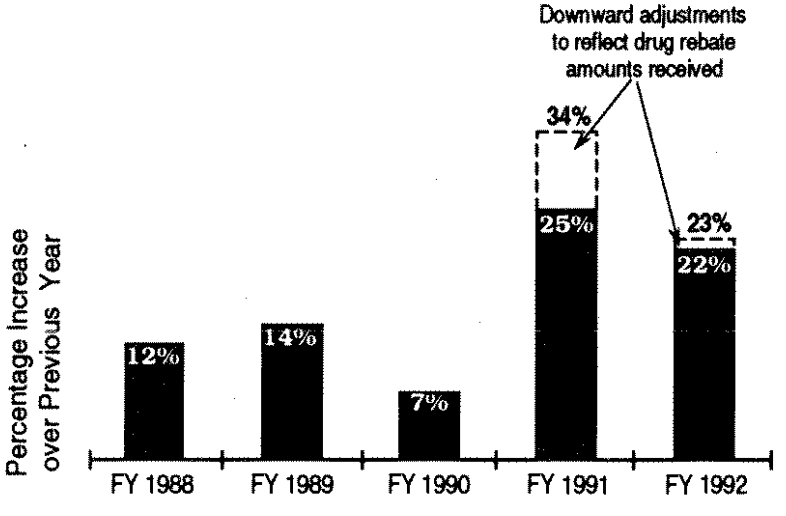
prescription drug price inflation. However, FY 1992 data indicate that growth in Medicaid pharmacy expenditures is gradually slowing. This lower level of growth appears to be related, in part, to the implementation of a prescription drug rebate program required by federal legislation.

The drug rebate program was established by the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). It was created by the U.S. Congress to assist states and the federal government in controlling the growth in Medicaid pharmacy expenditures. OBRA 90 required state Medicaid programs to participate in a drug rebate and discount program or face denial of federal financial participation in Medicaid. In order to be eligible for Medicaid coverage of drug products, pharmaceutical manufacturers were required to provide drug rebates to all state Medicaid programs. In return, states were required to cover all of the prescription drug products of manufacturers who agreed to participate in the drug rebate program.

The Virginia Medicaid program has received almost $16 million in drug rebates since the rebate program went into effect. Medicaid expenditures for pharmacy services totaled almost $103 million in FY 1991. In FY 1992, the Medicaid program recovered almost $7 million in rebates for drugs dispensed to Medicaid recipients between January and June 1991 (the second half of FY 1991). Consequently, with the rebates factored into FY 1991 pharmacy expenditures, expenditure growth for this year was slowed to 25 percent or about $96 million (Figure 25).

Figure 25

Increase in Pharmacy Expenditures Accounting for Drug Rebates, FY 1987 - FY 1992



Source: Department of Medical Assistance Services, CARS Medical Expenditures for "64" Report, FY 1991 - FY 1992; DMAS internal expenditure report, FY 1982 - FY 1991, derived from unaudited financial statements; and DMAS fiscal division report on pharmacy rebate collections as of June 30, 1992.

In FY 1992, total Medicaid reimbursement for pharmacy services was about $126 million. After applying the drug rebates received through the end of the fiscal year for drugs dispensed in FY 1992, the total outlay was about $118 million, a decline of about one percent in the growth of pharmacy reimbursements for that year. However, this does not account for rebate amounts for the fourth quarter of FY 1992. At the time this review was completed, DMAS had not received these fourth quarter rebates. (For accounting purposes, DMAS has credited all rebate amounts received through the end of FY 1992 to that year's pharmacy expenditures. Therefore, in DMAS financial statements, FY 1992 pharmacy expenditures total $110 million — $126 in total pharmacy reimbursements minus about $16 million in drug rebate amounts).

Nevertheless, the Virginia Medicaid program may not be receiving the entire savings to which the program is entitled. DMAS data on the amounts invoiced to drug manufacturers indicate that about $5 million has not been collected due to disputes with drug manufacturers. Disputed rebate amounts are due to disagreements in two areas: (1) the unit of measure for the drug product involved and (2) whether the pharmacy provider accurately accounted for the sale of a particular product.

Disputes with drug manufacturers are not unique to Virginia, however. The American Public Welfare Association (APWA) released a study in 1991 which cited problems that many states are experiencing in collecting the full rebate amounts which they have estimated are due and have been invoiced. Assessment of DMAS data revealed that for FY 1991 and FY 1992, Virginia received about 22 percent less in total rebates than was invoiced. According to staff of the Inspector General's Office at the U.S. Department of Health and Human Services, this is consistent with experiences of other states.

The drug rebate program is still in the initial stages of implementation and problems with the rebates may be resolved as more experience is gained by states and drug manufacturers. In the meantime, DMAS is taking some actions to resolve disputes in the absence of federal guidelines or regulations. DMAS has drafted a policy statement to guide them on dispute resolution. Review of the policy indicates that DMAS will be tracking the accounts receivable for the drug rebates closely. According to staff at the Inspector General's Office, this is important for states to do in order to facilitate the dispute process.

Complete resolution of the disputes with drug manufacturers appears to be dependent on additional action from HCFA. The State has little leverage to require drug manufacturers to settle disputed amounts because the agreements they sign to provide the rebates is with HCFA. Staff at the Inspector General's office also indicated that HCFA has not yet begun to resolve this issue, because until recently, HCFA staff were not aware of the extent of the problem, nor have they collected data from states to assess the problem.

THE REIMBURSEMENT SYSTEM FOR PHARMACY SERVICES

The current reimbursement system for Medicaid pharmacy services is retrospective and based on a fee-for-service methodology which contains some expenditure controls. These controls are the result of federal and State Medicaid laws and regulations which have evolved to ensure prudent purchasing of pharmacy products and services. Pharmacy reimbursement has been under scrutiny by federal and State lawmakers in the past few years, due to the rapid increases in these expenditures. As a result, a number of mechanisms have been created and implemented to control these expenditures through the reimbursement system.

The Virginia Medicaid program is in the initial stages of implementing several State and federal mandated changes which will effect reimbursement for pharmacy services, either directly or indirectly. However, it is important to note that certain mandated changes have reduced, to some extent, the State's flexibility in implementing mechanisms to further control these expenditures. For example, provisions in OBRA 90 do not allow the federal government or states to lower the current reimbursement for pharmacy providers or the upper limits imposed on Medicaid payments for drugs until January 1, 1995.

While Virginia cannot modify pharmacy reimbursement until 1995, the State can build on recent mandated changes by exploring additional options which may promote the prudent purchasing of pharmacy services. DMAS could begin planning changes to its current pharmacy reimbursement methodology so they can be implemented January 1, 1995. DMAS could also explore potential savings by contracting with selected pharmacies to provide pharmacy services to Medicaid recipients.

Other options for modifying reimbursement include: (1) tightening limits on reimbursement for quantities and number of prescriptions filled and (2) including coverage of certain over-the-counter drugs for certain Medicaid recipients. Because pharmacy expenditures continue to increase at a high rate, activities to identify and assess the viability of implementing additional cost control mechanisms should be assigned a high priority.

The Current Reimbursement System Limits Pharmacy Expenditures through Several Mechanisms

Federal and State regulations guide pharmacy reimbursement methodology. Generally these regulations contain several mechanisms to limit pharmacy expenditures. Payment for pharmacy services must be based on the lowest of the following cost determinations:

- the "upper limit" established by HCFA for multiple-source drugs plus a dispensing fee

- the Virginia maximum allowable cost for multiple-source drugs listed on the Virginia Voluntary Formulary plus a dispensing fee

- the estimated acquisition cost (of a pharmacy provider for the drug product) plus a dispensing fee

- a mark-up allowance (150 percent) of the estimated acquisition cost for covered non-prescription drugs and oral contraceptives, plus a dispensing fee

- the pharmacy's usual and customary charge as indicated by the claim.

These cost determinations are designed to exert some control over aggregate expenditures by states for pharmacy products. HCFA "upper limits" and the Virginia maximum allowable cost are generally used to control costs of multiple-source (or generic) drug payments. However, sole-source (or brand name) drug costs are controlled through the limits applied to the estimated acquisition cost or the pharmacy's usual and customary charge.

Reimbursement Based on HCFA "Upper Limits" Controls Costs of Generic Prescription Drugs. The HCFA "upper limits" are a federally-mandated listing of drugs that have at least three sources of supply and are therapeutically equivalent (termed multiple-source drugs or "generic" drugs). The drug listing contains the maximum allowable reimbursement amount for generic prescription drugs, thereby controlling Medicaid expenditures for these drugs. In order for reimbursement to exceed the HCFA "upper limits" the prescribing physician must note that the prescription is "brand necessary."

HCFA periodically updates its listing of the upper limits for generic drugs. However, the current listing supplied by HCFA has not been updated for the past two years. Maximum allowable amounts for drugs on the listing were frozen by HCFA at September 1990 levels. When this occurs effects of inflation on drug prices are reduced, and consequently, savings are achieved in Medicaid pharmacy expenditures. Recently, HCFA has sent states an updated drug listing which will become effective December 1, 1992. The new listing should reflect some changes due to inflation in prescription drug prices and may result in some increases in Medicaid pharmacy expenditures.

Reimbursement Based on the Virginia Maximum Allowable Cost Also Controls Costs of Generic Prescription Drugs. The Virginia maximum allowable cost (VMAC) applies to generic or multiple-source prescription drugs and serves to control expenditures for these drugs. The VMAC amounts apply to drugs that are listed on the Virginia Voluntary Formulary. The Virginia Voluntary Formulary is a listing of drug products that have at least two sources of supply and is approved by the Formulary Board. The multiple-source products must be therapeutically and chemically interchangeable. All Medicaid prescriptions for multiple-source drugs must be drugs listed on the Virginia Voluntary Formulary unless the physician indicates that the prescription is brand necessary.

The VMAC amounts are based on the 75th percentile of costs for non-unit dose drugs and the 60th percentile of costs for unit-dose dispensed drugs. (Unit-dose dispensing applies primarily to nursing facilities and involves the use of plastic, sealed compartments in which a pharmacist places all of the medication to be taken by a patient at a given time during the day.) The drug cost data are obtained from a private vendor who provides computerized data on published prevailing drug costs. Therefore, as mentioned in an earlier section, the limits do reflect some adjustments due to prescription drug price inflation. The percentiles are adjusted monthly based on changes in the published cost data.

Changes in Reimbursement Based on Estimated Acquisition Costs Have Also Contained Some Pharmacy Expenditure Growth. If the prescribing physician indicates that the prescription is brand necessary, the HCFA upper limit and VMAC cost do not apply. However, reimbursement is not to exceed the estimated acquisition cost determined by DMAS or the pharmacy's usual and customary charge. Reimbursement changes in the past two years have resulted in modifications to the definition of the estimated acquisition cost. These changes have helped to further contain growth in pharmacy expenditures. Expenditure savings due to these changes were about $2 million in FY 1991 and $4.6 million in FY 1992.

In the past, many states were reimbursing pharmacy providers based on the average wholesale price (AWP) paid by the pharmacy to a pharmacy wholesaler. However, several studies demonstrated that the AWP often does not reflect the actual acquisition cost to pharmacies for drug products. Many pharmacies are able to obtain discounts from the AWP based on the volume of products they purchase, payment habits, and other factors. Congressional testimony has also suggested that many pharmacy providers are able to obtain a 13 to 17 percent savings over the AWP. Consequently, HCFA directed state Medicaid programs to modify their reimbursement methods for determining the estimated acquisition cost.

Prior to October 1990, DMAS reimbursed pharmacy providers based on their usual and customary charges, which were based on the AWP or pharmacy providers' direct costs. To comply with the new federal requirements, DMAS issued emergency regulations to amend the State Plan effective October 1, 1990. The regulations set forth the estimated acquisition cost as the AWP minus nine percent.

Reimbursement Changes in Dispensing Fees Have Been Aimed at Curbing Pharmacy Expenditure Growth and Other Goals. Two significant reimbursement changes regarding dispensing fees have been implemented in the past few years. These changes have been directed at curbing some of the growth in pharmacy expenditures, as well as other goals such as ensuring continued access to pharmacy services for Medicaid recipients. The net result of these changes in controlling growth in Medicaid pharmacy expenditures has been mixed.

Beginning July 1, 1989, DMAS limited the reimbursement of pharmacy dispensing fees for covered outpatient prescription drugs. Pharmacy providers were limited to one dispensing fee per prescription drug per month for prescriptions dispensed to non-

institutionalized, Medicaid recipients. The only exceptions to this limit were for dispensing fees associated with oral contraceptives (which are packaged in set supplies) and Clozaril, which requires intensive monitoring.

It appears that this change in dispensing fees may have contributed to some decrease in the growth of pharmacy expenditures for FY 1990. In FY 1989, dispensing fees accounted for almost 19 percent of total Medicaid pharmacy expenditures. However, after the limits on dispensing fees were imposed in FY 1990, dispensing fees decreased to about 17 percent of total Medicaid expenditures for pharmacy services. The lower rate of growth in dispensing fees in FY 1990 may explain, in part, the lower growth in overall pharmacy expenditures during this year as well.

The second reimbursement change affecting Medicaid dispensing fees occurred when DMAS changed its reimbursement to reflect the estimated acquisition cost for drug products in October 1990. Prior to this time, the dispensing fee was $3.40 per outpatient prescription. However, due to the cost savings achieved by applying a discount to the average wholesale price paid by pharmacy providers for pharmacy products, the program was able to allow an increase in the dispensing fee to $4.40 per prescription and still achieve savings in pharmacy expenditures.

The increase in the dispensing fee per prescription was implemented to ensure that an adequate number of independent community pharmacies remained enrolled as Medicaid providers, thereby ensuring access to pharmacy services for Medicaid recipients. Although the reimbursement changes to lower the estimated acquisition costs of drug products to pharmacy providers reduced overall pharmacy expenditures, the $1 increase in the dispensing fee appears to have increased dispensing fees overall. In FY 1991, dispensing fees increased to almost 18 percent of total pharmacy expenditures from almost 17 percent in FY 1990.

Reimbursement Reductions Have Also Occurred Due to Recipient Cost-Sharing Requirements. Virginia is one of 21 states that controls utilization of pharmacy services through the imposition of cost-sharing requirements (or copayments) on recipients. The Medicaid program automatically reduces the amount of reimbursement to the pharmacy provider if the recipient's eligibility category indicates a copayment is required. In FY 1991, reimbursement to pharmacy providers due to copayment requirements was reduced by about $3 million. Accordingly, about three percent of total Medicaid pharmacy reimbursements was saved due to copayment requirements.

Theoretically, a copayment should discourage unnecessary utilization by Medicaid recipients, thereby reducing Medicaid pharmacy expenditures. It is difficult to assess precisely how many Medicaid recipients who are required to do so actually pay pharmacy providers the copayment amount. If the recipient is unable to make the copayment when one is due the provider may not refuse to provide the service. However, providers are not reimbursed for the uncollected copayment amount.

Whether the cost-sharing amount actually serves as a control on utilization depends upon the provider's discretion in collecting the copayment. DMAS staff have

indicated that it is probable that most pharmacy providers collect required copayment amounts from recipients. Staff of a pharmacy association also believe that most pharmacies are collecting the copayment amounts from Medicaid recipients and that there is little, if any, resistance by recipients to making the copayment for pharmacy services.

The Medicaid Program Could Further Enhance the Cost Effectiveness of Pharmacy Purchases

There are several options which are available to the State to further enhance the Medicaid program's ability to prudently purchase pharmacy services. As mentioned earlier, DMAS is beginning to implement a number of different mechanisms to further control pharmacy expenditures. Some of these mechanisms are required by federal and State mandates. Other options could also be adopted for use in the Virginia Medicaid program.

State Efforts to Implement A Drug Utilization Review Program Should Enhance the Cost-Effectiveness of Pharmacy Reimbursement. Virginia is in the process of implementing a drug utilization review (DUR) program which should enhance the quality and cost-effective delivery of pharmacy services. State and federal law both mandate that the Virginia Medicaid program implement a drug utilization review program. However, since this program is still being developed, it is difficult to assess the precise impact it will have on physicians, pharmacy providers, and Medicaid recipients.

Virginia's DUR program must include prospective and retrospective components for covered outpatient drugs. In addition, OBRA 90 also dictates that the DUR program ensure: (1) the appropriateness and medical necessity of prescribed drugs, and (2) prescribed drugs do not result in adverse health outcomes. The program must also include an educational component for physicians and pharmacists on issues such as therapeutic appropriateness and drug interactions. While not required to do so, DMAS is planning to incorporate retrospective DUR of drugs dispensed in nursing facilities.

It appears that DMAS will be in compliance with State and federal requirements, if the program is implemented on schedule by January 1, 1993. A DUR Board has been established to review and approve drug use criteria and standards for retrospective and prospective DUR. In addition, DMAS has contracted with a private vendor to generate utilization profiles for both ambulatory and long-term care recipients on a retrospective basis. These profiles will be reviewed by a pharmacist who will use clinical judgment to assess potential problems which require educational interventions to correct inappropriate prescribing, dispensing, or utilization practices. Consequently, the drug utilization review program should ensure delivery of high-quality pharmacy care to Medicaid recipients.

Planning Could Begin Now for Changes to Reimbursement Methodology in 1995. As mentioned earlier, OBRA 90 limits the State's ability to contain pharmacy expenditures by reducing reimbursement or dispensing fees. However, DMAS could begin planning for changes to its current reimbursement methodology. These changes

could involve revising and updating the calculation of the estimated acquisition cost for pharmacy products and revisions to the current dispensing fee to become effective January 1, 1995.

DMAS revised its methodology to calculate the estimated acquisition cost in 1990 to be in compliance with federal regulations. In order to determine a reasonable estimate of pharmacy acquisition costs, DMAS surveyed pharmacy providers to assess their acquisition costs for a one-month period. DMAS staff selected non-chain pharmacies on which to base the estimate.

At the time of the changes in the methodology, there were specific concerns about the impact of using a large discount rate applied to the average wholesale price to represent the estimated acquisition cost of pharmacy products by rural, community pharmacies. At issue were concerns about losing access to providers that may be the only source of pharmacy services for rural Medicaid recipients. Consequently, the survey of acquisition costs focused primarily on these providers and did not consider acquisition costs in relation to larger urban and chain pharmacies.

Because the methodology used to determine the AWP discount rate and dispensing fee amount systematically excluded chain pharmacies from the analysis, the current estimated acquisition cost may not be representative of the discount received by a number of pharmacy providers in Virginia. Discounts realized by urban, chain pharmacies may be twice as great as the discount currently applied by the Medicaid program.

DMAS plans for reimbursement changes could include a more thorough survey of rural and urban pharmacy providers' actual acquisition costs for drug products. Consideration could be given to constructing a reimbursement scheme which considers cost differences based on geographic location, size, and type of the pharmacy provider to ensure access to services by all Medicaid recipients.

Recommendation (4). **The Department of Medical Assistance Services should begin planning for pharmacy reimbursement changes to be implemented January 1, 1995. Consideration should be given to revising the calculation used to establish the estimated acquisition costs of drug products and the dispensing fees for pharmacy providers.**

DMAS Could Pursue Implementation of a Preferred Provider Network for Pharmacy Services. The Department of Medical Assistance Services could explore the impact of using a preferred provider network to deliver pharmacy services to ambulatory Medicaid recipients. It is possible that this type of arrangement could assist the program in containing additional increases in pharmacy expenditures. The director of DMAS has stated that implementation of this type of arrangement will not jeopardize the State's ability to obtain pharmacy rebates from drug manufacturers.

The majority of ambulatory Medicaid recipients are clustered in several urban areas of the State. These geographic locations have numerous pharmacy providers

available to provide access to recipients. Because adequate competition exists in these areas, the Medicaid program could begin to selectively contract with pharmacy providers to obtain a network of providers chosen through a competitive process. By guaranteeing a higher volume of Medicaid payments to these providers, DMAS should be able to negotiate the reimbursement rate to ensure access and obtain cost efficiencies.

However, in order to develop a preferred provider network which would limit freedom of choice for Medicaid recipients, DMAS will have to obtain a waiver from HCFA. DMAS already has obtained a waiver to limit freedom of choice for physicians services for ambulatory Medicaid recipients residing in four pilot sites in Virginia.

Recommendation (5). **The Department of Medical Assistance Services should pursue obtaining a waiver from the U.S. Department of Health and Human Services to provide pharmacy services to recipients through selected pharmacies chosen through a competitive process. If assessment of this arrangement indicates that the Medicaid program can obtain cost efficiencies without jeopardizing recipient access to pharmacy services, the department should implement this type of contractual arrangement for the provision of pharmacy services.**

Limitations on Coverage of Pharmacy Services Can Be Implemented through the Prior Authorization Program. The Virginia Medicaid program imposes fewer limits on pharmacy services compared to many other states. This may explain why average costs per recipient to provide these services are higher than most other states. The Medicaid program has established minimal limits on pharmacy services; however, current planning for the implementation of a prior authorization program presents several opportunities for the State to limit coverage to reduce waste without jeopardizing recipient health status.

The 1992 General Assembly required the Virginia Medicaid program to implement a prior authorization program for high-cost drugs. DMAS also appears to be on schedule for implementing the prior authorization program in 1993. Prior authorization involves approval of the prescribed drug before it is dispensed for any medically accepted indication as a condition of coverage or payment.

In order to conduct prior authorization, federal law requires the State to respond to authorization requests within 24 hours and provide a 72-hour emergency supply of the medication. DMAS is developing prior authorization criteria for certain classes of drugs such as: antiarthritic drugs, ulcer treatment drugs, antihistamines, benzodiazapines, antidepressants, and smoking cessation products.

Prior authorization could also be used in conjunction with other limits on pharmacy coverage to reduce waste in the program. For example, limits could be placed on the number of prescriptions that can be filled within a specific time period, the number of refills allowed within specific time periods, and the quantities for each prescription. Prior authorization could be applied to these limits so that medically necessary services are not limited, but coverage of unnecessary services are curtailed. An example of how

this could work is evident from the following federal assessment of certain Medicaid pharmacy expenditures:

> *During 1992, the Inspector General for the U.S. Department of Health and Human Services examined Virginia's payments for six high-cost ulcer treatment drugs. The Inspector General found that Virginia could save approximately $2 million each year by limiting payments for dosages that exceed those recommended by manufacturers.*

In 1991, about one-quarter of the states had limits on the number of prescriptions allowed per month per Medicaid recipient. About one-half of all states had limits on refills allowed for reimbursement. And, more than three-quarters of the states had limits on quantities for prescriptions. Virginia is one of 11 states with no limits on the quantity of drugs prescribed for Medicaid recipients.

There is some rationale for imposing few "absolute" limits on prescription drugs. Recent studies have indicated that these type of limitations do not appear to be as cost-effective as they may seem. Limits which are not applied appropriately may lead to adverse health outcomes in Medicaid recipients. These outcomes could actually increase the overall cost of the program due to increased incidences of hospitalization and increases in physician services. Therefore, decisions to impose such limits need careful consideration by health care experts and policy-makers.

An advisory panel has been formed to make determinations about the criteria to be used for the prior authorization of high-cost drugs. This panel is composed of physicians and pharmacists nominated by various pharmacy and medical schools deans and State pharmacy and medical professional associations. In addition, to consideration of high-cost drugs to be pre-authorized, the panel should also consider the merits of imposing limits on prescription drugs which would be subject to prior authorization to reduce waste in the pharmacy program.

Recommendation (6). **The Department of Medical Assistance Services should explore the impact of imposing limits on reimbursement for pharmacy services in the Medicaid program in conjunction with the implementation of the prior authorization program for high-cost drugs. These limits should be developed with the assistance of the prior authorization program's advisory panel.**

Expansions to Provide Reimbursement for Certain Drugs May Enhance the Cost Effectiveness of Pharmacy Expenditures. Expanding coverage of over-the-counter drugs to include certain non-institutionalized recipients could reduce expenditures on more expensive prescription drugs. The JLARC survey of physicians enrolled as Medicaid providers and interviews with DMAS staff have indicated that certain over-the-counter drugs can provide equivalent or better health outcomes than their more expensive prescription counterparts. DMAS supports this concept, if coverage is not unilateral for all over-the-counter products.

Some physicians enrolled as Medicaid providers have been troubled by the lack of this coverage in the Medicaid program. Physicians responding to a JLARC survey stated:

> Situations that discourage my participation include the following: a recent change in prescription drug reimbursement that has impacted greatly on a number of my patients. I treat about 50 children with atopic dermatitis/eczema. Now that VMAP [the Virginia Medical Assistance Program] no longer reimburses for one percent hydrocortisone ointment, a mainstay of treatment for this disorder, a substitute must be used. These mid-to-low potency hydrocortisone preparations cost 10 to 20 times more than the generic one percent ointment and are more likely to cause side effects. This change will dramatically increase VMAP's expenses, which heretofore had been minimal in comparison.
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> . . . "over-the-counter" drugs should [be] covered by Medicaid if approved by an M.D., e.g., Medicaid patients won't take cheap, safe, over-the-counter drugs for scabies and, rather, insist on being prescribed Kwell because Medicaid covers them and not Rid or Nix.
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> The limited formulary can cause increased cost. Patients are given prescriptions for more expensive medicine because Medicaid won't pay for an [over-the-counter] med[icine]. To me, it would make more sense to put some [over-the-counter] med[ications] on the formulary (i.e. Tylenol for kids, Robitussin DM) and charge a $2.00 copay[ment].

Under the current reimbursement structure, it appears that DMAS would not be able to limit coverage to only certain over-the-counter drugs. OBRA 90 does not allow states to exclude drug products of a pharmaceutical manufacturer who has agreed to participate in the drug rebate program. Coverage of over-the-counter drugs for all Virginia Medicaid recipients was discontinued in the mid 1970s. However, due to the rapid increase in the cost of prescription drugs, there is some merit to exploring potential cost savings of over-the-counter drug coverage further, if the current reimbursement structure is changed.

Recommendation (7). **The Department of Medical Assistance Services should explore the feasibility of expanding pharmacy coverage to include reimbursement for limited over-the-counter drugs in the Medicaid program for specific recipients as changes are made to the current reimbursement structure. Results of these assessments should be provided to the Joint Commission on Health Care and the House Appropriations and Senate Finance Committees for their consideration.**

IV. Medicaid Utilization Review and Other Cost Containment Practices

Item 3 of Senate Joint Resolution 180 directs JLARC to assess the effectiveness of current utilization review procedures in controlling costs. The mandate also requires JLARC to explore the costs of alternative administrative methods for implementing program requirements and options. This review focuses on specific aspects of utilization review related to ambulatory care, particularly physician and pharmacy services. It also examines the administration of program requirements to pursue payments for services for which other third parties are liable.

Utilization review involves monitoring the use of Medicaid services to: (1) guard against unnecessary or inappropriate use by program recipients and (2) prevent excess payments to providers for those services. The goal of utilization review is to ensure that the Medicaid program is providing needed care to recipients at the lowest possible cost. While the hospital and long-term care reports focused on prospective and concurrent utilization review, this report focuses on post-payment utilization review. Post-payment utilization review retrospectively analyzes Medicaid claims after they have been paid to determine if recipients or providers have developed patterns indicative of excessive use, medically unnecessary use, or unsound billing patterns.

A small proportion of active enrolled providers and recipients are reviewed each year through the Medicaid post-payment utilization review process. The administration of this process appears to be successful at controlling abusive recipients and initiating recovery of provider overpayments. The number of reviews initiated complies with minimum federal requirements. However, refinements and expansion of the process may lead to additional cost savings for the Virginia Medicaid program. The method of selecting providers could be enhanced and the number of providers reviewed could be increased. In addition, more attention needs to be given to addressing the extent of recipient fraud and drug diversion.

Another area with potential for cost savings is third-party liability. Federal law requires that Medicaid be the payer of last resort. Consequently, any other parties which have a liability to pay for services for Medicaid recipients must be pursued. Virginia Medicaid's third-party liability activity is credited with a significant amount of cost savings. A new third-party liability system is currently being developed and should further enhance savings. During the system's development, consideration should be given to expanding the number of data matches with other State agencies and conducting tests to identify the most productive cases to pursue.

POST-PAYMENT UTILIZATION REVIEW

The high incidence of fraud and abuse in the health care industry necessitates that utilization review be conducted. Post-payment utilization review helps ensure that Medicaid funds only medically necessary services. This function is especially important because a number of studies indicate that there is a high incidence of fraud and abuse associated with the health care service delivery system in the United States. For example,

> *In May 1992, the U.S. General Accounting Office (GAO) reported that losses resulting from fraud and abuse account for ten percent of the nation's total health care spending in 1991. Since health care spending was estimated at $700 billion in 1991, this means that about $70 billion was consumed by fraudulent and abusive health care practices.*
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> *One Medicaid fraud prosecutor from a large northeastern state estimated that ten to 12 percent of that state's Medicaid spending is wasted on fraud and abuse.*

Furthermore, according to the U.S. Department of Justice, fraud and abuse involves all segments of the health care industry and can be found in every geographic region of the country.

No estimate has been made about the cost of fraud and abuse to the Virginia Medicaid program. However, if fraud and abuse consumed just one-tenth the GAO estimate in Virginia, more than $10 million would have been lost by the Medicaid program in FY 1991. In just one Virginia case prosecuted in 1991, a psychiatrist was convicted of mail fraud which cost the Medicaid program more than $100,000.

In general, public programs have more payment safeguards and greater statutory authority to deal with provider and recipient improprieties than private insurers. The post-payment utilization review function performed by the Department of Medical Assistance Services (DMAS) is one of these safeguards, as are the prosecutions sought by the Attorney General's Office, and investigations conducted by two other State agencies. Post-payment utilization review and other activities performed by State agencies will recover a small portion of Medicaid dollars spent. Although difficult to estimate, post-payment utilization review also prevents more dollars from being lost to Medicaid fraud and abuse through its deterrent effect, and through provider and recipient education.

While the Virginia Medicaid program has complied with federal requirements for its fraud and abuse activities, it is not taking advantage of all opportunities to achieve additional cost savings. During a FY 1990 audit, the Auditor of Public Accounts recommended that DMAS revise its method of selecting providers for review and

determine if performing more provider reviews would increase recoveries from providers. While the department made some changes in its provider selection process and expanded the recipient medical management function in FY 1991, no action was taken to expand the provider review and other key fraud and abuse control functions that could also enhance cost savings.

Budget considerations in the past few years have limited the scope of Medicaid's fraud and abuse detection and enforcement efforts. Staffing constraints have curtailed the department's ability to more thoroughly review provider billing practices and fraudulent recipient practices. The department also curtailed its drug diversion activities. A unit created in June 1991 to handle drug diversion investigations was dismantled before it was fully staffed. At that time, DMAS requested the State Police to assume this function.

As the number of Medicaid providers and recipients increase and the claims volume continues to grow, more could be done to detect and deter Medicaid fraud and abuse, and achieve additional cost savings. When Medallion (Medicaid's managed care program) is expanded statewide, the current level of activity needed for some functions of post-payment utilization review may be reduced. However, since this program is still in its early stages of implementation, its effect on the scope of certain post-payment utilization review functions is unclear.

Medicaid Fraud and Abuse Can Be Committed by Both Providers and Recipients

Both Medicaid providers and recipients engage in fraudulent and abusive activities. Fraud and abuse cover a wide range of improper acts that include:

- misrepresenting or overcharging for services delivered
- seeking services that are not medically necessary
- concealing information in order to obtain Medicaid eligibility
- diverting pharmaceuticals for unintended uses.

Both fraud and abuse result in unnecessary costs to the Medicaid program. However, fraud involves a willful act, whereas abuse typically involves actions that are inconsistent with acceptable business and medical practices. Some providers and recipients have mistakenly abused Medicaid by overbilling or overusing Medicaid. However, others have employed various schemes with intent to receive services or payments which are not medically justified.

Examples of Provider Fraud and Abuse. Providers may bill Medicaid for services that were not provided or claim services rendered at a higher level of care than were actually performed. Providers may also receive benefits for making referrals. Some of these acts are nothing more than mistakes and these providers are educated on the correct method of billing and are required to return any overpayments greater than $300. However, subsequent similar errors are considered fraud. Ignoring instructions adds

intent to the act, which is the key element separating fraud and abuse. The following are examples of provider fraud:

> *A psychiatrist charged several third-party payers, including Medicaid, for psychotherapy sessions in excess of 45 minutes when in fact many sessions lasted less than ten minutes. Intent was demonstrated because the psychiatrist's appointment books showed the appointments were scheduled for only 15 minutes. Further, between several third-party payers, the psychiatrist had billed in excess of 24 hours of individual psychotherapy in one day. The psychiatrist was convicted, sentenced to jail, and ordered to pay restitution.*
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> *A doctor who co-owned a dental practice upgraded dental surgery services on claims submitted for reimbursement. For example, a full bony extraction was billed when the real diagnosis was a partial bony extraction. Distorted X-rays displaying problems which the actual patients did not have were used to document the need for these services. The doctor was convicted, sentenced to jail, and ordered to pay restitution.*

Some case examples of provider abuse include the following:

> *A hospital reported laboratory tests on a claim for Medicaid payment and was reimbursed. Medical records and documentation indicated the tests were sent to a laboratory outside the hospital. Both the hospital and laboratory billed Medicaid for the same services. Since the hospital did not deliver these services, it was not permitted to submit a claim for reimbursement for these tests. The Medicaid program overpaid the hospital $2,253 for these tests.*
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> *One association of emergency room physicians separately billed the Medicaid program for evaluating X-rays and electrocardiograms (EKGs) in conjunction with emergency room visits. Medicaid policy states that evaluation of X-rays and EKGs are to be included in the cost of the emergency room visit. The physicians were double billing for the same services. The overpayment was determined to be about $1,500.*
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> *A pharmacist often filled prescriptions with brand name drugs without the physician's order to do so. Medicaid policy states that reimbursement for brand name prescription drugs (which are typically more expensive) is allowed only when the physician explicitly orders them for*

a patient. Because the pharmacist should have filled the prescriptions with the cheaper generic equivalent drug, the Medicaid program expended more money than was necessary. The pharmacist was directed to return almost $2,000 in overpayments.

These cases could be considered fraud if the provider had ignored previous instructions on how to correctly make claims for these services.

Examples of Recipient Fraud and Abuse. Fraudulent and abusive behavior committed by recipients includes obtaining Medicaid benefits without being legitimately eligible, receiving care in an inappropriate setting (such as receiving routine care in emergency rooms), and visiting several different providers in a short time frame. Some examples of recipient fraud and abuse include the following:

When a patient appeared to have lost 200 pounds in the one month since her last visit to her physician, the physician refused to render service because he suspected Medicaid card-sharing. The actual recipient said the card had been lost earlier in the month.

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A pregnant woman was on Medicaid when her husband got a new job with health benefits. The case file indicated her husband's benefits should have cancelled her eligibility, but the woman never told the local social service office and she continued to use Medicaid benefits.

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Claims for one recipient showed utilization of eight doctors and seven pharmacies in addition to using the emergency room 13 times over a six-month period. The recipient received some duplicative treatments and medications as a result of all these visits.

Diverting Prescription Drugs Is Also Fraud. Another type of fraud involving both providers and recipients is drug diversion. Drug diversion, as defined by the State Police, is "the channeling of controlled substances to an illegal use, whether it be intended for personal use or for illegal distribution to another." Diverting pharmaceutical drugs for unintended uses has become more prevalent in the nation and Virginia since the late 1980s. Federal sources estimate that illegal trafficking of prescription drugs is a $25 billion per year industry, with 15 percent of all prescribed medicine diverted. However, the extent to which this activity affects the Medicaid program is unknown. The following cases illustrate some drug diversion schemes.

A Medicaid recipient and her eight year old son visited multiple physicians seeking treatment for her son's supposed Attention Deficit Disorder. The treatment for this disorder is the prescription of an amphetamine-like drug which has effects similar to cocaine. Over a 16-

month period the woman and her son obtained almost 7,000 dosage units. The woman was convicted of obtaining drugs by fraud, sentenced to jail, and ordered to pay restitution for the cost of physician and pharmacy services she utilized.

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The friend of a recipient tried to obtain Accutane (an expensive anti-acne drug) for a recipient using the recipient's card. Suspecting forgery, the pharmacist refused to fill the prescription and reported the incident through the Medicaid "HELPLINE." While card-sharing could not be proven, an investigator from DMAS discovered the individual had recently forged three prescriptions to get the same drug. The individual pleaded guilty and received a suspended sentence.

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A psychiatrist under suspicion of drug diversion prescribed 14 tablets of a depressant without legitimate medical need or purpose to an undercover officer posing as a Medicaid recipient. The psychiatrist was convicted and sentenced to jail.

State Activities to Control Fraud and Abuse Meet Minimum Requirements

To combat Medicaid fraud and abuse, the federal government requires state Medicaid agencies to implement a statewide surveillance and utilization control program that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments. The Division of Program Compliance within DMAS is the organizational unit with primary responsibility for detecting and controlling Medicaid provider and recipient fraud and abuse. Other State agencies also have a role in identifying and controlling some aspects of Medicaid fraud. The efforts of these agencies satisfy minimum federal requirements for controlling Medicaid fraud and abuse.

Broad Federal Regulations and State Provisions Guide Efforts to Control Medicaid Fraud and Abuse. Regulations issued by the U.S. Health Care Financing Administration (HCFA) require Medicaid agencies to have procedures for ongoing evaluation, on a sample basis, of the necessity, quality, and timeliness of Medicaid services. Federal regulations further require Medicaid agencies to have a post-payment review process that allows state personnel to develop and review recipient utilization profiles and provider service profiles. The post-payment review process must also use exception criteria that identify profiles which deviate from the "norms" so that the agency can correct abusive practices of recipients and providers.

HCFA monitors compliance with this regulation through the systems performance review. This review sets the number of minimum reviews that DMAS must initiate. The review also specifies the number of reviews that must be identified by the post-payment exception and profiling process (Exhibit 3).

Exhibit 3

Systems Performance Review Requirements for Post Payment Utilization Review

	Number of Participants in FY 1991	Minimum Number of Annual Reviews	Minimum Number Selected from SURS*
Provider Review Requirements			
Quarterly review .5 percent of all active providers; 80 percent of reviews to be selected by SURS	**18,904**	**380**	**304**
Annually review 10 inpatient hospitals; 50 percent of reviews to be selected by SURS		**10**	**5**
Recipient Review Requirements			
Quarterly review .01 percent of all active recipients; 80 percent of reviews to be selected by SURS	**365,748**	**148**	**120**

*SURS is the Surveillance and Utilization Review Subsystem which is the Department of Medical Assistance Service's exception and profiling system.

Source: JLARC staff analysis of System Performance Review, HCFA, 1990 and interviews with DMAS staff.

The *Code of Virginia* elaborates on the definitions of Medicaid fraud and abuse and assigns authority for investigating allegations of fraud. The *Code* states that providers receiving excess payments shall be required to return them and recipients will be liable for excess benefits obtained. Further, §32.1-320 of the *Code of Virginia* states that a unit in the Attorney General's Office shall audit and investigate providers who furnish services under the State Medical Assistance Plan. Section 32.1-321.1 et seq. of the *Code of Virginia* also assigns DMAS the responsibility for investigations and referrals for prosecution of recipients who inappropriately qualify for benefits, both fraudulently and without intent.

Several State Agencies Are Involved in Controlling Medicaid Fraud and Abuse. The Division of Program Compliance within DMAS is responsible for several functions to review and investigate providers and recipients. The division audits, educates, and initiates the collection of overpayments from providers who were found to

have billed the program inappropriately. Recipients who overutilize Medicaid services or receive services that are not medically necessary are restricted by the division to one primary physician who manages their care. Recipients may also be restricted to one pharmacy from which they are allowed to receive their prescribed medications.

In addition, the division has a function to investigate recipients whose eligibility determination was flawed, either by recipient intent or an error in the eligibility determination process. Prosecution is sought for individuals who have intentionally concealed facts in applying for Medicaid and recoveries are pursued for services paid on behalf of individuals who have received benefits by mistake.

Additional State agencies investigate allegations of fraud and abuse associated with Medicaid. The Medicaid Fraud Control Unit (MFCU) in the Attorney General's Office audits and investigates allegations of provider fraud. Working from referrals by DMAS and other sources, the MFCU investigates a few providers each year and, as appropriate, refers them to a Commonwealth's Attorney for prosecution. The domain of the unit is restricted solely to Medicaid. In federal fiscal year 1991, the MFCU closed 21 cases which included four criminal convictions and resulted in recoveries of almost $280,000. Compared to the performance of 38 other state MFCUs in that year, Virginia's MFCU ranked in the top one-half of states, both with respect to the number of convictions per staff member and amount of recoveries per staff member.

In addition to the MFCU, two other agencies have some functions related to controlling Medicaid fraud and abuse. The State Police has a Diversion Investigation Unit which has the authority to look into all allegations of prescription drug diversion for unintended uses. The unit investigates all types of diversion without respect to payer, therefore Medicaid diversion is not its sole focus.

The Department of Health Professions (DHP) is also involved in controlling fraud and abuse. Because DHP licenses medical providers in Virginia, any apparent violations of State statute or regulation concerning health care providers found during DMAS reviews are referred to DHP. DHP may take disciplinary action through one of its boards which regulate health care professionals.

The Activities of the Division of Program Compliance Comply with Federal and State Regulations. By opening the minimum number of provider and recipient reviews each quarter, the division complies with federal regulations. The division also meets requirements by employing an exception and profiling system to select 80 percent of the cases. However, there are no requirements beyond these broad federal regulations affecting the division's performance.

In FY 1991, almost 2,200 provider and recipient cases were opened. The Division of Program Compliance estimates it saved more than $574,000 in federal and State program costs and initiated recovery of almost $1.3 million in recipient fraud losses and provider overpayments. During FY 1992, almost 1,600 provider and recipient cases were opened for review. In that year, the division estimates it saved more than one million dollars in Medicaid program costs and initiated recovery on more than $961,000

in established losses and overpayments. This reflects the division's implementation of a 1990-1992 biennium cost savings initiative to emphasize managing recipient medical care.

To target providers and recipients for review, the division employs an exception and profiling system called the Surveillance and Utilization Review Subsystem (SURS). SURS creates exception reports and provider and recipient profiles on a quarterly basis. SURS groups providers together by their specialty and recipients together by their category of eligibility. SURS compares the claims of each provider and recipient to the claims of their peer group on various line items such as average number of injections given per patient, total Medicaid dollars paid, dollars earned, number of different doctors visited, or number of prescriptions received. Each provider or recipient receives one exception for each item that exceeds two standard deviations from the mean for their peer group's service claims.

At the end of the SURS processing, the total number of exceptions for each provider and recipient are summed. Separate lists of providers and recipients in descending order of the number of exceptions are printed quarterly. These lists are the source of the majority of the reviews undertaken by the units within the Division of Program Compliance. Other reviews are identified through referrals from staff inside and outside the division.

While the division satisfies federal requirements, no standards exist to assess the division's effectiveness or efficiency. According to GAO, meeting federal requirements on the number of reviews and method of selecting cases will not ensure effectiveness. In addition, the National State Auditor's Association, in conjunction with several other states, stated that an approval rating on the systems performance review is not an assessment of effectiveness or efficiency.

While there are no recognized standards for gauging division performance, the division appears to be successful at detecting abusive practices and establishing either cost savings or initiating recovery of overpayments and losses. However analyses of division caseloads, case completion timeliness, and case outcomes suggest there are opportunities for additional cost savings.

DMAS Could Be Doing More to Enhance Reviews of Providers

As mentioned, no federal standards for assessing outcomes or timeliness exist to measure the effectiveness and efficiency of DMAS fraud and abuse functions. However, JLARC staff reviewed the division's performance based on its overall case outcomes and caseloads. In the beginning of FY 1991, DMAS successfully expanded its recipient medical management function by increasing the number of recipients in restriction. This expansion, part of the agency's overall cost savings initiatives over the 1990-1992 biennium, saved the federal and State governments more than $700,000 throughout the biennium.

A similar expansion and enhancement of provider selection in the division's provider review activity may also lead to additional cost savings. In FY 1992, the division exceeded its required minimum number of provider cases by only 40. In FY 1991, the division exceeded the minimum by only 26 cases. In addition, less than one-third of the provider cases selected for review in FY 1990 and FY 1991 resulted in the establishment of an overpayment. This may indicate that: (1) additional staff is necessary to increase review activity and (2) better targeting of cases for review is necessary.

Expanding the Recipient Medical Management Program Led to Savings. The division estimates $115 in physician and pharmacy costs is saved monthly for each recipient restricted to one primary physician and/or one pharmacy because of abusive utilization. Prior to FY 1991, the division met its minimum number of recipient reviews and consistently managed about 300 recipients restricted to one primary physician and/or one pharmacy with about six staff members. Over the 1990-1992 biennium, six more staff members were added and restriction criteria were streamlined to allow DMAS to greatly exceed the minimum federal requirements. At the end of the biennium, almost 1,000 recipients were restricted in the medical management program, and savings exceeded $700,000 as a result of the expansion.

Cost savings associated with this function may decline as Medicaid's managed care program, Medallion, is implemented across the State. Like the medical management program, Medallion will also coordinate a recipient's care through a primary care physician. Consequently, some staff with responsibility for the medical management function may need to be shifted to the Medallion program. However, information received from DMAS indicates that staff involved in monitoring the recipients medical management "cannot currently monitor cases as closely as they should be with 1,000 plus restrictions." Therefore, even if the Medallion program decreases their workload, DMAS believes that current staff will be necessary to work with abusive recipients.

The Amount of Staff Responsible for Reviewing Providers Does Not Appear to Be Sufficient to Handle the Case Load. The Division of Program Compliance has met federal requirements in the number of cases initiated but has been unable to complete all the reviews. As of the end of FY 1992, a backlog of more than 300 uncompleted cases had developed. More than 50 of these cases were opened during FY 1991 and although some progress had been made in completing them, most were still in the early stages of review at the end of FY 1992. These reviews are not being completed in a timely manner because of staff vacancies and because replacement staff have little experience in Medicaid procedures for post-payment review. As time passes, the opportunity to identify and collect overpayments diminishes. More important, abusive providers have been allowed to continue their abusive patterns of Medicaid billing.

DMAS has requested additional staff for this function. More staff should be added to eliminate the backlog, complete reviews in a timely manner, and do even more reviews in the future. Since the total amount of overpayments established in FY 1991 and FY 1992 exceeds the amount of personnel costs for the same years by a ratio of almost two to one, adding more staff would be cost effective. Due to the clerical nature of some of their work, consideration could be given to hiring technicians as well as analysts.

Results from Past Provider Review Cases Should Be Used in the Provider Case Selection Process. Almost 70 percent of the provider review cases initiated in either FY 1990 or FY 1991, and which have been completed, resulted in no additional cost savings. In addition, about 35 percent of these completed cases had findings of no abuse whatsoever. The division estimates that historically, 40 to 50 percent of all cases have been closed with findings of no abuse. Changes in the provider selection process might increase the number of review cases that lead to overpayments.

After providers are identified by SURS as exceptions, a list of exceptional providers is printed by SURS. Currently, the provider review supervisor selects cases from the SURS exception lists and referrals based on professional judgment which incorporates the supervisor's medical background and experience. The selection takes into account the time since a previous review, the outcome of previous reviews, the provider's total Medicaid claims dollar volume, provider dollars earned, and the proportion of each provider type in the provider population. Since physicians comprise the largest number of providers in the provider population, a higher proportion of physicians are reviewed than any other provider types.

Better use of aggregate data the division maintains on the outcome of previous reviews may enhance judgment used to select cases for review. JLARC staff obtained data on review outcomes and found that in the past, some provider types and certain dollar thresholds have been more likely to lead to findings of abuse. For example,

> *Previous reviews of radiologists and emergency room physicians were more likely than other providers and physician types to have billing problems. Several reviews of radiologists found them to be billing for more services than they performed. In addition, a number of emergency room physicians were billing for services already included in emergency service claims.*
>
> * * *
>
> *The data from past cases also showed that cases of providers with annual Medicaid claims totaling more than $500,000 were more likely to lead to overpayments than providers with a lower claims volume. Furthermore, the amount of overpayments established for these providers was greater than other providers.*

Trends such as these could be used as the supervisor judgmentally selects cases from the SURS exception lists. Furthermore, since line items used by to create exceptions can be altered, these trends could be used by division staff to modify or create new line items in SURS that might better identify abusive provider patterns.

Recommendation (8). **The Department of Medical Assistance Services should consider expanding staff resources for the provider reviews to attain additional cost savings. In addition, the department should use data from past provider review cases to select providers for review.**

DMAS Activities to Investigate Recipient Fraud Are Lacking and Should Be Strengthened

While DMAS expanded its function to manage recipient utilization of program services as part of the 1990-1992 cost management initiatives, the department chose to minimize its efforts to investigate allegations of fraudulent or mistaken eligibility determinations and to recover lost monies. The recipient fraud and recovery function has been staffed at skeletal levels since FY 1990. This appears to be the result of budget shortfalls experienced by the State at that time. Positions with responsibility for this function became vacant and were not refilled.

The lack of staff appears to have had a negative impact on the division's ability to investigate recipient fraud and initiate recoveries. The unit initiated recovery procedures for $409,000 in losses in FY 1990. The amount of recipient losses established dropped ten percent to $368,000 in FY 1991 and then dropped another 30 percent to $256,000 in FY 1992.

The Division of Program Compliance reviews eligibility records and recipient claims histories when there is an allegation of fraud or an error in the determination of Medicaid eligibility. The division does not use SURS to identify these cases but instead relies on allegations made by local departments of social services. A few cases also come from providers, or from a recipient's relatives or neighbors. Most cases involve excess income and resources, property transfers, and residency which may have an effect on a recipient's eligibility. Some cases involve allegations of Medicaid card-sharing in which individuals other than the recipient are using the card to obtain medical services. Until the end of FY 1991, the division also investigated allegations of drug diversion.

Staffing levels of the unit within Program Compliance responsible for investigating recipient fraud remained low through the end of FY 1992. During the period of understaffing, a backlog of cases developed as the number of cases opened outpaced the number of cases closed. Though more than 1,000 older cases and drug diversion cases were closed during FY 1992, data obtained from the division tracking system indicated that more than 700 cases were still open at the end of FY 1992. JLARC staff selected a sample of 31 open cases that were assigned to unstaffed investigation regions of the State. Upon review, 54 percent of the cases were completely unworked or had no investigative activity for more than a year. Another 19 percent of the cases were closed just one day before the review and all of these cases also appeared to have been completely unworked for more than a year.

While the three vacant positions designated to this function were filled in September 1992, a significant amount of recipient fraud may have been uncontrolled during the period of low staffing. It is important to maintain adequate staffing in this function because fraud investigation requires immediate response to allegations, otherwise case leads dissipate. In addition, any deterrent effect has probably been reduced since there appears to be little threat of fraudulent behavior being curtailed. For example, one-quarter of all cases assigned during FY 1991 (approximately 186 cases) were assigned to the southwest Virginia investigation region. The single staff position

assigned to this region became vacant in September 1991 and as of the end of July 1992, 144 of these cases were still listed as open. Former division staff and law enforcement officials have indicated that this region has a history of fraudulent practices and presents potential for monetary recoveries.

Recommendation (9). **The Department of Medical Assistance Services should place higher priority on recipient fraud activities to ensure the Division of Program Compliance maintains adequate staff to detect and control recipient fraud and make additional monetary recoveries. The department should track the impact of this function, including the amount of program costs avoided, and assess if the current level of staffing is adequate to perform this function.**

Activities to Control Drug Diversion Should Be Strengthened

The *Code of Virginia* assigns DMAS the responsibility to investigate and refer cases which violate applicable State and federal laws and regulations regarding the receipt of Medicaid services or benefits. Diverting prescription drugs in the Medicaid program has been cited as a problem in 21 states, including three border states and the District of Columbia. Even though the department received more than 125 drug diversion allegations in FY 1991, DMAS no longer actively investigates diversion cases. Drug diversion investigations were eliminated in early FY 1992 due to required agency cost reductions along with efforts to streamline agency functions to eliminate duplication and overlap. DMAS should take steps to ensure that this function is performed.

DMAS pursued its first diversion case in 1986 and provided technical support to the Department of State Police when the State Police formed a diversion investigation unit in 1988. During the fall of 1990, DMAS submitted budget addendum which included a request to create a pharmaceutical diversion unit with responsibility for providing "essential information and investigative support to the diversion investigation unit of the State Police and to prosecute individuals who misuse the Medicaid card to obtain drugs illegally." At that time, DMAS had a backlog of about 357 drug diversion cases and believed additional investigative staff were needed to conduct diversion activities. Beginning July 1, 1991, DMAS pooled all Medicaid diversion investigations into this unit and began operating an automated system designed to target recipients, physicians, and pharmacists involved in diversion schemes.

The DMAS pharmaceutical diversion unit was dismantled shortly after its creation and before it was fully staffed. This was done because DMAS was required to reduce administrative expenditures and an assessment of the department's functions and staffing indicated that the drug diversion function would be better housed within the Department of State Police. Currently, DMAS does not actively investigate Medicaid drug diversion cases. Any allegations of drug diversion involving recipients are handled in the unit responsible for managing recipient medical care. Other allegations involving drug diversion are referred to the State Police.

More active pursuit of Medicaid diversion investigations presents an opportunity for achieving some additional cost savings and preventing fraudulent activities. Cost savings could be generated from recoveries made from fraudulent prescribers and pharmacists. In addition, the removal of fraudulent recipients from the program would decrease utilization costs. If convicted, the charge of Medicaid fraud bars a recipient from receiving any Medicaid services for one year.

Although the extent of the problem is unknown, staff both inside and outside of DMAS believe that the potential loss to Medicaid by drug diversion activities could be significant. Further, in its 1990 budget addenda, DMAS estimated that a pharmaceutical diversion unit with five people assigned to investigate Medicaid diversion cases could save the State $1.2 million in the first full year of operations and about half that amount in the second year of operations.

The effectiveness of DMAS' current policy towards drug diversion may be limited. The recipient medical management program may not be the right tool to combat drug diversion involving recipients. Restricting recipients only limits who can prescribe drugs and where they can be obtained over a certain period of time. It does not suspend all of the recipient's Medicaid benefits for one year, as would happen if fraud were proven.

In addition, DMAS has computer programs to target potential diverters which are currently used infrequently. The programs, called the Medicaid Abusable Drug Audit System (MADAS), focus solely on pharmaceuticals that the U.S. Drug Enforcement Agency has defined as likely to be abused. Though DMAS has concerns that MADAS is expensive to run, MADAS can and has detected drug activity that SURS cannot. For example:

> *One report from MADAS identified 53 potential drug diverters who were referred to the recipient monitoring unit for possible restriction in the recipient medical management program. About one-third of the MADAS referrals that matched up with a SURS exception were found to be abusive enough to warrant restriction. However, more than one-half of the 27 MADAS referrals not matched with SURS exceptions were found to be excessive enough for the restriction program.*

While these restricted recipients will now have their access to prescriptions limited by a primary care physician, this action may not be the most cost effective in the long run because they were not suspended from the program or penalized in any way.

Currently, the State Police handle all types of drug diversion investigations, including Medicaid. Of the 638 diversion cases the State Police opened during FY 1991, 27 were from DMAS referrals. This has decreased from 66 cases in FY 1988. Because the State Police resources and powers to handle all these diversion cases are limited, Medicaid diversion cases do not receive investigative priority.

Additional resources should be provided to the State Police for the explicit purpose of investigating allegations of Medicaid drug diversion. DMAS should create a

new interagency agreement with the State Police formalizing the State Police's responsibility to conduct Medicaid diversion investigations and DMAS' responsibility to support the State Police by regularly providing MADAS reports, referrals, and other information used in diversion investigations. In addition, federal matching funds should be used to support the State Police if DMAS determines such assistance is permitted.

Recommendation (10). **The Department of Medical Assistance Services should strengthen its drug diversion activities by entering into a new interagency agreement with the Department of State Police to conduct drug diversion investigations on behalf of DMAS. The Department of Medical Assistance Services should continue to support these investigations by providing referrals and any necessary information or records to conduct them, including regularly produced reports from the Medicaid Abusable Drug Audit System.**

The State Police should be allocated additional staff who are dedicated to Medicaid drug diversion investigation. Staffing requirements should be jointly determined by the Secretaries of Health and Human Resources and Public Safety. To the extent possible, federal financial participation through the Medicaid program should be utilized to fund the drug diversion investigations.

THIRD-PARTY LIABILITY

Medicaid has been defined by federal law to be the payer of last resort. Therefore, the Medicaid program also pursues third-party liabilities (TPL) to achieve cost savings. Third-party liabilities result when services for Medicaid recipients should be paid by other parties or their insurers.

Generally, there are two types of situations which result in the establishment of third-party liabilities. First, when a Medicaid recipient receives services which are covered by private health insurance or Medicare, the other insurer is responsible for payment. The private health insurance may be provided by the recipient's employer or, in the case of a child, an absent parent who may have health insurance to cover the child. Second, if a Medicaid recipient is injured in an accident, another person, entity, or other insurance carrier (such as automobile insurance or worker's compensation) may be responsible for paying for the services resulting from the accident.

State Medicaid agencies generally pursue TPL with two methods once a third party is identified. The first method, termed "pay and chase," pays the provider for the medical service and then seeks recovery from the liable party. The second method, termed "cost avoidance," denies payment from Medicaid, forcing the provider to get payment from the liable party.

Several federal regulations affect state TPL operations. During its most recent review of TPL activities, HCFA found no deficiencies or lack of compliance on the part of DMAS. In fact, DMAS estimates its TPL activities saved at least $80 million through cost avoidance and about $2 million through pay and chase activities in FY 1991. During FY 1992, an additional $92 million was saved through cost avoidance and $3 million was recovered through pay and chase activities. In addition, data matches performed by a private contractor have contributed nearly $2 million more to pay and chase savings during FY 1991 and FY 1992. The savings from cost avoidance activities are understated because many providers bill other insurance directly without going through DMAS; therefore, DMAS cannot track all cost avoidance savings.

While current collections are significant, additional cost savings could be achieved. Most of the tasks performed in the TPL unit are currently done manually. TPL staff spend much time gathering and sorting through claims details, entering data, and corresponding with other potential liable parties. With the acquisition of a TPL recovery system, DMAS has projected a $14 million increase in savings over a four-year period. The new system will automate many manual tasks associated with TPL and assist in identifying the most productive cases. As the new system enters its development stage, DMAS should consider adding some system components which have been successfully implemented in other states that may improve cost avoidance and collections.

DMAS TPL Operations Comply with Federal Guidelines

The *Code of Federal Regulations* outlines several components needed in the State's TPL operations (Exhibit 4). Responsibility for TPL operations is divided between DMAS and the Department of Social Services (DSS). DSS has responsibility for the eligibility, data matches, and absent parent medical support components and DMAS has responsibility for the remaining components. HCFA's systems performance review determines if DMAS and DSS are in compliance with federal requirements. The most recent review found both agencies in compliance with federal requirements.

Requirements Implemented by DSS. Three of the federal requirements in Exhibit 4 have been implemented through inter-agency agreements with DSS. Health insurance and absent parent information is obtained during the eligibility determination process which is done at local social service offices. In addition, DSS performs inquiries and data matches with the U.S. Social Security Administration, the Internal Revenue Service, the Virginia Employment Commission, and the Department of Motor Vehicles (DMV) to confirm the applicant's information. Finally, DSS notes other resources available to the recipient in the eligibility file.

DSS uses administrative orders to enforce absent parent medical support. However, DSS's efforts to meet this requirement are hindered by the federal Employee Retirement Income Security Act (ERISA). ERISA preempts State authority to require employers to enroll dependents onto absent parents' health insurance plans. DSS officials have estimated that 70 percent of the employers in Virginia, including the State's largest private employer, are exempted by ERISA and will not comply with the administrative orders.

Exhibit 4

Federal Requirements for TPL Activities and State Agency Responsible for Implementing Them

Federal Requirement	DMAS	DSS
Obtain health insurance and absent parent information during the Medicaid eligibility process		●
Incorporate all third-party resource information (including health insurance and absent parent) into the eligibility file	●	●
Perform data matches with Social Security Administration, Internal Revenue Service, Virginia EmploymentCommission, Department of Motor Vehicles		●
Edit claims for diagnosis and trauma codes	●	
Follow up on third-party resource leads to legally identify third-party liabilities	●	
Reject all claims when third-party liability probably exists. Third-party liability established when provider or third-party resource indicates the extent of the liability	●	
Pay all claims where the probable existence of a third-party liability cannot be established	●	
Recover reimbursement when a third-party liability is determined after the claim is paid	●	
Recovery of reimbursement until the recovery is not cost effective	●	

Source: JLARC analysis of *Code of Federal Regulations* §433 Subpart D and *State Plan for the Virginia Medical Assistance Program*, 1990.

Requirements Implemented by DMAS. All remaining requirements in Exhibit 4 are performed by DMAS. DMAS lists all third-party insurance or absent parent resources noted in the eligibility file on the recipient's Medicaid card. With some exceptions, providers are required to bill these other resources before billing Medicaid. If there are no other parties, DMAS pays the claim. However, if a third-party resource is identified after the claim is paid, DMAS must pursue recovery. Recovery is pursued

as long as it is cost effective. The current DMAS thresholds for cost effectiveness are set at $40 for health insurance cases and $50 for accident and trauma cases. Accounts that are uncollectible are either written off or turned over to the Attorney General's Office.

DMAS is also required to identify other resources after the claim is paid by searching for diagnosis codes that indicate a trauma. Trauma codes identify a range of diagnoses that cover injuries and emergency services. On a monthly basis, DMAS sends letters to all recipients who received services coded as a trauma. DMAS attempts to learn if another party is responsible for their injuries and subsequent medical services. If another party is identified, DMAS bills the other party for the services or establishes a lien against any future settlement.

TPL Operations Are Reviewed by the Systems Performance Review. Once every three years, HCFA reviews DMAS' TPL operations with the systems performance review. During the most recent review in 1990, DMAS TPL activities were found to be in compliance with federal regulations. The results of the HCFA review indicated that claims were always subjected to trauma code checks. In addition, DMAS avoided paying costs associated with claims which had other insurance coverage identified and for the collection of TPL resources, claims were properly identified. Finally, HCFA determined that DMAS or DSS performed or made reasonable attempts to make all the required data exchanges.

Nevertheless, the requirement that DMAS conduct data matches with the Virginia Workers' Compensation Commission and DMV is currently not being met. DMAS has attempted, but has not been able to perform any data matches with these agencies. Currently, the computer system used by DMV is incompatible with the DMAS system and the Virginia Workers' Compensation Commission rejected attempts by DMAS to match data because of privacy concerns. Since attempts have been made, HCFA has not found DMAS out of compliance with these requirements. DMAS is currently researching the cost effectiveness of making system changes to conduct data matches with DMV. However, according to DMAS staff, HCFA is reexamining the need for requiring data matches with DMV and the Virginia Workers' Compensation Commission because many states are not finding many additional cases by adding these data matches.

DMAS Plans for a New TPL System Should Automate Manual Tasks and Improve Cost Savings

Currently, most of the tasks performed in the TPL function are done manually. In addition, DMAS has virtually no ability to monitor and alter its operations based on the cost effectiveness of its operations. DMAS has proposed a new TPL recovery system to automate many tasks and select those cases that are most likely to lead to recoveries. Although it appears that the new system will improve TPL operations, DMAS should consider other components as the new system goes into development.

An Automated TPL System Will Speed the Process Currently Used by DMAS. The advanced planning document of the proposed TPL recovery system outlined three alternatives for the new system, with the costs and benefits for each. Since the projected benefits were the same, the lowest cost alternative was chosen. The system is expected to cost almost $2 million over the course of four years. The projected benefit over the same period is about $14 million for a return on investment of slightly less than nine to one. The system has been approved by HCFA and the Department of Accounts. A contractor has been selected and the contract is currently in negotiation.

The new TPL system will automate many TPL tasks that are currently done manually. The system will automatically create case files when a potential TPL is discovered. TPL technicians will be able to review and sort the claims using a computer screen rather than paging through long paper reports. Other benefits include:

- discontinuing reliance on paper claims histories by automatically entering case information into a TPL database
- automating claims histories that will facilitate faster and more reliable calculation of recovery amounts
- enhancing accounts receivable by automating billing, follow-up letters, and tracking.

In addition to automating manual tasks, the new system will also allow DMAS staff to:

- program and select cases based on their cost effectiveness
- regularly and more rigorously pursue claims which are currently pursued on an ad hoc basis because of staff and time limitations
- conduct in-house data matches with other insurance companies and State agencies.

DMAS Should Conduct Tests to Select Cases Based on Cost-Effectiveness. With the new system, DMAS can and should conduct tests to determine which cases are the most cost effective. Tests should also be used to determine if the current investigation thresholds should be altered. One of these tests should examine the cost effectiveness of cases originating from trauma codes. The new system should be used to test whether adding or deleting some trauma diagnosis codes would generate more cost-effective cases.

Currently, more than 8,000 letters are sent to injured recipients each month. Less than 20 percent of these letters are returned. If follow up were conducted on unreturned letters, more casualty TPL cases might be opened. By automating their work tasks, the technicians should have more time to pursue these cases.

In addition, only about 20 percent of returned letters actually lead to a case where a lien might be established. Federal guidelines permit state Medicaid agencies to modify the trauma codes which are used to create letters if it is found to be cost effective to do so. Therefore, DMAS could analyze the trauma cases for patterns in the trauma codes which result in the placement of liens. Codes that are not cost effective could be dropped, thereby decreasing the amount of time, effort, and cost of sending so many notices.

Furthermore, DMAS could test and consider adding other diagnoses codes that might identify TPL. One state uses 30 additional diagnosis codes that are outside the injury and emergency trauma code range required by HCFA. These codes include diagnoses such as maternal injury, lung diseases due to external agents, and food poisoning. In a six-month period, Wisconsin identified seven percent more personal injury claims leading to recovery using these additional codes. Automation should provide the time and the research tools to permit experimentation and analysis of codes inside and outside the injury and emergency codes are cost effective to pursue.

Recommendation (11). **When the new third-party liability system is operational, the Department of Medical Assistance Services should undertake tests, such as adding or deleting trauma codes, to identify the most cost-effective, third-party liability cases.**

The Proposed Recovery System Has Most Components of a Model TPL System. The anticipated benefits and costs of the proposed new TPL system do not appear unreasonable. The research used to prepare the advance planning document appears sound, and projected savings seem to be conservative. However, as the new system is still in the formative stages, DMAS could consider accommodating additional TPL practices that have been successful in other states.

JLARC staff obtained a guide from HCFA outlining successful TPL practices used in other states. The guide was used to develop the components of a model TPL system. Virginia's current and proposed new system is compared to these components in Exhibit 5.

Some successful practices mentioned in this guide are already being practiced by DMAS and others are not applicable to Virginia because of the State's Medicaid policies. However, some ideas do appear worthy of further research for inclusion into the new system. As the new system goes into development, DMAS should consider the merits and the system's support of the following functions:

- data matching with other State agencies such as the Department of Motor Vehicles, Virginia Employment Commission, Department of Personnel and Training, Virginia Retirement System, Virginia Workers' Compensation Commission, and the Virginia State Police as a means of identifying other health insurance or trauma victims

- conducting tests based on the outcomes of cases to identify the most cost-effective cases

Exhibit 5

Comparison of Medicaid's Current and Proposed TPL System with Model System

● Fully Meets ✇ Partially Meets ○ Does Not Meet ? Unknown if it Meets

Model Criteria	Current System	Proposed System
Lists other resources on Medicaid card	●	●
Subrogates recipient rights at time of application	●	●
Cost avoids all claims with other resources and instructs provider to bill other resources	●	●
Has detailed TPL database listing all third party resources and source of TPL information	✇	✇
Matches data with other insurers and agencies to identify other resources	✇	✇
Matches data with other agencies to identify recipient trauma victims	○	?
Searches for trauma codes when processing claims	●	●
Has automated recovery billing and tracking	○	●
Allows flexible tailoring of TPL cases selected for research	○	●
Allows determination of cost-effective thresholds to pursue health insurance liability and accident claims	?	●
Batches computer generated payment histories to other insurers in lieu of individual bills	●	●
Collects benefits information through employer quarterly reports or wage clearances	○	?
Supports evaluation of TPL identification performance at local office level	○	?
Establishes liens on any settlements in which Medicaid paid for services	●	●
Has electronic Medicaid eligibility verification with TPL notice	●	●
Is compatible with medical support orders	●	●
Supports TPL training for intake workers	○	?
Supports TPL information presentations	○	?

Source: JLARC staff analysis of *Third Party Liability In The Medicaid Program; A Guide To Successful State Agency Practices*, HCFA, 1990.

- interaction with DSS and other agencies to identify and process other insurance and medical support

- development of third-party resource identification training for social service workers and evaluation of local social service department's performance at identifying other resources

- flexibility to add estate liabilities at a later date

- presenting third-party resource information to personal injury bar conferences.

Recommendation (12). **As development of the new third-party liability system begins, the Department of Medical Assistance Services should consider incorporating additional TPL practices that other states have found to be successful. For example, other data matches, TPL training and evaluation of social service workers, and estate liability functions could be included in the design of the new system.**

Appendixes

Appendix A

Senate Joint Resolution No. 180

Requesting the Joint Legislative Audit and Review Commission to study the Commonwealth's Medicaid program and the indigent care appropriations to the state teaching hospitals and the Medical College of Hampton Roads.

Agreed to by the Senate, February 19, 1991
Agreed to by the House of Delegates, February 15, 1991

WHEREAS, a goal of the Commission on Health Care for All Virginians is to provide access to basic health care for all Virginians; and

WHEREAS, approximately 330,000 persons in Virginia are eligible for the Medicaid program, but an estimated 300,000 additional Virginians in poverty have no health insurance; and

WHEREAS, the number of Virginians eligible for Medicaid has increased by only 10 percent during the last 10 years, but Medicaid expenditures in Virginia have tripled during that period; and

WHEREAS, costs in the 1990-92 biennium are expected to be more than 40 percent greater than the costs in the 1988-90 biennium; and

WHEREAS, the Medicaid program now represents about 12 percent of the Commonwealth's general fund budget, with an estimated $1.4 billion (general fund) cost for the 1990-92 biennium; and

WHEREAS, Medicaid costs will continue to escalate at a rapid rate as inflation in health care costs far surpasses other goods and services; and new federal mandates are likely to continue as Congress expands health insurance for the elderly, disabled, and poor through Medicare and Medicaid; and

WHEREAS, federal mandates establish the core of the Medicaid program, but states can partially shape the benefits and costs through policy adjustments in reimbursement rates for service providers; services offered to recipients; utilization review to ensure appropriate care; and eligibility for groups of persons, and to some extent, how much recipients pay for their own care; and

WHEREAS, University of Virginia Medical Center, Medical College of Virginia Hospitals, and the Medical College of Hampton Roads provide a significant amount of care to low=income persons and receive state support for this care through Medicaid and direct general fund appropriations; now therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Legislative Audit and Review Commission be requested to study the Virginia Medicaid program and the indigent care appropriations to the state teaching hospitals and the Medical College of Hampton Roads.

The study shall include, but not be limited to:

1. Assessment of the cost savings and health policy implications of limiting the scope or duration of optional services, or adjusting recipients' contributions to their care;

2. Examination of the interpretation of federal requirements to determine if they have been implemented in the most effective and least costly manner;

3. Determination of the effectiveness of current utilization review procedures in controlling costs and exploration of additional options;

4. Evaluation of reimbursement methods to determine if they adequately encourage cost effective delivery of services;

5. Determination of the sufficiency of reimbursement rates to provide quality care at the lowest required cost;

6. Review of budget and forecasting methods to ensure that they adequately identify and project the cost of policy changes, service utilization, and new mandates;

7. Determination of how the legislative branch could increase its capacity to more closely monitor Medicaid forecasts and expenditures;

8. Exploration of the costs of alternative administrative methods for implementing program requirements and options;

9. Examination of the relationship with other State programs to promote optimal utilization of State funds;

10. Identification of options for using Medicaid funds for services currently supported with general funds; and

11. Review of eligibility scope of services, and reimbursement rates for indigent care at University of Virginia Medical Center, Medical College of Virginia Hospitals, and the Medical College of Hampton Roads, and a determination of the appropriateness of general fund and Medicaid allocation methodologies.

All agencies of the Commonwealth shall provide assistance upon request to the study as appropriate.

The Joint Legislative Audit and Review Commission shall complete its work in time to submit its findings and recommendations to the Governor and to the 1993 Session of the General Assembly, and shall provide interim reports to the Commission on Health Care for All Virginians and to the 1992 Session of the General Assembly and at other times as appropriate, using the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Appendix B

Limits on Physician Services Covered by the Virginia Medicaid Program

Services or Procedures with Frequency or Site of Service Limitations

- individual psychotherapy without preauthorization — 26 sessions
- comprehensive office visit — once annually
- extended office visit — once annually
- pap smears — once each six months
- nursing home visits (intermediate and extended) — one per month

Services or Procedures Not Covered Unless Certain Conditions Are Met

- house calls — unless patient is bedridden and a trip to a physician's office is inadvisable
- abortions — unless the life or health of the woman is endangered
- sterilizations — unless the individual is older than age 21, mentally competent, and has given informed consent in advance
- elective surgery — unless preauthorized
- transplant surgery — except for kidneys and corneas
- surgery for morbid obesity — only under limited conditions
- other designated procedures — only with second surgical opinions

Services or Procedures Not Covered

- cosmetic surgery
- experimental surgery
- inpatient surgery that could be performed on an outpatient basis

Source: Department of Medical Assistance Services, FY 1992 Baseline Budget Plan.

Appendix C

Data Tables for Physician Services

Table C-1

Number of Claims and Total Payments for Medicaid Physician Services From FY 1989 to FY 1991 by Recipient Eligibility Class and Category

Eligibility Class	FY 1989 Number of Claims	FY 1989 Total Amount Paid by Medicaid	FY 1990 Number of Claims	FY 1990 Total Amount Paid by Medicaid	FY 1991 Number of Claims	FY 1991 Total Amount Paid by Medicaid
Categorically Needy	2,108,692	$53,777,168	2,257,097	$69,429,306	2,925,704	$114,042,437
Money Payment	1,773,796	42,176,990	1,772,560	50,174,329	2,084,835	73,985,670
No Payment	334,896	11,600,178	484,537	19,254,977	840,869	40,056,767
Medically Needy	72,957	2,343,199	89,503	3,052,549	127,385	5,736,374
Dually Eligible	63,151	2,085,554	60,185	2,149,470	40,062	1,971,935
QMB/QDWI	5	124	1	17	2	-20
Refugee/Emergency Care	16,288	341,392	12,657	331,371	13,920	460,831
Eligibility Category						
Indigent Pregnant Women	128,700	$7,123,258	191,847	$11,208,557	310,432	$21,910,981
All ADC-Related	1,262,872	29,028,057	1,240,194	34,015,757	1,460,178	50,090,481
ADC-Related Adults	662,407	13,399,119	656,990	15,571,709	703,681	28,641,718
ADC-Related Children	600,465	15,628,938	583,204	18,444,048	756,497	21,448,763
Indigent Children	113,345	2,929,443	180,081	5,255,478	365,524	12,643,248
Other Children*	44,406	983,060	46,100	1,210,144	57,136	1,821,987
Aged	44,548	1,095,716	54,632	1,404,515	64,317	2,671,541
Blind and Disabled	652,934	17,046,510	693,931	21,536,891	835,566	32,612,487
Blind	7,462	190,683	8,005	235,598	9,110	415,679
Disabled	645,472	16,855,827	685,926	21,301,293	826,456	32,196,808
Refugees	16,288	341,392	12,657	331,371	13,920	460,831
Total All Recipients	2,261,093	$58,547,436	2,419,443	$74,962,713	3,107,073	$122,211,556

* Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS datasets, FY 1989 - FY 1991.

Table C-2

Percentage Increase in Physician Claims and Payments From FY 1989 to FY 1991 by Recipient Eligibility Class and Category

Eligibility Class	FY 1989 to FY 1990 Percentage Increase In Claims	FY 1989 to FY 1990 Percentage Increase In Payments	FY 1990 to FY 1991 Percentage Increase In Claims	FY 1990 to FY 1991 Percentage Increase In Payments	FY 1989 to FY 1991 Percentage Increase In Claims	FY 1989 to FY 1991 Percentage Increase In Payments
Categorically Needy	7.04 %	29.11 %	29.62 %	64.26 %	38.74 %	112.06 %
Money Payment	-0.07	18.96	17.62	47.46	17.54	75.42
No Payment	44.68	65.99	73.54	108.03	151.08	245.31
Medically Needy	22.68	30.27	42.32	87.92	74.60	144.81
Dually Eligible	-4.70	3.06	-33.44	-8.26	-36.56	-5.45
QMB/QDWI	-80.00	-86.29	100.00	-217.65	-60.00	-116.13
Refugee/Emergency Care	-22.29	-2.94	9.98	39.07	-14.54	34.99
Eligibility Category						
Indigent Pregnant Women	49.07 %	57.35 %	61.81 %	95.48 %	141.21 %	207.60 %
All ADC-Related	-1.80	17.18	17.74	47.23	15.62	72.56
ADC-Related Adults	-0.82	16.21	7.11	83.93	6.23	113.76
ADC-Related Children	-2.87	18.01	29.71	16.29	25.99	37.24
Indigent Children	58.88	79.40	102.98	140.57	222.49	331.59
Other Children*	3.82	23.10	23.94	50.56	28.67	85.34
Aged	22.64	28.18	17.73	90.21	44.38	143.82
Blind and Disabled	6.28	26.34	20.41	51.43	27.97	91.31
Blind	7.28	23.55	13.80	76.44	22.09	117.99
Disabled	6.27	26.37	20.49	51.15	28.04	91.01
Refugees	-22.29	-2.94	9.98	39.07	-14.54	34.99
Total All Recipients	7.00 %	28.04 %	28.42 %	63.03 %	37.41 %	108.74 %

* Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS datasets, FY 1989 - FY 1991.

Table C-3

Average Expenditures and Utilization for Medicaid Physician Services From FY 1989 to FY 1991 by Recipient Eligibility Class and Category

	FY 1989			FY 1990			FY 1991		
Eligibility Class	Average Cost Per Recipient	Average Cost Per Claim	Average Number of Claims Per Recipient	Average Cost Per Recipient	Average Cost Per Claim	Average Number of Claims Per Recipient	Average Cost Per Recipient	Average Cost Per Claim	Average Number of Claims Per Recipient
Categorically Needy	$250.22	$25.50	9.8	$297.75	$30.76	9.7	$398.85	$39.78	10.2
Money Payment	234.53	23.78	9.9	272.76	28.31	9.6	357.34	35.49	10.1
No Payment	241.98	34.64	7.0	301.21	39.74	7.6	403.01	47.64	8.5
Medically Needy	195.77	32.12	6.1	252.57	34.11	7.4	428.98	45.03	9.5
Dually Eligible	433.32	33.02	13.1	474.50	35.71	13.3	559.57	49.22	11.4
QMB/QDWI	62.00	24.80	2.5	17.00	17.00	1.0	-20.00	-10.00	2.0
Refugee/Emergency Care	178.93	20.96	8.5	197.72	26.18	7.6	256.59	33.11	7.8
Eligibility Category									
Indigent Pregnant Women	$443.49	$55.35	8.0	$515.79	$58.42	8.8	$721.61	$70.58	10.2
All ADC-Related	186.55	22.99	8.1	214.39	27.43	7.8	281.83	34.30	8.2
ADC-Related Adults	243.59	20.23	12.0	283.35	23.70	12.0	462.12	40.70	11.4
ADC-Related Children	155.35	26.03	6.0	177.84	31.63	5.6	185.30	28.35	6.5
Indigent Children	193.98	25.85	7.5	223.65	29.18	7.7	275.81	34.59	8.0
Other Children*	172.56	22.14	7.8	203.25	26.25	7.7	273.94	31.89	8.6
Aged	168.36	24.60	6.8	187.14	25.71	7.3	274.62	41.54	6.6
Blind and Disabled	483.81	26.11	18.5	576.18	31.04	18.6	763.67	39.03	19.6
Blind	338.09	25.55	13.2	424.50	29.43	14.4	678.11	45.63	14.9
Disabled	485.95	26.11	18.6	578.04	31.05	18.6	764.35	38.96	19.6
Refugees	178.93	20.96	8.5	197.72	26.18	7.6	256.59	33.11	7.8
Average All Recipients	$254.83	$25.89	9.8	$302.78	$30.98	9.8	$406.38	$39.33	10.3

* Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS datasets, FY 1989 - FY 1991.

Table C-4

Number and Cost of Physician Services for All Medicaid Recipients During FY 1991 By Recipient Eligibility Category

Eligibility Category	Number of Recipients*	Number of Claims	Percentage of Total Claims	Average Number of Claims Per Recipient	Total Amount Paid By Medicaid	Percentage of Total Payments**	Average Cost Per Claim	Average Cost Per Recipient
Indigent Pregnant Women	30,364	310,432	9.99 %	10.2	$21,910,981	17.93 %	$70.58	$721.61
All ADC-Related	177,730	1,460,178	47.00	8.2	50,090,481	40.99	34.30	281.83
ADC-Related Adults	61,979	703,681	22.65	11.4	28,641,718	23.44	40.70	462.12
ADC-Related Children	115,751	756,497	24.35	6.5	21,448,763	17.55	28.35	185.30
Indigent Children	45,840	365,524	11.76	8.0	12,643,248	10.35	34.59	275.81
Other Children***	6,651	57,136	1.84	8.6	1,821,987	1.49	31.89	273.94
Aged	9,728	64,317	2.07	6.6	2,671,541	2.19	41.54	274.62
Blind and Disabled	42,705	835,566	26.89	19.6	32,612,487	26.69	39.03	763.67
Blind	613	9,110	0.29	14.9	415,679	0.34	45.63	678.11
Disabled	42,123	826,456	26.60	19.6	32,196,808	26.35	38.96	764.35
Refugees	1,796	13,920	0.45	7.8	460,831	0.38	33.11	256.59
	300,734	3,107,073	100.00 %	10.3	$122,211,556	100.02 %	$39.33	$406.38

* Total number of recipients is lower than the sum of the individual categories of recipients (314,845) due to recipient changes in eligibility status. Many recipients were enrolled in more than one category during the year. For example, the combined total of blind and disabled recipients (42,705) is lower than the sum of the individual categories (42,736) due to shifting between categories.

** The percentage of total payments does not sum to 100 due to rounding.

*** Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS dataset, FY 1991.

Table C-5

Number and Cost of Physician Services for Ambulatory Medicaid Recipients During FY 1991 By Recipient Eligibility Category

Eligibility Category	Number of Recipients*	Number of Claims	Percentage of Total Claims	Average Number of Claims Per Recipient	Total Amount Paid By Medicaid**	Percentage of Total Payments	Average Cost Per Claim	Average Cost Per Recipient
Indigent Pregnant Women	29,970	302,958	10.77 %	10.1	$21,441,035	19.89 %	$70.77	$715.42
All ADC-Related	176,353	1,419,121	50.46	8.0	47,964,798	44.50	33.80	271.98
ADC-Related Adults	61,414	684,979	24.36	11.2	27,664,636	25.67	40.39	450.46
ADC-Related Children	114,939	734,142	26.10	6.4	20,300,162	18.83	27.65	176.62
Indigent Children	45,174	342,440	12.18	7.6	11,235,949	10.42	32.81	248.73
Other Children***	6,493	53,236	1.89	8.2	1,611,470	1.50	30.27	248.19
Aged	7,090	48,057	1.71	6.8	1,946,165	1.81	40.50	274.49
Blind and Disabled	35,111	633,001	22.51	18.0	23,145,148	21.47	36.56	659.20
Blind	503	6,520	0.23	13.0	284,381	0.26	43.62	565.37
Disabled	34,629	626,481	22.28	18.1	22,860,767	21.21	36.49	660.16
Refugees	1,787	13,527	0.48	7.6	438,947	0.41	32.45	245.63
	288,320	2,812,340	100.00 %	9.8	$107,783,513	100.00 %	$38.33	$373.83

* Total number of recipients is lower than the sum of the individual categories of recipients (301,999) due to recipient changes in eligibility status. Many recipients were enrolled in more than one category during the year. For example, the combined total of blind and disabled recipients (35,111) is lower than the sum of the individual categories (35,132) due to shifting between categories.

** The amount paid by Medicaid does not sum to the total due to rounding.

*** Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS dataset, FY 1991.

Table C-6

Number and Cost of Physician Services for Long-Term Care Medicaid Recipients During FY 1991 By Recipient Eligibility Category

Eligibility Category	Number of Recipients*	Number of Claims	Percentage of Total Claims	Average Number of Claims Per Recipient	Total Amount Paid By Medicaid	Percentage of Total Payments	Average Cost Per Claim	Average Cost Per Recipient
Indigent Pregnant Women	394	7,474	2.54 %	19.0	$469,946	3.26 %	$62.88	$1,192.76
All ADC-Related	1,377	41,057	13.93	29.8	2,125,683	14.73	51.77	1,543.71
ADC-Related Adults	565	18,702	6.35	33.1	977,082	6.77	52.24	1,729.35
ADC-Related Children	812	22,355	7.58	27.5	1,148,601	7.96	51.38	1,414.53
Indigent Children	666	23,084	7.83	34.7	1,407,299	9.75	60.96	2,113.06
Other Children**	158	3,900	1.32	24.7	210,517	1.46	53.98	1,332.39
Aged	2,638	16,260	5.52	6.2	725,376	5.03	44.61	274.97
Blind and Disabled	7,594	202,565	68.73	26.7	9,467,339	65.62	46.74	1,246.69
Blind	110	2,590	0.88	23.5	131,298	0.91	50.69	1,193.62
Disabled	7,494	199,975	67.85	26.7	9,336,041	64.71	46.69	1,245.80
Refugees	9	393	0.13	43.7	21,883	0.15	55.68	2,431.44
	12,414	294,733	100.00 %	23.7	$14,428,043	100.00 %	$48.95	$1,162.24

* Total number of recipients is lower than the sum of the individual categories of recipients (12,846) due to recipient changes in eligibility status. Many recipients were enrolled in more than one category during the year. For example, the combined total of blind and disabled recipients (7,594) is lower than the sum of the individual categories (7,604) due to shifting between categories.

** Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS dataset, FY 1991.

Table C-7

Summary of Physician Claims Data for the Ambulatory, Long-Term Care, and Total Recipient Populations During FY 1991

Recipient Population	Number of Claims	Number of Recipients	Total Amount Paid By Medicaid	Average Number of Claims Per Recipient	Average Cost Per Claim	Average Cost Per Recipient
Ambulatory	2,812,340	288,320	$107,783,513	9.8	$38.33	$373.83
Long-Term Care	294,733	12,414	$14,428,043	23.7	$48.95	$1,162.24
All Recipients	3,107,073	300,734	$122,211,556	10.3	$39.33	$406.38

Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS dataset, FY 1991.

Table C-8

Average Cost Per Claim for Physician Services During FY 1991 by Recipient Eligibility Category

Eligibility Category	Ambulatory Population	Long-Term Care Population	Total Population
Indigent Pregnant Women	$70.77	$62.88	$70.58
All ADC-Related	33.80	51.77	34.30
ADC-Related Adults	40.39	52.23	40.70
ADC-Related Children	27.65	51.38	28.35
Indigent Children	32.81	60.96	34.59
Other Children*	30.27	53.98	31.89
Aged	40.50	44.61	41.54
Blind and Disabled	36.56	46.74	39.03
Blind	43.62	50.69	45.63
Disabled	36.49	46.69	38.96
Refugees	32.45	55.68	33.11
Total All Categories	$38.33	$48.95	$39.33

* Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS dataset, FY 1991.

Table C-9

Average Number of Physician Services per Recipient During FY 1991 by Recipient Eligibility Category

Eligibility Category	Ambulatory Population	Long-Term Care Population	Total Population
Indigent Pregnant Women	10.1	19.0	10.2
All ADC-Related	8.1	29.8	8.2
ADC-Related Adults	11.2	33.1	11.4
ADC-Related Children	6.4	27.5	6.5
Indigent Children	7.6	34.7	8.0
Other Children*	8.2	24.7	8.6
Aged	6.8	6.2	6.6
Blind and Disabled	18.0	26.7	19.6
Blind	13.0	23.6	14.9
Disabled	18.1	26.7	19.6
Refugees	7.6	43.7	7.8
Total All Categories	9.8	23.7	10.3

* Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services practitioner claims, SAS dataset, FY 1991.

Appendix D

Calculation of Percentage of Medicaid Expenditure Increases Explained by Measurable Factors

To assess the growth in Medicaid physician and pharmacy expenditures, JLARC staff calculated the percentage of expenditure increases explained by measurable factors. Expenditures for each service category were projected forward from FY 1989 (the baseline year) to FY 1991. Actual claims data from these years were used for the potentially explanatory factors. Measurable factors were defined as:

- the number and mix of recipients of each service
- the number and mix of claims for each service
- inflation in the appropriate component (physician services or prescription drugs) of the consumer price index (CPI) for medical care services.*

The size of the projected increase in expenditures could then be expressed as a percentage of the actual increase in expenditures:

$$\frac{\text{(Projected FY 1991 Cost) - (Baseline FY 1989 Cost)}}{\text{(Actual FY 1991 Cost) - (Baseline FY 1989 Cost)}}$$

This approach was used to calculate the portion of the expenditure increase due to an individual factor (holding all other factors constant) or due to the interactive (or combined) effect of more than one factor. The interactive effect of factors typically exceeded the sum of the individual effects of the factors.

The following pages illustrate the approach — using actual claims data to assess the effect of changes in the number and mix of claims on increased expenditures for physician services. Formulas for all other calculations are also included.

Physician Service Claims Data

Baseline Year Data (FY 1989)

A = Indigent pregnant women claims	128,700
B = ADC-related adults claims	662,407
C = ADC-related children claims	600,465
D = Indigent children claims	113,345
E = Other children claims	44,406
F = Aged recipient claims	44,548
G = Blind recipient claims	7,462
H = Disabled recipient claims	645,472
I = Refugee claims	16,288
J = Total claims	2,261,093
K = Total expenditures	$58,547,436
L = Average cost per indigent pregnant woman claim	$55.35
M = Average cost per ADC-related adult claim	$20.23
N = Average cost per ADC-related child claim	$26.03
O = Average cost per indigent child claim	$25.85
P = Average cost per other child claim	$22.14
Q = Average cost per aged claim	$24.60
R = Average cost per blind claim	$25.55
S = Average cost per disabled claim	$26.11
T = Average cost per refugee claim	$20.96

Recent Year Data (FY 1991)

a = Indigent pregnant women claims	310,432
b = ADC-related adults claims	703,681
c = ADC-related children claims	756,497
d = Indigent children claims	365,524
e = Other children claims	57,136
f = Aged recipient claims	64,317
g = Blind recipient claims	9,110
h = Disabled recipient claims	826,456
i = Refugee claims	13,920
j = Total claims	3,107,073
k = Total expenditures	$122,211,556
l = Average cost per indigent pregnant woman claim	$70.58
m = Average cost per ADC-related adult claim	$40.70
n = Average cost per ADC-related child claim	$28.35
o = Average cost per indigent child claim	$34.59
p = Average cost per other child claim	$31.89
q = Average cost per aged claim	$41.54
r = Average cost per blind claim	$45.63
s = Average cost per disabled claim	$38.96
t = Average cost per refugee claim	$33.11

Calculation # 1: Percentage of Expenditure Incrase from FY 1989 to FY 1991 Due to Increase in Total Number of Claims (All Other Factors Constant)

Projected FY 1991 expenditure

= [FY 1991 number of claims] * [FY 1989 average cost per recipient]

= j * (K/J)

= $80,452,753

Percentage of increase explained

= (80,452,753 - K) / (k-K)

= 34.4 %

Calculation # 2: Percentage of the Expenditure Increase from FY 1989 to FY 1991 Due to Changes in the Mix of Recipient Claims (All Other Factors Constant)

Projected FY 1991 expenditure

= [FY 1989 total claims, allocated by recipient eligibility category based on FY 1991 proportions] * [FY 1989 average cost claim by recipient eligibility category]

=	[2,261,093	*	(a/j)]	*	L =	$12,502,634.60
+	[2,261,093	*	(b/j)]	*	M =	10,360,542.92
+	[2,261,093	*	(c/j)]	*	N =	14,331,497.06
+	[2,261,093	*	(d/j)]	*	O =	6,873,632.28
+	[2,261,093	*	(e/j)]	*	P =	921,115.02
+	[2,261,093	*	(f/j)]	*	Q =	1,151,393.78
+	[2,261,093	*	(g/j)]	*	R =	167,535.69
+	[2,261,093	*	(h/j)]	*	S =	15,703,878.76
+	[2,261,093	*	(i/j)]	*	T =	203,266.29

= $62,215,496

Percentage of increase explained

= (62,215,496 - K) / (k-K)

= 5.8 %

Calculation # 3: Percentage of the Expenditure Increase from FY 1989 to FY 1991 Due to the Interactive Effect of the Increase in Total Number of Claims by Mix in Recipient Eligibility Category

Projected FY 1991 expenditure

= [FY 1991 claims by type] * [FY 1989 average cost per claim by recipient eligibility category]

=	a	* L	=	$17,182,411.20
+	b	* M	=	14,235,466.63
+	c	* N	=	19,691,616.91
+	d	* O	=	9,448,795.40
+	e	* P	=	1,264,991.04
+	f	* Q	=	1,582,198.20
+	g	* R	=	232,760.50
+	h	* S	=	21,578,766.16
+	i	* T	=	291,763.20

= $85,508,769

Percentage of increase explained

= (85,508,769 - K) / (k-K)

= 42.4 %

Calculation # 4: Percentage of the Expenditure Increase from FY 1989 to FY 1991 Due to Medical Inflation (All Other Factors Constant)

Projected FY 1991 expenditures

= [FY 1989 total expenditures] * [FY 1991 inflation multiplier]

= K * x = y where x = inflation multiplier

Percentage of increase explained

= (y - K) / (k-K)

Calculation # 5: Percentage of the Expenditure Increase Due to the Interactive Effect of all of the Measured Changes (Claims Increases and Medical Inflation)

Projected FY 1991 expenditures

= [projected expenditure from calculation # 3] * [FY 1991 inflation multiplier]

= $85,508,769 * x = z

Percentage of increase explained

= (z - K) / (k-K)

Note: Calculations for recipients would simply substitute recipient data for claims data.

Appendix E

Data Tables for Pharmacy Services

Table E-1

Number of Claims and Total Payments for Medicaid Pharmacy Services From FY 1989 to FY 1991 by Recipient Eligibility Class and Category

	FY 1989		FY 1990		FY 1991	
Eligibility Class	Number of Claims	Total Amount Paid by Medicaid	Number of Claims	Total Amount Paid by Medicaid**	Number of Claims	Total Amount Paid by Medicaid
Categorically Needy	3,558,079	$55,875,043	3,566,353	$60,501,195	4,229,742	$80,591,485
Money Payment	3,300,956	$52,354,039	3,203,078	$55,292,303	3,637,991	$71,461,116
No Payment	257,123	3,521,004	363,275	5,208,892	591,751	9,130,369
Medically Needy	34,038	422,132	378,913	4,973,232	641,012	9,614,649
Dually Eligible	1,135,125	14,617,526	808,581	10,849,153	817,247	12,251,314
QMB/QDWI	0	0	19	186	0	0
Refugee/Emergency Care	9,864	169,801	8,229	153,532	9,380	199,523
Eligibility Category						
Indigent Pregnant Women	33,538	$419,775	49,168	$634,048	76,932	$1,084,984
All ADC-Related	924,850	11,937,775	899,435	12,505,940	1,051,961	16,502,042
ADC-Related Adults	515,503	7,305,595	480,584	7,350,979	561,308	9,682,107
ADC-Related Children	409,347	4,632,181	418,851	5,154,961	490,653	6,819,935
Indigent Children	41,887	397,176	73,405	744,822	167,585	1,992,126
Other Children*	26,684	396,486	28,693	457,397	36,853	639,467
Aged	2,213,804	31,779,268	2,224,729	33,583,797	2,618,478	43,922,363
Blind and Disabled	1,486,479	25,984,221	1,478,436	28,397,763	1,736,192	38,316,466
Blind	31,526	514,050	29,593	527,310	30,599	594,824
Disabled	1,454,953	25,470,171	1,448,843	27,870,453	1,705,593	37,721,642
Refugees	9,864	169,801	8,229	153,532	9,380	199,523
Total All Recipients	4,737,106	$71,084,502	4,762,095	$76,477,298	5,697,381	$102,656,971

* Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

** The FY 1990 total amount paid by Medicaid does not sum to the total due to rounding.

Source: JLARC staff analysis of Department of Medical Assistance Services pharmacy claims, SAS datasets, FY 1989 - FY 1991.

Table E-2

Percentage Increase in Pharmacy Claims and Payments From FY 1989 to FY 1991 by Recipient Eligibility Class and Category

	FY 1989 to FY 1990		FY 1990 to FY 1991		FY 1989 to FY 1991	
Eligibility Class	Percentage Increase In Claims	Percentage Increase In Payments	Percentage Increase In Claims	Percentage Increase In Payments	Percentage Increase In Claims	Percentage Increase In Payments
Categorically Needy	0.23 %	8.28 %	18.60 %	33.21 %	18.88 %	44.24 %
Money Payment	-2.97	5.61	13.58	29.24	10.21	36.50
No Payment	41.28	47.94	62.89	75.28	130.14	159.31
Medically Needy	1,013.21	1,078.12	69.17	93.33	1,783.22	2,177.64
Dually Eligible	-28.77	-25.78	1.07	12.92	-28.00	-16.19
QMB/QDWI*	n/a	n/a	n/a	n/a	n/a	n/a
Refugee/Emergency Care	-16.58	-9.58	13.99	29.96	-4.91	17.50
Eligibility Category						
Indigent Pregnant Women	46.60 %	51.04 %	56.47 %	71.12 %	129.39 %	158.47 %
All ADC-Related	-2.75	4.76	16.96	31.95	13.74	38.23
ADC-Related Adults	-6.77	0.62	16.80	31.71	8.89	32.53
ADC-Related Children	2.32	11.29	17.14	32.30	19.86	47.23
Indigent Children	75.25	87.53	128.30	167.46	300.09	401.57
Other Children**	7.53	15.36	28.44	39.81	38.11	61.28
Aged	0.49	5.68	17.70	30.78	18.28	38.21
Blind and Disabled	-0.54	9.29	17.43	34.93	16.80	47.46
Blind	-6.13	2.58	3.40	12.80	-2.94	15.71
Disabled	-0.42	9.42	17.72	35.35	17.23	48.10
Refugees	-16.58	-9.58	13.99	29.96	-4.91	17.50
Total All Recipients	0.53 %	7.59 %	19.64 %	34.23 %	20.27 %	44.42 %

* Percentage change cannot be calculated because no pharmacy claims or expenditures were made on behalf of individuals classified as QMB/QDWI FY 1989 and FY 1991.

** Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services pharmacy claims, SAS datasets, FY 1989 - FY 1991.

Table E-3

Average Expenditures and Utilization for Medicaid Pharmacy Services From FY 1989 to FY 1991 by Recipient Eligibility Class and Category

	FY 1989			FY 1990			FY 1991		
Eligibility Class	Average Cost Per Recipient	Average Cost Per Claim	Average Number of Claims Per Recipient	Average Cost Per Recipient	Average Cost Per Claim	Average Number of Claims Per Recipient	Average Cost Per Recipient	Average Cost Per Claim	Average Number of Claims Per Recipient
Categorically Needy	246.06	15.70	15.7	247.93	16.96	14.6	279.45	19.05	14.7
Money Payment	261.83	15.86	16.5	269.25	17.26	15.6	318.17	19.64	16.2
No Payment	95.90	13.69	7.0	105.04	14.34	7.3	116.06	15.43	7.5
Medically Needy	56.01	12.40	4.5	330.58	13.12	25.2	516.89	15.00	34.5
Dually Eligible	685.37	12.88	53.2	521.12	13.42	38.8	784.94	14.99	52.4
QMB/QDWI	–	–	–	186.00	9.79	19.0	–	–	–
Refugee/Emergency Care	112.01	17.21	6.5	114.24	18.66	6.1	142.52	21.27	6.7
Eligibility Category									
Indigent Pregnant Women	$46.08	$12.52	3.7	$48.69	$12.90	3.8	$57.61	$14.10	4.1
All ADC-Related	88.85	12.91	6.9	90.68	13.90	6.5	106.26	15.69	6.8
ADC-Related Adults	142.13	14.17	10.0	143.21	15.30	9.4	167.63	17.25	9.7
ADC-Related Children	55.83	11.32	4.9	59.54	12.31	4.8	69.92	13.90	5.0
Indigent Children	40.80	9.48	4.3	45.68	10.15	4.5	57.51	11.89	4.8
Other Children*	92.40	14.86	6.2	101.06	15.94	6.3	124.53	17.35	7.2
Aged	601.50	14.36	41.9	606.23	15.10	40.2	746.27	16.77	44.5
Blind and Disabled									
Blind	505.95	16.31	31.0	528.90	17.82	29.7	597.21	19.44	30.7
Disabled	558.83	17.51	32.9	575.24	19.24	29.9	714.97	22.12	32.3
Refugees	112.01	17.21	6.5	114.24	18.66	6.1	142.52	21.27	6.7
Average All Recipients	$280.04	$15.01	18.7	$281.53	$16.06	17.5	$322.39	$18.02	17.9

* Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services pharmacy claims, SAS datasets, FY 1989 - FY 1991.

Table E-4

Number and Cost of Pharmacy Services for All Medicaid Recipients During FY 1991 by Recipient Eligibility Category

Eligibility Category	Number of Recipients*	Number of Claims	Percentage of Total Claims	Average Number of Claims Per Recipient	Total Amount Paid By Medicaid	Percentage of Total Payments**	Average Cost Per Claim	Average Cost Per Recipient
Indigent Pregnant Women	18,834	76,932	1.35 %	4.1	$1,084,984	1.06 %	$14.10	$57.61
All ADC-Related	155,297	1,051,961	18.46	6.8	16,502,042	16.07	15.69	106.26
ADC-Related Adults	57,759	561,308	9.85	9.7	9,682,107	9.43	17.25	167.63
ADC-Related Children	97,538	490,653	8.61	5.0	6,819,935	6.64	13.90	69.92
Indigent Children	34,641	167,585	2.94	4.8	1,992,126	1.94	11.89	57.51
Other Children***	5,135	36,853	0.65	7.2	639,467	0.62	17.35	124.53
Aged	58,871	2,618,478	45.96	44.5	43,922,363	42.79	16.77	746.08
Blind and Disabled	53,709	1,736,192	30.47	32.3	38,316,466	37.32	22.07	713.41
Blind	996	30,599	0.54	30.7	594,824	0.58	19.44	597.21
Disabled	52,760	1,705,593	29.94	32.3	37,721,642	36.75	22.12	714.97
Refugees	1,400	9,380	0.16	6.7	199,523	0.19	21.27	142.52
	318,422	5,697,381	100.00 %	17.9	$102,656,971	100.00 %	$18.02	$322.39

* Total number of recipients is lower than the sum of the individual categories of recipients (327,934) due to recipient changes in eligibility status. Many recipients were enrolled in more than one category during the year. For example, the combined total of blind and disabled recipients (53,709) is lower than the sum of the individual categories (53,756) due to shifting between categories.

** The percentage of total payments does not sum to 100 due to rounding.

*** Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services pharmacy claims, SAS dataset, FY 1991.

Table E-5

Number and Cost of Pharmacy Services for Ambulatory Medicaid Recipients During FY 1991 by Recipient Eligibility Category

Eligibility Category	Number of Recipients*	Number of Claims	Percentage of Total Claims	Average Number of Claims Per Recipient	Total Amount Paid By Medicaid	Percentage of Total Payments**	Average Cost Per Claim	Average Cost Per Recipient
Indigent Pregnant Women	18,516	163,979	4.61 %	8.9	$1,910,520	2.78 %	$11.65	$103.18
All ADC-Related	154,071	1,034,525	29.11	6.7	16,152,524	23.53	15.61	104.84
ADC-Related Adults	57,225	551,456	15.52	9.6	9,456,337	13.78	17.15	165.25
ADC-Related Children	96,846	483,069	13.59	5.0	6,696,187	9.76	13.86	69.14
Indigent Children	34,170	75,033	2.11	2.2	1,057,810	1.54	14.10	30.96
Other Children***	4,989	32,564	0.92	6.5	570,834	0.83	17.53	114.42
Aged	33,391	985,317	27.73	29.5	20,117,758	29.31	20.42	602.49
Blind and Disabled	43,408	1,252,900	35.26	28.9	28,631,487	41.71	22.85	659.59
Blind	754	18,502	0.52	24.5	395,242	0.58	21.36	524.19
Disabled	42,682	1,234,398	34.74	28.9	28,236,245	41.14	22.87	661.55
Refugees	1,396	9,352	0.26	6.7	196,986	0.29	21.06	141.11
	280,958	3,553,670	100.00 %	12.6	$68,637,919	100.00 %	$19.31	$244.30

* Total number of recipients is lower than the sum of the individual categories of recipients (289,941) due to recipient changes in eligibility status. Many recipients were enrolled in more than one category during the year. For example, the combined total of blind and disabled recipients (43,408) is lower than the sum of the individual categories (43,436) due to shifting between categories.

** Percentage of total payments does not sum to 100 due to rounding.

*** Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services pharmacy claims, SAS dataset, FY 1991.

Table E-6

Number and Cost of Pharmacy Services for Long-Term Care Medicaid Recipients During FY 1991 by Recipient Eligibility Category

Eligibility Category	Number of Recipients*	Number of Claims	Percentage of Total Claims**	Average Number of Claims Per Recipient	Total Amount Paid By Medicaid	Percentage of Total Payments	Average Cost Per Claim	Average Cost Per Recipient
Indigent Pregnant Women	318	1,899	0.09 %	6.0	$27,174	0.08 %	$14.31	$85.45
All ADC-Related	1,226	17,436	0.81	14.2	349,518	1.03	20.05	285.09
ADC-Related Adults	534	9,852	0.46	18.4	225,770	0.66	22.92	422.79
ADC-Related Children	692	7,584	0.35	11.0	123,748	0.36	16.32	178.83
Indigent Children	471	3,606	0.17	7.7	81,606	0.24	22.63	173.26
Other Children***	146	4,289	0.20	29.4	68,633	0.20	16.00	470.09
Aged	25,480	1,633,161	76.18	64.1	23,804,605	69.97	14.58	934.25
Blind and Disabled	10,301	483,292	22.54	46.9	9,684,979	28.47	20.04	940.20
Blind	242	12,097	0.56	50.0	199,582	0.59	16.50	824.72
Disabled	10,078	471,195	21.98	46.8	9,485,397	27.88	20.13	941.20
Refugees	4	28	0.00	7.0	2,537	0.01	90.61	634.25
	37,464	2,143,711	100.00 %	57.2	$34,019,052	100.00 %	$15.87	$908.05

* Total number of recipients is lower than the sum of the individual categories of recipients (37,946) due to recipient changes in eligibility status. Many recipients were enrolled in more than one category during the year. For example, the combined total of blind and disabled recipients (10,301) is lower than the sum of the individual categories (10,320) due to shifting between categories.

** The percentage of total claims does not sum to 100 due to rounding.

*** Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services pharmacy claims, SAS dataset, FY 1991.

Table E-7

Summary of Pharmacy Claims Data for the Ambulatory, Long-Term Care, and Total Recipient Populations During FY 1991

Recipient Population	Number of Claims	Number of Recipients	Total Amount Paid By Medicaid	Average Number of Claims Per Recipient	Average Cost Per Claim	Average Cost Per Recipient
Ambulatory	3,553,670	280,958	$68,637,919	12.6	$19.31	$244.30
Long-Term Care	2,143,711	37,464	$34,019,052	57.2	$15.87	$908.05
All Recipients	5,697,381	318,422	$102,656,971	17.9	$18.02	$322.39

Source: JLARC staff analysis of Department of Medical Assistance Services pharmacy claims, SAS dataset, FY 1991.

Table E-8

Average Cost Per Claim for Pharmacy Services During FY 1991 by Recipient Eligibility Category

Eligibility Category	Ambulatory Population	Long-Term Care Population	Total Population
Indigent Pregnant Women	$11.65	$14.31	$14.10
All ADC-Related	15.61	20.05	15.69
ADC-Related Adults	17.15	22.92	17.25
ADC-Related Children	13.86	16.32	13.90
Indigent Children	14.10	22.63	11.89
Other Children*	17.53	16.00	17.35
Aged	20.42	14.58	16.77
Blind and Disabled	22.85	20.04	22.07
Blind	21.36	16.49	19.44
Disabled	22.87	20.13	22.12
Refugees	21.06	90.61	21.27
Total All Categories	$19.31	$15.87	$18.02

* Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services pharmacy claims, SAS dataset, FY 1991.

Table E-9

Average Number of Pharmacy Services Per Recipient During FY 1991 by Recipient Eligibility Category

Eligibility Category	Ambulatory Population	Long-Term Care Population	Total Population
Indigent Pregnant Women	8.9	6.0	4.1
All ADC-Related	6.7	14.2	6.8
ADC-Related Adults	9.6	18.4	9.7
ADC-Related Children	5.0	11.0	5.0
Indigent Children	2.2	7.7	4.8
Other Children*	6.5	29.4	7.2
Aged	29.5	64.1	44.5
Blind and Disabled	28.9	46.9	32.3
Blind	24.5	50.0	30.7
Disabled	28.9	46.8	32.3
Refugees	6.7	7.0	6.7
Total All Categories	12.6	57.2	17.9

* Other children include those in foster care, subsidized adoption (who are not ADC-related under Title IV-E), corrections, and intermediate care facilities.

Source: JLARC staff analysis of Department of Medical Assistance Services pharmacy claims, SAS dataset, FY 1991.

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