CASE STUDY

State Medicaid Physician Reimbursement

Working with State Policy Makers

Issue

Increasing physician reimbursement, whether for Medicaid or any other service or program, is a touchy, difficult issue to lobby. Legislators and agency official often grimace and frown whenever the issue arises. They perceive high physician salaries and lifestyles as evidence that reimbursement must not be too much of a problem, regardless of the cuts managed care may have imposed.

ACEP Position

In September 2000, the ACEP Board of Directors adopted as part of its policy, "Emergency Physician Rights and Responsibilities," the following:
"Emergency physicians shall be reasonably compensated for clinical and administrative services and such compensation should be related to the physician qualifications, level of responsibility, experience, and quality and amount of work performed."

ACEP also believes that "any government agency, legislative body, insurance carrier, third party payer, or any other entity that mandates that a service or product be provided by emergency physicians or other providers, should also mandate an adequate source of funding to ensure appropriate compensation for those services or products." (Adopted as revised, June 1999, by the ACEP Board of Directors).

Background Information

New Jersey's emergency physicians receive the lowest Medicaid reimbursement rates in the country--$7 to $9 per visit. In October 1999, the chapter chaired a coalition representing most of organized medicine that began working in a cooperative effort to advocate an increase in Medicaid reimbursement rates.

Legislative/Regulatory History in New Jersey

In January 2001, the hard work of the reimbursement advocacy coalition paid off. Governor Christie Whitman (R) announced a $70 million increase in Medicaid physician reimbursement. Of the $70 million, $45 million would be applied to fee-for-service rates, and would bring Medicaid reimbursement rates up to 50 percent of Medicare rates. This represented a significant increase for many specialties. It represented a *303 percent* increase for emergency physicians. The remaining $25 million would pass through Medicaid HMOs, with a requirement that it be used to significantly increase underpaid specialists—emergency physicians, dentists, and pediatricians.

Arguments in Favor of this Position

New Jersey state legislators and regulators listened to the advocacy message of the state's emergency physicians by singling out our specialty with this additional reimbursement increase. As the state with the lowest Medicaid reimbursement in the nation, the first significant rate increase in 20 years will help improve the program quality and timeliness of care provided program enrollees. The proposed new rates move the state from 50th to 46th in the nation with respect to Medicaid reimbursement levels. The effort to increase Medicaid rates was a top priority of New Jersey ACEP, the Medical Society of New Jersey, the New Jersey Association of Osteopathic Physicians and Surgeons, and multiple medical specialty organizations, representing pediatricians, family physicians, dentists, radiologists, anesthesiologists, podiatrists, obstetricians/gynecologists, orthopedic surgeons, opthamologists, psychiatrists, pathologists, and others.

The coalition convinced state leaders that the shortfall in reimbursement was no longer being offset by insured patients; that physicians were frequently operating at a loss; and that many physicians don't even bother to bill for the Medicaid reimbursement as billing costs exceed the low reimbursement rates.

Arguments Against This Position

The state funds needed to increase Medicaid reimbursement could be better utilized by other needy programs or services.

Lawmakers' perceptions that high physician salaries and lifestyles don't justify using scarce state resources for increased physician reimbursement.

Potential Proponent Organizations

State Medical Society and most office-based and hospital-based medical specialties. Social workers and consumer and patient advocacy organizations should be recruited as supporters of this effort to improve access to quality medical care.

Potential Opponent Organizations

Organizations competing for state funds. In a legislator's mind, these organizations also have very worthwhile goals and objectives and may be very important to lawmakers.

Legislative and regulatory officials who are preoccupied with short-term cost containment budgetary constraints and who do not understand the longer-term implications of fair reimbursement on quality and access to medical care for the state's Medicaid patients.

Legislators and state officials who perceive that physicians and hospitals already have enough money and do not need the additional funds.

Possible Strategies

First, "whining" about low reimbursement is not a "winning" strategy. Physicians cannot win any issues—especially increases in reimbursement—if lawmakers perceive that "whining" is at the center of their argument.

Here are some concrete suggestions for a "winning" strategy in achieving higher reimbursement:

- Gather the best and brightest in a room. Invite no more than six politically adept physicians and their lobbyist to brainstorm the issue as completely as possible. Analyze and evaluate all the pros and cons. No issue should be a "given" or a "no brainer."

- Remember the three golden rules of lobbying legislators:

1. <u>You can't win them all</u>. They won't let you and they keep better score than you do. You need to determine how your issue fits with your chapter's other priorities and how it will impact your chapter's other advocacy issues and concerns.

2. <u>Everything comes at someone else's expense</u>. There are always at least two sides to every issue. You should never assume that lawmakers understand the history, context, or "rightness" of your issue. With respect to the Medicaid reimbursement issue, "we haven't received an increase in 20 years" or "there's a huge surplus in the state this year" or "we're the lowest paid physicians in the country" may resonate with you and your partners but there are always multiple sides to the issue. It is critically important to anticipate all the potential opposition and develop strategies to address it.

3. <u>Sooner or later, it all comes down to money</u>. Just because it's the right thing to do may not be enough. Are you considered "players" in the legislative arena? Do you have an active political action committee (PAC)? Do your members know key legislators personally? Never discount the importance of being an active participant in your state's legislative/political cycle that begins the day after the November elections.

- Second, is this your chapter's number one priority issue? It better be if your are leading the charge or working it along. It will most likely consume most of your attention and resources. Use an easel and pad to record the steps needed to achieve success-the issue's pros/cons, your allies and enemies, the time line attached to each action item, the reasons your issues makes sense (and should be achieved), and the reasons your issue may make no sense (and should be defeated). Then develop the research materials needed to make sound and persuasive arguments and how you will obtain those materials. The cost of doing all this—the lobbyist fees, the grassroots materials, and the research costs need to be factored into the decision matrix. In New Jersey, for example, we needed to determine how specialties are paid currently and how much it would cost the State to increase the Medicaid rates (one consulting firm submitted a bid that exceeded $100,000—a figure that was prohibitive to our small coalition).

- Third, make sure you consider the history of the issue, but don't dwell in the past. Times have changed and the economics of the health care environment are quite different than five or ten years ago. You need to learn from the past, but look to the future and make sure you understand the new players, the new economies, and the current health care policy arena.

- Fourth, talk to your colleagues in other states—those who succeeded and those who didn't. Learn from the mistakes made by others. Also be careful not to assume that what worked in Michigan, Illinois, or Florida will work in your state. Every state is different. You need to understand the uniqueness of your state's environment but benefit from the experience of others.

- Fifth, make sure your advocacy "action plan" is flexible enough to account for unexpected barriers. For example, what if the current partisan control of the legislature changes? What if

the governor opposes your initiative? What if the only remedy left is a lawsuit? These "what ifs" can involve significant time and money and should be considered as part of your legislative planning process.

- Finally, should your chapter develop a coalition or not? Are emergency physicians going to do this alone or should the effort include all physicians and physician organizations. Should the effort be targeted to hospital-based physicians only or should it include office-based physicians too? Are hospitals natural allies in this effort?

The New Jersey Chapter determined that our success in this effort hinged on developing a collaborative partnership with the entire physician community. The Chapter built a broad based and inclusive coalition that included the State Medical Society, osteopathic physicians, and all other physician specialties that have representation in Trenton. Communication to the physician leaders was the responsibility of each lobbyist and coalition correspondence was conducted mostly by email.

The coalition effort was led by the New Jersey ACEP chapter because emergency physicians had the most compelling story to tell. However, since the other specialties had not received Medicaid reimbursement increases in many years, they were also at the table. The coalition quickly discovered that hospital-based specialties have unique problems and efforts were made early in the coalition meetings to squelch any "in-fighting," pitting office-based against hospital-based physicians and specialty physicians against family or primary care physicians.

As with all coalitions, to be successful, it must have an organized, strong, and vocal leader/advocate. The coalition partners must also have a strong commitment from their organizations' members and a desire to achieve a positive result for everyone involved.

Be sure to identify and invite all the "appropriate" stakeholders to your coalition party. New Jersey's coalition includes only physician groups, podiatrists, and dentists. It did not include allied health care professionals—hearing aid dispensers, psychologists, optometrists, chiropractors, nurses, physician assistants. These provider organizations are working to increase their members' Medicaid reimbursement but did not work within our coalition.

Know your facts. Learn everything about the past and current Medicaid system. How are physicians currently paid? How much? Since most physicians do not know, work through practice managers and billing companies who are key sources of knowledge and expertise on reimbursement issues. If your state has Medicaid managed care, the stakes are much different than a "fee for service" program. For example, if your physicians have signed contracts with managed care companies contracted with Medicaid to handle their enrollees, how can you get between those contracts and achieve an increase in their reimbursement?

Educate yourself on the state's current and future economic situation. For example, there are hundreds of groups counting on their state's tobacco settlement funds to pay for any number of very deserving projects. Legislators tire quickly of these requests. Make sure that you have a clear strategy for securing a funding source before going to legislators.

Put it in writing. Any one you meet with will need a "leave behind" fact sheet that concisely (no more than one page) and clearly (keep it as simple as possible) lays out the background, the issue, and the action you are requesting. New Jersey ACEP borrowed extensively from the Illinois Chapter, and drafted a white paper that laid out the issue on behalf of the emergency physicians.

The paper was shared with legislators, administration officials, and the coalition (see attachment #1).

How does your state compare to others? While you think it may help your case if your state has the lowest Medicaid reimbursement rate in the country, it may in fact be a "badge of honor" to some policymakers. Research the data but don't assume that it will conclusively sway all lawmakers—it may work against you.

How can you fix the problem and how much will that cost? You may need outside help for this. New Jersey's Medicaid program conducted its own internal survey to determine reimbursement rates for various specialties and commonly-used CPT codes. They then asked our coalition to conduct a similar, "apples to apples" survey. Unfortunately, we did not have much success with this effort. Even though it was a direct request from the state, and would help reinforce our anecdotal stories about low rates, the physicians and their billing staffs were unwilling to comply with our numerous requests. It should be noted that during the course of our data collection efforts, we discovered that many physicians don't know what they are paid or by whom. Our data collection efforts were somewhat more successful in dealing directly with billing practice managers.

Suggest a method for fixing the problem. In fee-for-service states, it is much easier. Managed care muddies the water significantly. We frequently heard from state officials: "we're out of the business of setting fees" or "let the free market reign." Many indicated that they saw relatively few access/network issues. Also remember that legislators and policymakers don't want to revisit a controversial issue (let's face it—increasing physician incomes is controversial!) on a regular basis. Our coalition struggled to develop a strategy for a long-term fix to the problem. Policymakers and our coalition wanted a fix that would ensure the increases are ongoing and tied to a cost-of-living adjustment.

If you convince lawmakers to increase Medicaid reimbursement rates—you need to determine how the increases will be allocated:

- Should they be tied to Medicare rates?
- Should they be linked to usual and customary reimbursement (UCR)?
- Do you increase only commonly-used CPT codes?
- Should you use a range or a three-tiered system?
- Should there be an across-the-board percentage increase?

The reimbursement coalition continues at this writing to struggle with these issues.

Keep in mind how long the government process takes. In many ways, it's just the opposite of emergency medicine—it works at a very slow and deliberative pace. Don't get discouraged. You will need committed volunteers that are persistent and in it for the long haul. You need to remind yourself and your members to feel good about incremental successes and not to dwell on bad responses.

Your goal in this process is to ensure a win-win situation for as many stakeholders as possible (keeping in mind that you can't please everyone all of the time) and that the outcome will actually make a positive impact on your physician members.

In the final analysis, there are many similarities between lobbying and practicing emergency medicine. We always have our eye on a positive outcome for our patients (clients) and our members.

For more information on this issue,
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