Applying RBRVS to Medi-Cal: Case Studies in Seven States

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Prepared for the Medi-Cal Policy Institute by

PricewaterhouseCoopers

Sandra Hunt, MPA
Susan Maerki, MHSA, MAE
Doug Porter, BA
Janice Fang, MBA
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Medi-Cal Policy Institute
476 Ninth Street
Oakland, CA 94607
tel: (510) 286-8976
fax: (510) 238-1382
www.medi-cal.org

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Executive Summary

A. Background

The Medi-Cal Policy Institute contracted with the Healthcare Consulting Practice of PricewaterhouseCoopers to conduct case studies of seven states that have adopted Medicare Resource Based Relative Value Scale (RBRVS) as a benchmark for setting their Medicaid provider payment rates. The goals were to better understand the policy debate and objectives that drove the states’ decisions to adopt the RBRVS methodology, to document how RBRVS has been implemented in each state, and to assess whether the original objectives have been achieved.

We first conducted a survey of all the state Medicaid programs to determine the methodology they use to set physician rates. We then conducted case studies with seven of the states that have adopted RBRVS – or a modified version of the methodology – to reimburse physicians in their Medicaid fee-for-service payments.

This report:

- Describes the Medicare RBRVS methodology;
- Describes the California Medicaid physician payment system and its recent update that benchmarked against RBRVS;
- Describes the selection of the case study states and the survey methodology; and
- Summarizes findings and issues that will help California policymakers and program administrators understand and evaluate options for adopting the RBRVS system of reimbursement.

B. Development of RBRVS

On January 1, 1992, the federal Medicare program stopped reimbursing providers on the basis of the amount charged by the provider, and implemented a payment system that would recognize three distinct categories comprising the costs of providing services, reflect the geographic impact
on the cost of care, and take into account changes in the volume of services. The three cost components (called Relative Value Units or RVUs) for all providers are:

1. Physician work units, which include the time, intensity of effort, skill and risk to the patient associated with each service;
2. Practice expense units, which include the cost of non-physician staff, office space, equipment and supplies; and
3. Professional liability insurance expense units.

Since 1992, nearly half of all states have adopted RBRVS as a benchmark for physician payment rates for their Medicaid programs.

C. Case Study Methodology

We conducted a search of Internet sites and placed phone calls to Medicaid programs across the country in order to determine the various payment methodologies used by states and to identify those states that have adopted RBRVS as a benchmark for reimbursing Medicaid physicians. We also spoke with representatives of the American Medical Association, the American Academy of Pediatrics, and the American College of Obstetrics and Gynecology.

In consultation with the staff of the Medi-Cal Policy Institute we developed the following selection criteria to identify which states to include in the case study:

- Percentage of total population within urban areas
- Diversity of the population
- Size of the Medicaid population
- Medicaid managed care penetration
- The experience of the state’s transition from a fee schedule to RBRVS.

Seven states (Florida, Indiana, Iowa, Massachusetts, Michigan, Texas, and Washington) were selected for the case studies. A semi-structured interview survey was developed and reviewed by staff at the California Department of Health Services and the California Medical Association. Key state representatives were identified for interviews based on their technical expertise and historical perspective. Each representative was sent the survey ahead of time and called for telephone interviews, which lasted approximately one hour. We asked each state about its previous payment method, what its policy objectives were in adopting the RBRVS methodology, and what the outcome and program impact was as a result of the change.
D. Case Study Findings

Objectives and Planning Process

States varied in how they implemented RBRVS. Organizations responsible for the planning and evaluation for RBRVS implementation in various states included state legislatures, state Medicaid agencies and/or health departments, and state medical societies. Implementation often occurred at the same time that physician fee increases were authorized in the state budget.

States reported a number of different objectives for adoption of RBRVS, including:

- redistribution of physician payments (make the payments more equitable and reimburse based on service not specialty type)
- cost containment
- standardization of rates (a belief that Medicare would be the norm for all payers)
- maintenance of physician participation in the Medicaid program
- increasing payments for primary and preventive care
- use of a logical method based on extensive research and data.

Technical Aspects of Implementation

Only one state, Iowa, has implemented a Medicaid physician fee schedule based on RBRVS that completely matches the Medicare reimbursement methodology. Other states have modified the methodology to accommodate state policy decisions and budget constraints. Some examples of this variation are discussed below.

- **Transition Period.** Five of the case study states established a single implementation date rather than phase-in use of the RBRVS unit values. Two states phased-in the RBRVS to soften the impact of the redistribution of physician payments. They did this by setting fee corridors that limited the amount any code could increase or decrease in reimbursement as a result of the RVU realignment.

- **Codes and Services.** All seven case study states adopted the RVU component of the Medicare RBRVS for CPT codes and for Level II HCPCS codes for most services and supplies. However, Indiana and Texas reported that they do not use the RBRVS for selected services for pregnant women and children because they believe the low reimbursement would have a negative impact on access to health care for those populations. All states must maintain a fee schedule for services that do not have an RVU value because they are not covered under the Medicare program. This includes vision, dental and many medical supply codes, as well as “local codes” that have evolved over time.

- **RVU Updates.** Five of the case study states have moved to an annual update of the physician fee schedule RVUs. This often lags six months behind the January Medicare update and takes effect at the beginning of the state fiscal year in July. One of those five
states (Massachusetts) established fee change corridors so that no code will fall by more than 10 percent or increase by more than 18 percent in one year. The two states that do not have an annual update (Indiana and Texas) have sustained the RVUs at the values in effect in 1992 (the year of Medicare’s RBRVS implementation) with updates for new codes only.

- **Conversion Factors.** Four of the states use multiple dollar value conversion factors while three have a single conversion factor similar to Medicare. The different conversion factors may be applied to primary and non-primary care services, maternity and newborn services, or adult and child. Only one state has a statutory requirement to adopt the annual Medicare conversion factor; most states link their conversion factor to a level that can be supported by the state Medicaid budget. These Medicaid conversion factors are generally low, ranging from 50 to 75 percent of the Medicare conversion factor.

- **Geographic Adjusters.** All of the case study states use a single statewide Medicaid fee schedule. Three states use the national Medicare average value, with no geographic adjustment, while the other four states do apply a geographic adjuster.

- **Policy Change.** The case study states closely follow policy changes implemented by Medicare. These include use of code modifiers, different work expense RVUs for services provided in clinic or outpatient facilities in comparison to a private office, and claims editing procedures. In many cases, the Medicare methodology is adopted for the Medicaid fee schedule, but may lag behind the Medicare implementation timeframe.

**Assessment of Impact**

None of the states has done a formal assessment of the impact of implementing a Medicaid fee schedule based on RBRVS, such as tracking changes in the number of physicians that participate in the Medicaid program. Anecdotally, some state representatives reported that the RBRVS system is well understood and accepted as a reimbursement methodology by physicians.

**Conclusions**

The case studies indicate that the RBRVS implementation timeline has often depended on an initial increase in funding. They also demonstrate that a Medicaid program can benchmark Medicaid fee-for-service physician payments to the Medicare RBRVS system and operate within state budget appropriations.

The ongoing administration and updating of a RBRVS payment system is not difficult, but policy decisions must be made regarding frequency of updates and cost. As California and other states evaluate whether to benchmark their Medicaid physician fee schedules to the Medicare RBRVS, they must consider to what extent they will adopt all the components of the Medicare RBRVS system. States that annually update the RVU component will have a reimbursement system that recognizes new technology and the comparative cost and resources needed to provide services. The decision to adopt the other features of the Medicare physician payment methodology, including use of geographic factors, calculation of the conversion factor(s), policy changes, and claims adjudication procedures will determine how closely the Medicaid physician reimbursement system resembles Medicare’s RBRVS system.
E. Rates Roundtable

This study is part of an ongoing effort by the Medi-Cal Policy Institute to provide objective analysis of the Medi-Cal program’s payment policies. On March 5, 2001, the findings from this research were presented at a Medi-Cal Rates Roundtable in Sacramento, California. Participants included state legislative staff, Department of Health Services staff, physician association members, and Medi-Cal health plan representatives. The Medi-Cal Policy Institute is committed to fostering informed discussion and sound decision-making in the area of Medi-Cal payment.
I. Introduction

Almost half of the Medicaid programs across the country have adopted the Medicare Resource Based Relative Value Scale (RBRVS) as a benchmark for establishing physician fee-for-service payments (see Appendix A). California does not benchmark its physician payment to the Medicare RBRVS. However, the Medi-Cal physician rate increases that went into effect in August 2000 were calculated by comparing the Medi-Cal payment levels to the Medicare payments and assuring that all Medi-Cal payments were set to a minimum percentage relative to the Medicare amount. A recent report from the Legislative Analyst’s Office concluded that the California Department of Health Services should establish a more rational process for reviewing and adjusting Medi-Cal rates. The report specifically recommended that in the interim, Medi-Cal physician payments should be based on the Medicare program.

The Medi-Cal Policy Institute contracted with the Healthcare Consulting Practice of PricewaterhouseCoopers to conduct case studies of seven states that have adopted Medicare RBRVS as a benchmark for their Medicaid programs. The goals were to better understand the policy debate and the objectives that drove the decision to adopt the RBRVS methodology, to document how RBRVS has been implemented in each state, and to assess the impact of the conversion to RBRVS.

The purposes of this report are to:

1. Provide an overview of Medicare physician RBRVS payment;
2. Provide an overview of the Medi-Cal physician fee-for-service payment methodology and describe how Medicare payment amounts were used in the August 2000 Medi-Cal physician fee update;
3. Describe the state selection process and case study methodology;
4. Present the results of case studies of seven states that have adopted Medicare RBRVS or a modified Medicare RBRVS to set physician payment levels in their Medicaid programs (including a description of the major technical and operational policies adopted by the case study states in benchmarking their physician fee schedules to the Medicare RBRVS); and
5. Summarize issues that will help California policymakers and program administrators understand and evaluate options for adopting the RBRVS system of reimbursement.
II. Background on Medicare and Physician RBRVS

A. Introduction of Medicare

The Federal Medicare program was established in 1965 as part of President Lyndon Johnson’s Great Society. Medicare provides health insurance to approximately 39 million Americans who are age 65 and over, those who have permanent kidney failure, and certain people with disabilities. It is the nation's largest health insurance program and is administered by the Health Care Financing Administration (HCFA).

Medicare benefits are divided into two parts. Part A pays for hospital services, skilled nursing facility services, home health services, and hospice care. Part B pays for physicians’ services, hospital outpatient services, medical equipment and supplies. HCFA made Medicare payments totaling $213 billion in federal fiscal year 1999.\(^3\) The program is funded by mandatory contributions from employers and employees, and to a lesser degree by general tax revenues, premiums paid by beneficiaries, and deductibles and co-payments. Approximately 89 percent of the annual revenue for Medicare comes from the payroll taxes of people under the age of 65, with 11 percent coming from the monthly contributions of the beneficiaries.\(^4\)

Like most other health insurance programs, the Medicare program initially reimbursed providers based on their charges. In the mid-1980s, HCFA established a prospective payment system for Part A hospital inpatient services using Diagnosis Related Groups (DRGs). This policy change was designed to contain the escalation in hospital costs by standardizing payments for services HCFA purchased from hospitals, and to better adjust for the diagnosis and severity of illnesses for which beneficiaries received treatment.

Inpatient hospital payments were not the only cost concern. Physician payments increased at an average annual rate of 11.7 percent over the first 25 years of the program. Because payments were based on provider “reasonable charge” profiles, they were not directly related to resource use or to changes in the practice of medicine and technological advances. The Omnibus Budget Reconciliation Act of 1989 (OBRA 1989) provided for the implementation of a new physician payment system beginning January 1, 1992, that would be based on a resource-based relative value scale. OBRA 1989 also established a “volume performance standard” to moderate the rate
of growth in physician expenditures, and limited the amount physicians could bill beneficiaries in excess of Medicare’s approved payment amount.\textsuperscript{5}

In announcing the proposed rule establishing the new physician fee schedule, the Secretary for Health and Human Services at that time, Louis Sullivan said, the new system “will provide fair reimbursement to physicians based on the work and costs involved in providing medical services. It will also help address longstanding imbalances between Medicare payments to urban and rural physicians and between primary care physicians and certain specialties, such as surgeons.”\textsuperscript{6}

B. Physician Resource Based Relative Value Scale (RBRVS)

Development of RBRVS
Economics professor William Hsiao and his colleagues at the Harvard School of Public Health laid the foundation for the implementation of Resource Based Relative Value Scale reimbursement. Their original research dates back to the late 1970s. Its goal was to develop methods to define the resources and costs incurred in providing physician services. Hsiao’s work produced four major findings that would underpin all subsequent and related work:

- Physician work can be defined and reliably measured through the use of physician surveys;
- A common scale of work can be developed to link inter-specialty relative values in a reproducible fashion;
- The RBRVS is an accurate reflection of variation in intensity between different types of services; and
- The RBRVS presents a significant change in the incentive structure for physician services.\textsuperscript{7}

Relative Value Units
OBRA 1989 directed HCFA to work with the Harvard researchers in order to implement a new Medicare fee schedule in 1992. The fee schedule that was ultimately developed contained measures of resource utilization called Relative Value Units (RVUs). RVUs are assigned to services billed by physicians and other providers using the national standard coding systems, the Common Procedure Terminology (CPT), and the Health Care Financing Administration Common Procedure Coding System (HCPCS). The RVUs correspond to three distinct types of resources necessary to the provision of physician services:

- Physician work units, which include the time, intensity of effort, skill and risk to the patient associated with each service;
- Practice expense units, which include the cost of non-physician staff, office space, equipment and supplies; and
- Professional liability insurance expense units, which include malpractice insurance.

Governed reimbursement for more than 7,000 physician services, the new fee schedule was implemented in 1992. At that time, research on resource-based work RVUs had been established, but comparable estimates for practice expense and professional liability insurance were not available. Therefore, RVUs for those two components in the fee schedule were based on
historical charges. Since then, resource-based malpractice RVUs have been implemented. Medicare is in the transition process for implementing resource-based practice expense RVUs. RVUs are updated annually and allow for the introduction of new codes and changes in the values assigned to existing codes. According to the Medicare Payment Advisory Commission (MedPAC), on average, a service’s total RVUs are distributed across the three components as follows:\(^8\)

- Work 54.5 percent
- Practice expense 42.3 percent
- Malpractice expense 3.2 percent

**Geographic Practice Cost Indexes (GPCIs)**

In the calculation of payment rates, RVUs are adjusted for geographic differences in cost with geographic practice cost indexes (GPCIs, sometimes referred to as “gypsies”). Each of the RVU components—physician work, practice expense, and malpractice expense—has a separate GPCI. Together, they total to the Geographic Adjustment Factor (GAF) for a given locality. Although there is a separate GPCI adjustment for each RVU component, the law requires that the adjustment for physician work can not be greater than a 25-percent variation between living expenses in the specified locality and the average cost of living in the nation.

These GPCIs vary according to the 89 payment localities defined by HCFA. Although the localities usually conform to state boundaries, a single state may have multiple payment localities. The larger metropolitan areas in a state are usually assigned their own GAF and the remainder of the state forms a separate “Rest of State” geographic area. There are nine GPCI areas in California, eight for the major urban areas and one “Rest of State.”

**Dollar Conversion Factor (CF)**

The payment amount for a service is calculated by multiplying its geographically adjusted RVUs by a dollar conversion factor. The conversion factor is updated annually under another provision of OBRA 1989 called the “sustainable growth rate system.” That system allows for updates that reflect medical inflation, changes in Medicare enrollment, changes in the economy, and changes in spending caused by the introduction of new laws and/or regulations. To the extent Medicare expenditures exceed the targeted rate of growth, the dollar conversion factor can be reduced. Conversely, if actual program spending is below the targeted amount, the dollar conversion factor is increased. Medicare began the RBRVS implementation with a single conversion factor, switched to multiple conversion factors, and then returned to a single conversion factor in 1998. Table 1 presents the changing dollar value of the Medicare conversion factor for the past ten years.
Table 1. Medicare Physician RBRVS Conversion Factors, 1992-2001

<table>
<thead>
<tr>
<th>Year</th>
<th>Single CF</th>
<th>Surgical CF</th>
<th>Non-Surgical CF</th>
<th>Primary Care CF</th>
</tr>
</thead>
<tbody>
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<td>2001</td>
<td>$38.2581</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2000</td>
<td>$36.6137</td>
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<td>1999</td>
<td>$34.7135</td>
<td></td>
<td></td>
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<tr>
<td>1998</td>
<td>$36.6873</td>
<td></td>
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<td>1997</td>
<td>$40.9603</td>
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<tr>
<td>1996</td>
<td>$40.7986</td>
<td>$34.6293</td>
<td>$35.4173</td>
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<tr>
<td>1995</td>
<td>$39.447</td>
<td>$34.616</td>
<td>$35.382</td>
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<td>1994</td>
<td>$35.158</td>
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<td>$31.962</td>
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</tr>
<tr>
<td>1992</td>
<td>$31.001</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Calculation of the RBRVS Payment
The Medicare allowed payment amount for a given procedure is the product of the three RBRVS components:

- Relative value of the service;
- Geographic adjustment factor for the fee schedule service area; and
- National conversion factor for the year.

Using each of the components above, the payment calculation for each procedure can be simplified as follows:

\[
\text{Medicare Allowed Amount} = \text{CF} \times [(\text{RVU}_w \times \text{GPCI}_w) + (\text{RVU}_p \times \text{GPCI}_p) + (\text{RVU}_m \times \text{GPCI}_m)]
\]

Where:
- \( \text{CF} \) = Medicare Conversion Factor
- \( \text{RVU} \) = Relative Value Units
- \( \text{GPCI} \) = Geographic Practice Cost Index
- \( w \) = RVU physician work component
- \( p \) = RVU practice expense component
- \( m \) = RVU malpractice component

For example, in the year 2000, CPT code 99203, Initial Office Visit, New Patient, is assigned 2.43 RVUs. This is made up of:

- Work RVU 1.34
- Practice Expense RVU 1.02
- Malpractice RVU 0.07

Los Angeles is a high cost area with GPCI factors above the national average. They are:

- Work GPCI 1.055
- Practice Expense GPCI 1.199
- Malpractice GPCI 0.846
The conversion factor for year 2000 was $36.61. When the appropriate values are inserted into the payment formula, the calculation indicates that Medicare paid $98.71 for CPT code 99203 in Los Angeles in 2000.

$$LA_{2000} = 36.6137 \times (1.34 \times 1.055) + (1.02 \times 1.199) + (0.07 \times 0.846) = 98.71$$

C. RBRVS Updates and Current Implementation Issues

Updates and Implementation Issues

The Medicare RBRVS system continues to undergo changes in addition to the routine annual RVU, GPCI and conversion factor updates. Even if a state adopts the Medicare RVUs as a Medicaid benchmark, the payment system will not mirror Medicare unless the state also adopts program revisions, policy guidelines, and claims adjudication protocols. Some of the important current policy issues and a brief discussion of their impact on payment and program operations follow.

Practice Expense RVUs

HCFA is in the process of implementing resource-based practice expense RVUs over a four-year transition period that will end in 2002. This is the last RVU component to be resource-based. The work units have been resource based since the implementation of Medicare RBRVS and resource-based malpractice RVUs replaced the charge-based malpractice RVUs in January 1, 2000. The RVUs for Medicare in 2002 will all be resource based and are referred to as “fully implemented RVUs.”

As charge-based practice expense RVUs are replaced by the resource-based practice expense, there is a significant redistribution of payment because the revisions are calculated to be budget neutral. General practice physicians, family practice physicians, and Obstetrics/Gynecology physicians will see a net reduction in reimbursement due to the reduction in the resource-based practice expense RVU values. Some physician specialties, including radiologists, nephrologists and non-physician practitioners, will see an increase. The transition period is designed to allow physicians to adjust to the redistribution that will result. For the year 2000, the transitional practice expense RVUs were 50 percent resource based and 50 percent charge based.

HCFA relied on data from Clinical Practice Expert Panels (CPEPs) for the estimates of direct costs related to practice expense RVUs. Those costs include the salaries of non-physician clinical staff and the costs of medical supplies and equipment associated with the service. The CPEP recommendations have been reviewed by the Practice Expense Advisory Committee (PEAC) of the American Medical Association’s Relative Value Scale Update Committee (RUC). In addition to physician members, PEAC includes representatives from the American Nurses Association, the American Academy of Physician Assistants, and the Medical Group Management Association.

One major result of the CPEP review was the recent recommendation to refine the 15 major evaluation and management (E&M) codes. These 15 codes cover office visits and other consultations and represent more than 25 percent of the payments made to physicians. HCFA accepted the recommendation to increase the RVU value for E&M codes and characterized this development as a “breakthrough,” saying that a major contentious issue had been resolved, and
that agreement with the medical societies on the inputs for E&M services “may make it easier in the future to refine the post-surgical visits for thousands of services.”

Site-of-Service Differentials
In addition, HCFA is refining its “site-of-service” differential policy. The site-of-service differential reduces practice expense payments for services provided in facility settings, such as outpatient hospital and ambulatory surgical centers. The rationale is that practice costs are generally lower outside of the physician office setting, and Medicare wants to avoid making duplicate payments to facilities and physicians for shared practice costs.

Prior to 1999, the site-of-service differential applied to approximately 700 services provided in physician offices and the Practice Expense RVU component payment was reduced by 50 percent for services provided in facility settings.

When the transition to resource-based practice expense RVUs began in 1999, the site-of-service differential policy changed. As the new RVUs are phased in through 2002, the uniform 50 percent differential is replaced with service-specific differentials based on CPEP data.

In the final rule, HCFA defines “hospitals, skilled nursing facilities (SNFs), [community mental health centers] and ambulatory surgical centers as facilities because they will receive a facility payment for their provision of services. Non-facility practice expense RVUs will be applied to all outpatient therapy services (physical therapy, occupational therapy and speech language pathology), even when they are provided in a facility, because under Medicare, only the facility can bill for these services furnished to hospital and SNF patients.”

Use of Modifiers
Medicare billing policies permit the use of various CPT modifiers to distinguish services that are eligible for different levels of payment. These include:

- Unusual procedural services
- Significant, separately identifiable E&M service by the same physician on the same day
- Professional component
- Multiple procedures
- Decision for surgery
- Distinct procedural service.

Allowing use of the modifiers makes it possible for Medicare to use a single conversion factor and is viewed by physician associations as an essential component of implementing a RBRVS system. If RVU values are used but claims adjudication processes vary, the actual implementation could be quite different from a RBRVS system.

Common Coding Initiative
Medicare billing policies also include the Common Coding Initiative (CCI) that provides guidelines on acceptable and unacceptable bundling or unbundling of services. These guidelines are to be incorporated into claims adjudication edits to assure that the most comprehensive group of codes is billed rather than their component parts. The edits also check for mutually exclusive pairs of codes and the maximum allowed number of units for each HCPCS code.
III. Medi-Cal Physician Payments

A. Background

In California, the Medicaid program is known as the California Medical Assistance Program (Medi-Cal) and is administered by the California Department of Health Services. Medi-Cal provides health care coverage to over five million eligibles at a total annual cost of approximately $20 billion.

Almost two thirds of the eligibles are families with children while one third are in aged and disabled aid categories. Slightly more than half of total eligibles are enrolled in Medi-Cal managed care programs. The managed care enrollees are primarily families with children, leaving the traditional fee-for-service system to cover a case load that is more than half aged, blind, and disabled.

Of the $20 billion in total program expenditures, approximately $18 billion is a combination of state and federal funds used to pay providers. More than $10 billion goes to fee-for-service payments to physicians, hospitals, pharmacies, nursing homes, and other providers. The remaining provider payments cover Early Periodic Screening Detection and Treatment screening services, Medi-Cal managed care plan capitation payments, Short-Doyle mental health services and Disproportionate Share Hospital payments.

In calendar year 1999, over $800 million was spent on physician services in the Medi-Cal fee-for-service program. For the fiscal year 2000-2001, the California Budget Analyst’s office estimates that more than $1.2 billion will be spent on fee-for-service physician services.11

B. Current Medi-Physician Fee-for-service Payment Methodology

Physician Payment Methodology

The current Medi-Cal physician payment methodology uses the same component approach to calculating payment as most insurers and health plans. Services are billed by a procedure code that is assigned a Relative Value Unit (RVU). This Relative Value Unit is then multiplied by a dollar conversion factor to arrive at a payment amount.

The procedure codes used to bill Medi-Cal services are drawn from a combination of coding systems. These systems include the national standard Current Procedural Terminology (CPT) used for physician office visits, surgical procedures and interpretation of laboratory and
radiology services, the Health Care Financing Administration Common Procedure Coding System (HCPCS) used for tests, medical supplies and services by non physician health professionals, and uniquely developed “local codes.” Together, there are more than 10,000 Medi-Cal procedure codes.

The Relative Value Units used for Medi-Cal payment were originally developed by the California Medical Association as a result of a 1969 study. Over time, new codes were added and codes were selectively reviewed and modified. These RVUs changed with the August 2000 payment rates update. Because of the methodology, the current RVUs are more appropriately viewed as a component of the payment calculation and do not maintain a systematic relationship to either the historic RVUs or the Medicare RBRVS unit values.

Medi-Cal uses multiple conversion factors to convert a procedure code RVU to a payment amount. The conversion factors vary by the service type/range of codes, site-of-service/provider type, and for primary care, by adult and child. For example, there are more than 20 service types with nearly as many different conversion factor values for physician services in an office or hospital outpatient department. If some of those services are provided in a hospital emergency room or a clinic setting, a different, usually higher, dollar conversion factor may be used. These conversion factor dollar values range from less than a dollar for pathology services to $10.00 for adult primary care, $37.23 for most surgery, and $50.67 to $120.15 for OB-Gyn related procedures.

The implication of the multiple conversion factors is that a given procedure code is paid at many different rates. The most variation is seen in primary care codes which include E&M services such as office visits. Table 2 demonstrates that an office visit in a community clinic for a child under 17 is reimbursed 36 percent more than the same service in a physician office or hospital outpatient department for an adult. The same services delivered in an emergency room will be paid 14 percent to 24 percent more than in the physician office.

Table 2. Medi-Cal Physician Payment Calculation: Office Visit 99203: New Patient, Medium Intensity

<table>
<thead>
<tr>
<th></th>
<th>Adult</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Doctor Office</td>
<td>Community Clinic</td>
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<td>Unit Value</td>
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</tr>
<tr>
<td>Conversion Factor</td>
<td>$10.00</td>
<td>$12.38</td>
</tr>
<tr>
<td>Payment</td>
<td>$57.20</td>
<td>$70.81</td>
</tr>
<tr>
<td>Ratio to Adult in Doctor Office</td>
<td>1.000</td>
<td>1.238</td>
</tr>
</tbody>
</table>

Fee-for-service Payment Levels
Numerous studies have shown that California Medi-Cal payments for physician services are low relative to other payers. A review of Medicaid physician payments in 1993 estimated that California paid approximately 63 percent of Medicare.\textsuperscript{12} By 1998, an Urban Institute study reported that Medi-Cal physician payments were at 77 percent of the national Medicaid average.
and 47 percent of Medicare. A recent update by The Lewin Group estimated that California Medi-Cal fees ranked 45th among the nation and averaged 65 percent of Medicare. A 1999 PricewaterhouseCoopers’ study of Medi-Cal managed care rates concluded that Medi-Cal capitation rates were low, relative to other payers, and reflected the low fee-for-service payment levels.

These low relative payment levels were due in part to the fact that the most recent across-the-board increase in physician rates was in 1985-1986. In the early 1990s, physician rates were actually decreased for surgical procedures and other selected services. In the late 1990s, the California legislature increased payment levels for targeted services, including primary care and emergency room. The 2000-2001 Budget Act approved a $266 million total increase (state General Fund and federal matching funds) for Medi-Cal physician services to finance a 15.6 percent average increase. The monies permitted higher levels of increase for preventive health screening, California Children Services, emergency room physicians, and neonatal intensive care. These increases were effective on August 1, 2000.

**Implementation of August 2000 Physician Fee Increase**

The August 2000 Medi-Cal physician fee update used the Medicare payment level as a guideline for the revisions to the Medi-Cal fee schedule. However, the update did not adopt the Medicare RBRVS methodology, but conducted an analysis that compared the Medicare dollar payment amount to the Medi-Cal dollar amount for a given procedure code.

The Provider Payment Unit of the Department of Health Services calculated a Medicare Relative Rate (MRR) for each procedure code. They analyzed historical claims data from 1995 and applied the appropriate California-specific year 2000 Medicare factors to arrive at a weighted average estimate for each code. The state used the non-facility practice expense RVUs and the following statewide GPCI values:

- Work RVU 1.0335
- Practice RVU 1.1370
- Malpractice RVU 0.7623

The code-specific MRR was then compared to the existing Medi-Cal payment amount. All services that were below 38 percent of the MRR were raised to 43 percent of the MRR value. Services between 38 percent and 80 percent of the MRR, received a flat 13.26 percent increase, subject to the condition that the increase did not raise reimbursement above 80 percent of the MRR. All services above 80 percent of the MRR were held at current levels. Prior to the rate increase, Medi-Cal payments were estimated at 50 to 53 percent of Medicare. After these adjustments, average Medi-Cal fee-for-service payments are estimated to be 60 percent of Medicare.

Table 3 presents the dollar values of the August 2000 Medi-Cal physician office payment rate. These are compared to the Medicare national average payment and the California Medicare Relative Rate (the latter was calculated by DHS as its benchmark for selected high volume procedure codes).
### Table 3. Medi-Cal Physician Office Payment Compared to Medicare National Average and California Medicare Relative Rate

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Office Visit</th>
<th>Hospital Visit</th>
<th>Maternity Care</th>
<th>Vision Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Office Rate</td>
<td>Medicare National Average</td>
<td>California DHS MRR</td>
<td>Medi-Cal Office vs. MRR</td>
</tr>
<tr>
<td>99203</td>
<td>Office/outpatient visit, new</td>
<td>$57.20</td>
<td>$88.97</td>
<td>$110.52</td>
</tr>
<tr>
<td>99204</td>
<td>Office/outpatient visit, new</td>
<td>$68.90</td>
<td>$128.51</td>
<td>$156.46</td>
</tr>
<tr>
<td>99213</td>
<td>Office/outpatient visit, est</td>
<td>$24.00</td>
<td>$47.23</td>
<td>$55.88</td>
</tr>
<tr>
<td>99222</td>
<td>Initial hospital care</td>
<td>$73.20</td>
<td>$115.70</td>
<td>$114.02</td>
</tr>
<tr>
<td>99232</td>
<td>Subsequent hospital care</td>
<td>$37.80</td>
<td>$56.02</td>
<td>$56.63</td>
</tr>
<tr>
<td>99283</td>
<td>Emergency dept visit</td>
<td>$44.60</td>
<td>$64.07</td>
<td>$62.48</td>
</tr>
<tr>
<td>99431</td>
<td>Initial care, normal newborn</td>
<td>$49.30</td>
<td>$75.42</td>
<td>$61.62</td>
</tr>
<tr>
<td>59400</td>
<td>Obstetrical care</td>
<td>$1,088.56</td>
<td>$1,452.10</td>
<td>$1,480.65</td>
</tr>
<tr>
<td>59409</td>
<td>Obstetrical care</td>
<td>$544.28</td>
<td>$812.82</td>
<td>$750.50</td>
</tr>
<tr>
<td>59510</td>
<td>Cesarean delivery</td>
<td>$1,088.62</td>
<td>$1,650.55</td>
<td>$1,688.79</td>
</tr>
<tr>
<td>59514</td>
<td>Cesarean delivery only</td>
<td>$544.72</td>
<td>$957.45</td>
<td>$888.26</td>
</tr>
<tr>
<td>33533</td>
<td>CABG, arterial, single</td>
<td>$1,871.92</td>
<td>$2,009.36</td>
<td>$1,928.31</td>
</tr>
<tr>
<td>71020</td>
<td>Chest x-ray</td>
<td>$25.98</td>
<td>$35.88</td>
<td>$37.75</td>
</tr>
<tr>
<td>92004</td>
<td>Eye exam, new patient</td>
<td>$57.79</td>
<td>$105.45</td>
<td>$134.39</td>
</tr>
<tr>
<td>92014</td>
<td>Eye exam and treatment</td>
<td>$46.44</td>
<td>$77.25</td>
<td>$98.94</td>
</tr>
</tbody>
</table>
IV. Case Study Methodology

A. Background

Almost half of the Medicaid programs across the country have adopted the Medicare Resource Based Relative Value Scale as a benchmark for establishing physician fee-for-service payments (see Appendix A). In 1998 the American Medical Association surveyed 222 public and private payers and reported that 63 percent used RBRVS in at least one product line. A recent report from the California Legislative Analyst’s Office concluded that the state agency should establish a more rational process for reviewing and adjusting Medi-Cal rates and specifically recommended that in the interim Medi-Cal physician payments should be based on the Medicare program.

The Medi-Cal Policy Institute contracted with the Healthcare Consulting Practice of PricewaterhouseCoopers to conduct case studies of seven states that have adopted Medicare RBRVS as a benchmark for their Medicaid programs. The goals were to better understand the policy debate and objectives that drove the decision to adopt the RBRVS methodology, to document how RBRVS has been implemented in each state, and to assess the impact of the shift to the RBRVS payment methodology.

B. Criteria for RBRVS Case Study States

The case studies focused on seven states that were selected after an Internet search and a brief telephone survey of Medicaid agencies in each state. This process provided basic information on the fee-for-service physician payment methodology and demographics of the state Medicaid program. The major criteria for selecting the case study states, from among those with Medicaid programs that use the Medicare Resource Based Relative Value Scale for physician reimbursement, was each state’s comparability to the California Medi-Cal program.

Factors that were considered included:

- Total population within major urban areas
- Diversity of the population
- Size of Medicaid population
- Medicaid managed care penetration.
An additional consideration was the experience of the state in the transition from a state Medicaid fee schedule to RBRVS. This includes both the length of time that RBRVS physician reimbursement has been in place and how it was implemented.

Based on these criteria, the following states were selected for the case study:

- Florida
- Indiana
- Iowa
- Massachusetts
- Michigan
- Texas
- Washington

Florida, Massachusetts, Michigan, Texas, and Washington were selected as the large state case study sites. Indiana was added because it was one of the first states to adopt the RBRVS for Medicaid physician payment. Iowa was added as a contrasting case study; it was the most recent state to adopt RBRVS and the policy change was initiated by the state medical association in an attempt to obtain higher levels of reimbursement.

C. Case Study Interview Protocol

All interviews were conducted by telephone and supplemented by additional communications via fax and e-mail. The interviews were conducted using a semi-structured questionnaire that covered: prior method of fee-for-service physician payment; planning and evaluation for RBRVS implementation; the objectives of implementation; technical aspects of the administration and operation of the RBRVS system; and outcomes and impact of the implementation of RBRVS in the Medicaid program (see Appendix B). The questionnaire had been reviewed by staff at the California Department of Health Services and the California Medical Association prior to its use in the field.

The initial state interviews were conducted with staff at the appropriate state agency (see Appendix C). For the most part, the staff that were interviewed were in the Medicaid agency, but in some cases, the interviews were conducted with staff from separate policy or payment divisions. These initial interviews were used to identify others for follow up and corroborating interviews, including staff involved in the original planning process. A limited number of representatives of the state medical societies were also interviewed.

All participants received an advance copy of the questionnaire, which allowed them time to invite others to join the interview, to collect documents and other information, and to prepare a response to each question. Most of the initial telephone interviews lasted approximately one hour.

Interviews were also conducted with staff at the American Medical Association and two of the medical specialty societies, the American Academy of Pediatrics, and the American College of Obstetrics and Gynecology. The AMA conducted a 1998 survey of use of RBRVS in non-Medicare markets and health insurance products and has a standing committee, the Relative Value Scale Update Committee (RUC), that serves in an advisory role to HCFA in its RBRVS updates and policy considerations.
V. Case Study Findings

A. Background

Washington and Indiana adopted RBRVS for their Medicaid programs in the early 1990s, just as Medicare was implementing the payment system. Iowa is the most recent state to adopt RBRVS, with an effective date of November 2000. Despite the range of experience, the case studies indicate that state Medicaid programs have made similar decisions about how they use the RBRVS system, about which methods of updating physician payment rates they prefer, and about which modifications to RBRVS they have felt necessary to engage to accommodate the health care service needs of the Medicaid population.

The findings are reported in the following sections: (1) prior methods of payment, (2) planning and evaluation, (3) objectives of implementation, (4) implementation and administration, and (5) other questions regarding Medicare RBRVS.

B. Prior Methods of Physician Payment

Prior to the adoption of the RBRVS methodology, the states in this study used a variety of methods for reimbursing Medicaid physicians. These methods ranged from the use of historical maximum fee schedules and use of Medicare charge profiles, to usual customary and reasonable (UCR). More details follow:

- **Florida** used the Medicare allowable charge as a guideline for those codes with RVUs available. For codes not reimbursed by Medicare, the state used other methods, including the analysis of Florida Medicaid utilization and payment history, and other state Medicaid reimbursement methods and fee schedules.

- **Indiana** used a maximum fee schedule based on charges and specialty type. Fees also varied based on geographic locality.

- **Iowa** previously reimbursed physicians based on the “usual, customary and reasonable” payment approach.

- **Massachusetts** used a fee schedule based on historical rates, adjusted annually.

- **Michigan** based their fees on statewide utilization and costs.
• **Texas** used a combination of charge-based and maximum-allowable fees. This methodology was based on the Medicare Profiling system, whereby payment is based on the physician’s lowest UCR in the locality for comparable services, and on Maximum Fees for selected services without Medicare pricing profiles.

• **Washington** used a combination of the 1969 California relative weights and updated the values as needed.

C. Planning and Evaluation for RBRVS Implementation

Overall, it appears that the planning and evaluation process for adopting the RBRVS methodology for Medicaid in the case study states was not as contentious or politically charged as anticipated. In many cases, adoption of RBRVS was prompted by action of the state legislature. Debates appear to have focused less on the appropriateness of the Medicare RBRVS system than on transition issues due to its impact on specialty services. Most states reported little problem with acceptance of the Relative Value Unit component although providers continue to raise issues with the level of the conversion factor and total reimbursement.

**Florida**
The Florida Legislature mandated the establishment of a committee within the Department of Health Services to review the Medicaid physician payment method in 1993. The state determined that the existing system was too complex and sought a more logical method to rationalize relative payment levels. The internal Medicaid workgroup was comprised of a variety of physician specialists and policy personnel and was responsible for updating the Medicaid fee schedule to place services in line with the tasks and resources required. It met sporadically for approximately one year and conducted focus groups and interviews with specialists in public meetings around the state. The physician concerns were addressed through the use of primary and non-primary conversion factors when RBRVS was implemented in 1995.

**Indiana**
In 1992, Indiana decided to re-evaluate its current Medicaid physician payment program in response to rising costs and the need to standardize rates. This process led the state to adopt the RBRVS method for the majority of its services. Certain maternity and primary care services were excluded from the change because RVU payment would have reduced rates. These procedures continue to be reimbursed at their maximum fee rates. The state hired consultants to develop its RBRVS-based fee schedule.

**Iowa**
In 1998, the state legislature mandated a review of the existing physician payment method relative to access to care, utilization, and adequacy of current reimbursement in conjunction with approval of fiscal year 1999 payment increases. This required that the Iowa Department of Human Services, Division of Medical Services convene a task force comprised of provider representatives. A committee was established in 1998 and consisted of:

- three members of the Division of Medical Services;
- two members of the state’s fiscal agent; and
Iowa’s evaluation process was divided into two phases. Phase I analyzed the then-current fee schedule relative to access, utilization, and adequate reimbursement under the Iowa Medicaid program. CPT codes were examined individually to determine which procedures warranted an increase. This level of evaluation was required by the legislature when it allocated a 2 percent increase in physician reimbursement for primary care and preventive services in fiscal year 1999, a mandate that translated into a 2 percent increase in total physician expenditures over the prior fiscal year for those services selected for the payment increase.

Phase II compared the FY 1998 Iowa Medicaid expenditures to the FY 1998 Iowa Medicare physician fee schedules and included a CPT code level review. Overall findings indicated that the current payment methodology was archaic and resulted in inconsistent provider increases. Medicaid expenditures, in the aggregate, were approximately 30.5 percent lower than the estimated Medicare expenditures for physician services.

In a final report, issued in January 1999, the state Legislature recommended the adoption of the Medicare fee schedule for physician services. The method would be phased in over a three-year period to facilitate the transition. However, due in part to inadequate funds, the actual adoption of the Medicare RBRVS fees was delayed until November 1, 2000, and was implemented on a single effective date rather than as a phase-in.

**Massachusetts**

In 2000, Massachusetts decided to reassess its current Medicaid physician payment methodology in order to simplify the administration and to increase the fairness of the physician fee schedule. This process led the state to move to a more pure RBRVS fee schedule. Massachusetts had historically looked to Medicare as a reimbursement guideline. The state concluded that the resource-based relative value system would become a Medicaid standard for physician payment in the United States, not only for Medicare, but for other payers as well. Massachusetts hired consultants to develop its RBRVS based fee schedule.

**Michigan**

Michigan did not establish a committee to evaluate its Medicaid fees. Instead, the transition to RBRVS was the result of a collaborative effort between the Medicaid program and the two state medical associations. The decision to adopt RBRVS was a direct result of Michigan’s participation in an RBRVS simulation case study conducted by the Cambridge Health Economics Group in 1989, which created state-specific relative value units. Based on the study findings, the Medicaid program decided to base physician fees on the Medicare RVUs when they were first published in 1991.

**Texas**

The Texas Department of Human Services (DHS) created the Texas Medicaid Physician Payment Advisory Committee (PPAC) in April 1991 to evaluate the existing reimbursement method for Medicaid physicians. The PPAC was charged with making recommendations to the DHS Board.
regarding how the system could be improved to maximize health care access. The committee’s first monthly meeting was held in May 1991 and consisted of 15 members who were jointly appointed by the DHS and the Texas Medical Association. Five appointees were experts in health policy and research; the remaining ten were physicians representing a range of specialties (including obstetrics, family practice and pediatric surgery). Based on the committee’s initial analyses the current system was found to be inadequate and in need of reform.

Texas cited two significant weaknesses in its previous charge-based Medicaid reimbursement approach that prompted it to consider alternative methods. First, the historic UCR method had led to lower rates of increase for primary care services as compared to increases for specialized services. Consequently, there were more participating specialists than primary care physicians. Second, there was often no correlation between the physician’s UCR and the resources required to perform the service. The state’s adoption of the Medicare RBRVS method in April 1992 addressed both of these issues.

However, only one year after the adoption of the RBRVS, financial constraints led the state legislature to freeze physician payment levels.

**Washington**

Washington began evaluation of the RBRVS system before it was implemented by Medicare in 1992. The Health Care Authority (HCA) performed a study of the physician reimbursement methodology in December 1990. Based on the study results and the need for a logical payment method, the state Legislature mandated the creation of a Steering Committee in November 1991 to explore the options related to RBRVS. This committee was composed of the HCA, the state Department of Labor and Industries (DLI), and the state Medical Assistance Administration (MAA – the state Medicaid agency), as well as representatives from a technical advisory group. The technical advisors were an external group of providers representing the various specialties that would be impacted by the adoption of RBRVS.

During the review process, the Steering Committee met once a week. After the decision to adopt the RBRVS, this workgroup met twice a month, except for November and December, when they met once a week to discuss the implications of the new HCFA policy updates released annually on November 1st for a January 1 effective date. The larger committee, which included the technical advisors, met once every three months until implementation. It continues to meet three times a year, unless a critical issue arises that requires its immediate attention.

As part of the RBRVS evaluation process, the Committee hired an outside consultant to conduct an analysis of Medicare reimbursement methods and their application to the Health Care Authority, Department of Labor and Industries, and the Medical Assistance Administration. The final deliverable in April 1993 was a summary of the final policy decisions, relative values, and conversion factors made by the RBRVS Steering Committee.

**D. Objectives of Implementation**

The states included in this study reported a number of common objectives that could be achieved through the implementation of the Medicare RBRVS. As indicated in Table 4, the primary purpose of adopting RBRVS was to make payments more equitable among the different specialty types. The desire to implement a logical reimbursement method was also a key motivation.
Table 4. State Objectives for RBRVS Implementation

<table>
<thead>
<tr>
<th>State</th>
<th>Re-distribute Physician Payments</th>
<th>RBRVS as Insurer Payment Standard</th>
<th>Re-base Payments on Resources</th>
<th>RBRVS Methodology Logical and Less Complex</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Iowa</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Michigan</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Texas</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Washington</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Specific objectives reported by states are as follows:

**Florida**
- Use a more equitable method for reimbursing physicians from different specialties
- Reduce complexity associated with current procedures
- Base reimbursement on the time and work necessary to diagnose and treat patients

**Indiana**
- Cost containment
- Need to standardize rates

**Iowa**
- Need to maintain physician participation in the Iowa Medicaid program
- Desire to increase Medicaid payments for primary and preventive care specialists

**Massachusetts**
- To simplify the administration and increase fairness of the physician fee schedule
- Maintenance of adequate payment for primary care services, maternity, family planning, and newborn care

**Michigan**
- Increase primary care service fees
- Adopt a logical method for physician reimbursement
• Allow the state to be more equitable when reimbursing physicians from different specialties for services other than primary care

Texas
• Shift expenditures into primary care services
• Make payments more equitable among the different specialty types
• Reimburse physicians for tasks performed, not specialty type

Washington
• Use the purchasing power of three large state agencies—Health Care Authority, Department of Labor and Industries and the Medical Assistance Administration—to obtain consistency across the state
• Reimburse physicians based on services provided, not specialty type
• Improve equity in the distribution of funds for services

E. Implementation and Administration

Program administrators were asked questions related to the technical implementation and administration of their Medicaid RBRVS method. The purpose of these questions was to determine how their implementation compared to policy guidelines and claims adjudication relative to Medicare. In general,

• States have adopted Medicare RVUs for all applicable CPT and HCPCS codes, but have conducted their own evaluation of selected codes where the RVU value may result in a reimbursement level that is lower than desired. This often includes primary care and maternity codes that are considered important to maintain adequate level of service and access for the Medicaid population.

• Most states use multiple conversion factors. Most use a higher value for primary care, maternity and/or Evaluation and Management services.

• There is no geographic variation in payment levels within the states. All case study states use a single statewide set of RVU factors. The RVUs may be the weights used when RBRVS was first adopted for the Medicaid program, the national average values, or state specific RVUs based on the Medicare geographic factors.

• All of the case study states actively review policy changes implemented by Medicare. For the most part, states have adopted methodological and policy changes instituted by Medicare but may not implement according to the same time-frame.
Table 5 summarizes the technical components of Medicaid RBRVS implementation in each of the case study states. More detailed description of these operational elements is discussed in the remainder of the section.

### Table 5. Summary of Medicaid RBRVS Program Characteristics
#### State FY 2000-2001

<table>
<thead>
<tr>
<th>State</th>
<th>Year RBRVS Adopted</th>
<th>Current RVU</th>
<th>Type of CF Used</th>
<th>CF Value</th>
<th>Geographic Adjustment Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td>1995</td>
<td>2001</td>
<td>Primary Non-Primary</td>
<td>$19.92 $20.10</td>
<td>National Average Value; No adjustment</td>
</tr>
<tr>
<td>Indiana</td>
<td>1994</td>
<td>Varies</td>
<td>Physician</td>
<td>$28.61</td>
<td>Uses a Geographic Adjustment Factor Developed Specifically for Indiana; Not Medicare Based.</td>
</tr>
<tr>
<td>Iowa</td>
<td>2000</td>
<td>2000</td>
<td>Physician</td>
<td>$36.61</td>
<td>Medicare Geographic Adjustment Factor for Iowa</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>2000</td>
<td>2000</td>
<td>Physician Selected Services*</td>
<td>$23.81 $31.66</td>
<td>Medicare Geographic Adjustment Factor for Boston</td>
</tr>
<tr>
<td>Michigan</td>
<td>1991</td>
<td>2000</td>
<td>Physician</td>
<td>$22.43</td>
<td>National Average Value; No adjustment</td>
</tr>
<tr>
<td>Texas</td>
<td>1992</td>
<td>Varies</td>
<td>Physician Selected Services§</td>
<td>$26.41 $18.21</td>
<td>National Average Value; No adjustment</td>
</tr>
<tr>
<td>Washington</td>
<td>1993</td>
<td>2001</td>
<td>Maternity Adult Child Other</td>
<td>$45.33 $21.17 $35.89 $22.37</td>
<td>Statewide Average Factor Developed by HCFA</td>
</tr>
</tbody>
</table>

* Includes family planning, maternity and newborn services
§ Includes some psychiatric and obstetric services

### Florida

Florida implemented the Medicare RBRVS method on January 1, 1995, with no transition period. Relative values for all available CPT and HCPCS codes were adopted. The state currently uses the 2001 version of HCFA RVUs for its Medicaid physician payments and annually updates these values in January.

No geographic adjustment factor or Medicare Site of Service Facility/Non-Facility RVU is used in the calculation of state Medicaid fees. The Medicaid RBRVS payment level compared to Florida’s Medicare payment level is currently estimated at 52 percent overall and varies by service category. The state uses two conversion factors: Primary Care and Non-Primary Care. The Primary codes consist of eleven Evaluation and Management and Early Periodic Screening Detection and Treatment procedures, including office visit codes 99201-99205 and 99211-99215. For 2001, the conversion factors are $19.92 for Primary Care, and $20.10 for Non-Primary Care.
Since the inception of RBRVS, Florida has seen only small physician fee increases. The state has maintained budget neutrality and, as a result, the rates have been low historically and adjusted annually for inflation purposes only. The annual rates have been a combination of the budgeted conversion factor and the current HCFA RVUs.

**Indiana**

Indiana implemented RBRVS on October 6, 1994, with no transition period. The Office of Medicaid Management and Policy (OMPP) is responsible for the program’s administration and EDS serves as the fiscal agent. At the program’s inception, the RBRVS payment was used for all services except established patient office or outpatient visits (CPT code 99211), and certain maternity services, including amniocentesis, fetal stress tests, normal labor and delivery, cesarean section, and abortion. These were excluded from the RBRVS conversion and given special consideration due to their importance to the state Medicaid program.

Neither the RVUs nor the Conversion Factor have been updated since 1992 due to budget constraints.

- All procedures are reimbursed using their initial RVU and are not automatically adjusted with changes in the annual Medicare RVU update. Codes adopted for the implementation in 1994 are based on the 1992 HCFA relative values. Beginning in 1995, new codes added by HCFA were paid using the new code RVU multiplied by the 1992 Indiana conversion factor.

- The Medicaid conversion factor is $28.61, and is the same conversion factor originally developed by outside consultants using the state’s Medicaid claims data for fiscal year 1992.

Indiana uses one geographic adjustment factor (GAF) for the entire state. The total GAF of 2.4 is a combination of the three statewide geographic practice cost indices (GPCI) and is the original urban Indiana GAF developed by HCFA in 1992. The individual GPCI values are as follows:

- Work GPCI 0.980
- Practice Expense GPCI 0.905
- Malpractice GPCI 0.516

Anesthesia procedures are reimbursed using the product of the Indiana anesthesia Medicaid conversion factor of $13.88 and the total base and time units for each procedure.

The Medicare site of service reduction was used until 1998. Currently, the state does not compensate differently for facility or non-facility sites of service.

**Iowa**

Iowa is the most recent state to adopt the resource based relative value system for Medicaid reimbursement. Effective November 2000, the Iowa Medicaid RBRVS is equal to 100 percent of the Medicare RBRVS for the state.

Preliminary analysis found that estimated total “Medicare-level” physician services expenditures would be 30.5 percent higher in the aggregate compared to the existing total Medicaid
expenditures. Evaluation and management (E&M) services would increase significantly under RBRVS, while many non-E&M services would decrease.

In its original recommendation, the 1998 Iowa Legislature suggested a phase-in over a three-year period. An incremental change was suggested that would allow: Year 1—Fees increased or decreased up to 25 percent; Year 2—Fees increased or decreased an additional 35 to 60 percent; and Year 3—Full implementation of RBRVS fees. However, due in part to budget constraints, the RBRVS recommendation was postponed until the 2000 legislative session. The 2000 legislative directive required the state to adopt the Medicare fees on a single effective date of November 1, 2000. The increase in Medicaid physician payments was financed from tobacco settlement money received by Iowa and the state intends to continue subsidizing future physician payment increases from tobacco funds.

The state uses the January 2000 RVUs and plans to update its Medicaid rates annually in July with the Iowa Medicare fees issued by HCFA effective each January 1. Iowa uses the Medicare RBRVS for all CPT and HCPCS codes with an RVU value, with the exception of anesthesia. Anesthesia services were excluded in response to public comment and are reimbursed at the then current Iowa Medicaid fee schedule rate plus any annual increases dictated by the legislature.

The Medicare geographic adjusters, site-of-service facility, and non-facility RVUs, and other Medicare practices are used to the extent that they are reflected in the Iowa Medicare RBRVS schedule. The Medicaid program uses the same national conversion factor and the geographically adjusted relative value units. No modifications are made to the Iowa Medicare RBRVS fees.

The Medicaid program is administered by the Division of Medical Services in the Iowa Department of Human Services, which is responsible for the policy decisions and rates related to physician payments and RBRVS, in general. The state’s Medicaid fiscal agent, Consultec Inc., is charged with implementing these policies and rates.

Due to the program’s relatively recent implementation, it is difficult to judge whether or not the program’s original policy objectives have been met. It is anticipated that over time, these goals will be achieved. Initially, the program encountered minor problems due to the manual method used to implement codes into the IT system, issues that have been addressed subsequently.

Massachusetts
Massachusetts began using the Medicare RBRVS as a guideline in 1992. From 1993 to 1999, the fee schedule was modified so that the relationship within a family of codes reflected the relative weights but the relationship among code ranges was not consistent with the overall RBRVS. Prior to July 1, 2000, there were still hundreds of conversion factors being used. Because of this complexity, the state hired an outside consultant to reduce the number of conversion factors and to develop a more purely based RBRVS fee schedule. Multiple conversion factors have now been reduced to two.

Beginning July 1, 2000, the Medicare RVUs were adopted and a two-year phase-in was established. During the phase-in period, the state will annually update the RVU values and change the payment amount within an allowed range. Fee change corridors were established such
that no individual code will be permitted to fall by more than 10 percent, or increase by more than 18 percent in a given year. By state FY 2003, the Massachusetts Medicaid program implementation of RBRVS should essentially mirror Medicare. The RVUs will be updated and payment levels will be permitted to increase or decrease.

Two divisions under the Department of Human Services contribute to the process of developing fee-for-service rates. The Division of Healthcare Finance and Policy has the primary responsibility for setting the Medicaid rates. The Division Medical Assistance is the primary payer under the system and thus has policy input.

Medicaid physician rates using the current Medicare RVUs are now updated annually. These new rates are generally developed by July and therefore lag Medicare by six months. For entirely new codes that require new pricing, the Division of Health Care Finance and Policy issues administrative bulletins. In these bulletins, new codes are listed and are used to apply individual consideration in reimbursing physicians until appropriate rates can be developed. Massachusetts uses a single, statewide geographic adjustment factor, the higher Medicare factors assigned to Boston.

Currently, the state is not using the separate site of service facility/non-facility RVUs. Massachusetts intended to adopt these values but, due to system implementation difficulties, will not add them until July 1, 2001. The state’s overall goal is to adopt the Medicare payment method and rules as appropriate. Massachusetts suspends multiple surgery claims for review and in order to apply reductions. The state allows use of most Medicare modifiers (approximately 70 percent) and is following the Correct Coding Initiative (CCI).

Overall, the state estimates that its Medicaid payment level is 65 percent of the Medicare rate. Select codes, primarily those for family planning, maternity and newborn care are adjusted to provide higher levels of reimbursement. These policy-adjusted services are estimated at 86 percent of Medicare.

The state currently has two conversion factors (CF) for physician services and one for anesthesia.

- The majority of codes use a CF of $23.81.
- Family Planning, Maternity and Newborn care use a policy adjusted CF of $31.66.
- The Anesthesia CF is $18.00 per unit. Anesthesia is reimbursed using the American Board of Anesthesiology units plus time in fifteen-minute increments. The state uses the legislative budget target and updated HCFA Medicare RVUs and backs into an annual conversion factor.

**Michigan**
Effective January 1, 2000, Michigan updated all RVUs to the 2000 Medicare values. Prior to this date, the state used the original Medicare RVUs established by HCFA in 1991. Any new codes added after 1991 were implemented using the original HCFA RVU for the year that the code was introduced and had remained unchanged until 2000. In August 2001, Michigan will adopt the fully implemented RVUs. Going forward, the state intends to update RVUs annually to match values established by HCFA. The target implementation date for these annual updates is January
1 of each year. However, this policy may change depending upon resource constraints. HCFA typically releases new RVU values on November 1 for a January 1 effective date, which only gives states two months to perform any required analyses.

The Department of Community Health administers the state Medicaid Program. Within the DCH, the budget division is responsible for claims payments and rate setting. The Medical Services Division, Plan Administration office, is responsible for policy decisions.

Prior to January 1, 2000, Michigan used a single geographic adjustment factor for the state, which was a 50/50 blend of the Medicare factors for ‘Detroit’ and the ‘Rest of Michigan’. In 2000, the state no longer used any adjustment factor for geography and is using the national average.

Michigan uses one conversion factor (CF) for physician services. As of May 1, 2001, the state will recognize medical direction related to anesthesiology and will reimburse anesthesiology similar to the Medicare methodology that is linked to the surgical procedure code. For 2001, the physician CF is $22.43 and the anesthesia CF is $10.92.

The state uses the legislative budget target and updated HCFA Medicare RVUs to calculate an annual conversion factor. Michigan did not increase the actual physician fees from the original implementation date in 1991 until 2000 when the state re-based its fees to the national average fully implemented Medicare RVUs. The 2000 adjustment was an 11 percent increase in the aggregate and had a different effect on each specialty. For example, E&M codes increased by 30 percent, surgery decreased by 3 percent, and hospital radiology dropped 15 percent. Overall, the state estimates that it now pays 58 to 60 percent of the Medicare RBRVS’ fee schedule.

In 1999, the state issued a lump sum payment to physicians based on primary care visits. However, these payments were not applied to the fees. In the future, if additional funds are available due to overly conservative budget targets, the program will allocate excess funds based on an evaluation of the current Medicare RVUs and state utilization data.

**Texas**

Texas adopted the Medicaid physician RBRVS on April 1, 1992, with no phase-in. The state chose to exclude what they define as “access-based services” from the RBRVS implementation because the RVU value for many of these services would have reduced payment up to 65 percent. These access-based services are codes for pregnant women and children and the state believed the low rates would have a negative impact on adequate access to health care for the Medicaid population. Texas therefore examined all access-based codes that dropped by more than 35 percent under RBRVS and developed new fees for them.

Texas has approximately 800 access-based services that account for an estimated 50 percent of the Medicaid physician budget. Access-based services are typically reimbursed at a higher rate than similar services using the relative value scale. Vaginal deliveries and cesarean sections are paid at 75 and 70 percent of the Medicare rate, respectively. The state currently pays an average of 60 percent of the Medicare rate for those services that use the RBRVS method.
Texas does not use a geographic adjustment factor, nor does it use the Medicare Site of Service Facility/Non-Facility RVU. Rather, it has developed its own method for recognizing the difference in the cost of providing services by using the ‘place of service’ indicator field on the claim form. Texas pays physicians according to the fee schedule for a given service. If the service occurs in a hospital facility, the overhead is included in the fee schedule payment. If the visit occurs in an office, an additional overhead fee is paid to the doctor.

The state currently uses various versions of the Medicare RVU values and does not automatically adopt the January 1 Medicare RVU updates. Texas annually evaluates each RVU and determines whether or not it agrees with the current Medicare value. In general, Texas will consider updating physician Medicaid fees if HCFA proposes a change to the individual RVU, if a fee change is necessary for access purposes, or if conversion factor adjustments for general inflation must be offset or enhanced for access reasons.

In state Fiscal Year 2000-2001, between 700 and 1000 changes were made to the RVUs. These modifications included the addition of new procedures and updating of old values.

Decisions on fee changes are the responsibility of two groups within the Texas Medicaid Agency. The Pricing Organizational workgroup handles all codes without a medical policy impact while the Medical Policy workgroup deals with procedures with a policy impact. Both of these groups meet monthly to discuss outstanding issues. They determine the allocation of funds and changes to the conversion factor and RVUs. Approximately four times a year, these groups set-up ‘Blue Ribbon Panels’ and meet with external constituents from the hospital association, state medical association, and state specialty associations (e.g., Texas Pediatric Association and Texas Family Care Association) to discuss relevant topics. Public hearings may also be held, if necessary, to communicate and debate critical issues.

The original access-based fees were developed through meetings of the Pricing Organization focus groups and Blue Ribbon committees. The Texas Medical Association also hired the original developer of the RBRVS resource-based work units, Dr. William Hsiao, to calculate the costs for pediatric services.

Ultimately, however, the Texas legislature decides if any changes are made, depending on if they allocate the appropriate funds. The Medicaid budget was frozen from the inception of Medicaid RBRVS in 1992 until 1999, when the legislature approved a 2.7 percent increase in fees. This aggregate amount was divided among the three conversion factors: Medical Services, Anesthesia, and Special Services (includes some psychiatric and obstetric services). This 1999 increase was allocated as follows:

- Increase of 0.5 percent in the CF for general physician services from $26.278 (original Medicare CF developed by HCFA) to $27.59;
- Increase of 1.2 percent for Anesthesia Services to $15.55;
- Increase of 1.2 percent for Special Services to $18.21.

These conversion factors have remained unchanged and are current as of 2001.
The Texas legislature meets every two years to discuss allocations. In some years the costs for services are lower than the expected budget. The surplus is distributed to specialists based on findings from the Blue Ribbon panel. As stated previously, the Medicaid program holds monthly meetings for the Medical Policy and Pricing Organization focus groups. Quarterly meetings are held each year, which include individuals from medical associations, hospital associations, and other relevant groups. Those participating discuss and approve appropriate methods of distributing these excess funds during these meetings.

The transition and follow-up of RBRVS has not been entirely smooth. For example, Texas received complaints from emergency room physicians after the state implemented a policy whereby physicians were reimbursed the clinic rate if patients came to the ER in a non-emergency situation. The physicians felt it was not their fault if patients came to the ER instead of the clinic. Texas responded by arguing that the hospital should implement new procedures and triage processes to encourage patients to go to the clinic in non-emergency situations.

From a technology standpoint, program administration has become easier for the state. Previously, Texas divided the state into 32 geographic regions used by Medicare for charge profiling; all statistical and survey results for the state’s 40 specialties had to be summarized by the multiple regions. After the state eliminated all geographic adjustment factors, the administrative burden was lessened considerably. The state is currently working with its fiscal intermediary to develop a new processing system for Medicaid claims. The system, however, has yet to receive federal approval.

Washington

Washington phased-in implementation when it adopted the Medicare RBRVS method in its Medicaid program in 1993. Physician fees were adopted in January 1993 and anesthesia base units were first used in August 1993. In order to facilitate a smooth transition for their participating physicians, the Washington Medicaid program transitioned their payments as follows:

- Phase 1: Fees could not increase or decrease more than 15 percent;
- Phase 2: Fees could not increase or decrease more than 60 percent;
- Phase 3: Full RBRVS implementation.

RVUs are updated annually based on changes published by HCFA in November. RVUs for new codes take effect the following January. Updates to existing codes are implemented in July with the start of the state fiscal year. Rather than do their own calculation to combine the published geographic factors for the two state Medicare areas, Washington obtains the single state geographic adjustment factors directly from HCFA. The state uses most of the Medicare policies for claims adjudication. It is currently evaluating adopting the Current Coding Initiative. As with many of the other states, Washington uses the legislative budget target and updated HCFA Medicare RVUs to back into the calculation of the annual conversion factors.

The Medical Assistance Administration currently uses multiple conversion factors for physician services. These factors are as follows:

- Anesthesia $50.10
- Maternity $45.33
• Adult E&M  $21.17
• Pediatric  $35.89
• Other  $22.37
• Lab (percent of Medicare Lab)  0.694 percent

Changes to these conversion factors are based on Medicare updates, budget neutrality, and on any increases directed by the state legislature.

F. Other Issues Regarding Medicaid Payment Policies

Payment Levels for Physician Services Not Covered by Medicare

The RBRVS is a physician payment methodology that was developed for the aged and disabled population that receives benefits under the Federal Medicare program. As already indicated, a number of states determined that the RVUs for selected primary care, pediatric, and maternity codes were not acceptable for the Medicaid population; they have revised the RVUs, and use different conversion factors or have developed a separate payment methodology.

The annual update published by HCFA is also limited to services that are covered under Medicare benefits. While most CPT codes have RVU values, many of the HCPCS codes do not. These codes include categories of services, such as dental, much of vision, as well as a wide variety of medical equipment and supplies. For some services, such as ambulance and laboratory, Medicare does not use the RBRVS methodology and has developed a different payment system. Under these circumstances, the case study states use a combination of methods to set payment levels that range from adopting the other Medicare payment structures to maintaining local codes.

• **Florida** uses the Medicare RVUs for all applicable CPT and HCPCS codes. It has adopted the Medicare laboratory payment schedule and will pay 70 percent of the Medicare rate for new lab codes, not to exceed 85 percent of Medicare in subsequent years. Existing fees are updated as dictated by the legislature.

• **Indiana** hires a consultant to perform actuarial calculations and to develop rates for services that are not reimbursed according to the RBRVS method. Rates are calculated using a maximum fee schedule method or based on analysis of claims data.

• **Iowa** has continued to use the fee schedule that was in effect prior to the November RBRVS implementation.

• **Massachusetts** maintains local codes. Durable Medical Equipment is paid using the Massachusetts methodology and does not use the available HCPCS RVUs.

• **Michigan** uses the Medicare RVUs for all applicable procedures including maternity and prenatal services. The state provides an enhanced reimbursement of $75 for delivery services. Rates for local codes are calculated using an actuarial method and are based on analysis of claims.
• **Texas** has a Pricing Organization workgroup that is responsible for establishing fees for services that do not involve medical policy. The Medical Policy workgroup handles procedures impacted by policy changes. In general, fees are developed through collaboration between these groups and Blue Ribbon focus groups consisting of external experts in specialty fields.

• **Washington** sets maximum allowable fees or a ‘Pay by Report’ basis. Fees are updated annually based on legislative increases, if any. No adjustments are made for inflation.

**Medicare Payment Methodology for Other Medicaid Services**

In addition to the Medicare physician RBRVS methodology, a number of the case study states have examined Medicare payment methodologies for hospital inpatient and other services and adopted those Medicare guidelines as well. Table 6 summarizes the states’ use of Medicare payment methodologies for other services in their Medicaid programs.

**Table 6. Use of Other Medicare Payment Systems by Medicaid Programs**

<table>
<thead>
<tr>
<th>State</th>
<th>Inpatient DRG</th>
<th>Outpatient Hospital/ Ambulatory Surgical Center</th>
<th>Clinical Lab</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Iowa</td>
<td>X</td>
<td>X ASC only</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Massachusetts</td>
<td></td>
<td>Outpt Hosp APG only</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Washington</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

• **Florida** currently uses the Medicare payment method for clinical lab services. For new lab codes, the state pays 70 percent of the Medicare rate, not to exceed 85 percent in subsequent years due to any designated fee increases.

• **Indiana** adopted outpatient hospital services using a fixed fee based on a 50/50 blend of the Medicare ambulatory surgical center rate and the Indiana Medicaid statewide median-allowed amount. The clinical lab fee schedule is fixed at 95 percent of the Medicare allowance in effect in 1992. Indiana also uses the 1993 Medicare rates for durable medical equipment.

• **Iowa** uses the Medicare RBRVS method including DRGs for its inpatient and ambulatory services. The state also uses prospective reimbursement for intermediate care facilities for the mentally retarded. Rehabilitation and home health services, such as encounter services and private duty nursing, use retrospective cost-settling based on the Medicare cost reports. In addition, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RCHs) are paid based on Medicare reimbursement principles.
Applying RBRVS to Medi-Cal: Case Studies in Seven States

- **Massachusetts** uses Ambulatory Payment Groups for hospital outpatient.
- **Michigan** uses the Medicare hospital DRG inpatient and clinical lab payment.
- **Texas** only uses Medicare payment methods for medical services using a CPT or HCPCS code since they are based on the AMA approach. Nurses are reimbursed at 85 percent of the physician rate.
- **Washington** currently uses the Medicare payment methodology for Inpatient, Outpatient and Ambulatory Surgical services, and Clinical Lab. Clinical lab fees are set as a percentage of the Medicare allowable and were adopted at the same time as the RBRVS methodology. DME and non-wheelchair and supplies are reimbursed at the Medicare rate but the state does not use Medicare ambulance rates.

**Medicare Payment Methodology for Other State Health Programs**

States that have implemented the State Children’s Health Insurance Program (SCHIP) as a Medicaid expansion also use the Medicaid RBRVS system for that program’s physician payment. In some cases, other state health insurance programs, such as public employees or worker’s compensation, have also adopted the Medicare RBRVS for physician payment. Payment policies are usually similar to Medicaid RBRVS, but conversion factors and payment levels will differ. Table 7 summarizes the state’s use of RBRVS for these other state programs.

### Table 7. State Use of Physician RBRVS in Other State Programs

<table>
<thead>
<tr>
<th>State</th>
<th>Public Employees</th>
<th>Worker’s Comp</th>
<th>SCHIP</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Florida</td>
<td>Unknown</td>
<td>Unknown</td>
<td>X</td>
<td>Unknown</td>
</tr>
<tr>
<td>Indiana</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iowa</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Unknown</td>
<td>Unknown</td>
<td>X§</td>
<td>Unknown</td>
</tr>
<tr>
<td>Michigan</td>
<td>Unknown</td>
<td>X</td>
<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>Texas</td>
<td></td>
<td>X</td>
<td></td>
<td>Unknown</td>
</tr>
<tr>
<td>Washington</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Unknown = Survey respondents were unfamiliar with these programs

§ SCHIP is a non-Medicaid expansion but is funded using RBRVS payment assumptions.

- **Florida** SCHIP is administered by two separate offices according to age. Children from infancy through age 4 are the responsibility of the Medicaid program and their physician services are reimbursed under the Medicaid RBRVS system. SCHIP children from age 5-18 are handled by Florida Kids Corp which sets its own payment rates.
- **Indiana** SCHIP falls under the state Medicaid program and uses the physician RBRVS.
- **Iowa** uses the Medicare RBRVS method for Public Employees and Worker’s Compensation programs to the extent that the participating individuals are covered under
private health insurance plans. Many of these plans use an RBRVS related payment method to reimburse physicians. The Iowa SCHIP program is a combination of Medicaid expansion and private insurance. Physicians providing services to SCHIP enrollees under the Medicaid expansion portion of the SCHIP program are paid at the current Primary Care Patient Management (PCCM) program rate under the Iowa Medicaid program. Services rendered to Medicaid expansion members enrolled in a contracted HMO are reimbursed based on negotiated rates.

- **Massachusetts** SCHIP is a non-Medicaid expansion. The state was already at 200 percent of the Federal Poverty Limit (FPL) and obtained matching funds to 250 percent of the FPL. The state funded the program using RBRVS physician payment assumptions. Massachusetts did not provide information on other state programs.

- **Michigan** uses a modified version of RBRVS for the Worker’s Compensation program. However, specific details are unknown. The SCHIP program was implemented as a managed care program, and is contracted out to commercial carriers that established their own physician payment methodology.

- **Texas** SCHIP participants are included in the Medicaid program and physicians are paid according to the Medicaid RBRVS schedule.

- **Washington** uses the Medicare RBRVS payment method for its Public Employees, Worker’s Compensation, and SCHIP programs. Durable medical equipment and non-wheelchair and supplies are also reimbursed using the relative value system. For inpatient hospital and ambulatory surgical center, the state uses the Medicare classifications multiplied by the state conversion factors.
VI. Conclusions

The case studies of seven states indicate that the RBRVS implementation timeline has often depended on an initial increase in funding. They also demonstrate that a Medicaid program can benchmark Medicaid fee-for-service physician payments to the Medicare RBRVS system and operate within state budget appropriations.

The primary reason that the case study states adopted Medicare RBRVS as a benchmark for Medicaid physician payment was their interest in having payments reflect the level of effort and cost that is required in order to provide a service. This objective is reinforced by other features of the Medicare RBRVS: it is a logical method that can be understood by physicians, and, in general, it redistributes payments to primary care and medical services relative to surgical specialties.

Only one state, Iowa, has fully adopted the Medicare RBRVS system for Medicaid physician payments as it is used by Medicare. All of the other case study states found it necessary to make modifications. There are three primary reasons for making modifications,

- The reaction of the physician community to the redistribution of payments under RBRVS;
- The difference in the health care needs of a Medicaid population compared to a Medicare population; and,
- State budget constraints.

Some of the ways that states have varied in their implementation are:

**Transition period.** Five of the case study states established a single implementation date rather than phase-in use of the RBRVS unit values. Two states phased in the RBRVS to soften the impact of the redistribution of physician payments. They did this by setting fee corridors that limited the amount any code could increase or decrease in reimbursement as a result of the RVU realignment.

**Codes and services.** All seven case study states adopted the RVU component of the Medicare RBRVS for CPT codes and for Level II HCPCS codes for most services and supplies. However, Indiana and Texas reported that they do not use the RBRVS for selected services for pregnant
women and children because they believe the low reimbursement would have a negative impact on access to health care for those populations. All states must maintain a fee schedule for services that do not have an RVU value because they are not covered under the Medicare program. This includes vision, dental, and many medical supply codes, as well as “local codes” that have evolved over time.

**RVU updates.** Five of the case study states have moved to an annual update of the physician fee schedule RVUs. This often lags six months behind the January Medicare update and takes effect at the beginning of the state fiscal year in July. One of those five states (Massachusetts) established fee change corridors so that no code will fall by more than 10 percent or increase by more than 18 percent in one year. The two states that do not have an annual update (Indiana and Texas) have kept the RVUs at the values in effect in the year of Medicare’s RBRVS implementation (1992), with updates for new codes only.

**Conversion factors.** Four states use multiple dollar value conversion factors while three have a single conversion factor similar to Medicare. The different conversion factors may be applied to primary and non-primary care services, maternity and newborn services, or adult and child services. Only one state has a statutory requirement to adopt the annual Medicare conversion factor; most states tie their conversion factor to a level that can be supported by the state Medicaid budget. These Medicaid conversion factors are generally low, ranging from 50 to 75 percent of the Medicare conversion factor.

**Geographic adjusters.** All states use a single statewide Medicaid fee schedule. Three states used the national Medicare average value, with no geographic adjustment, while the other four states do apply a geographic adjuster.

**Policy changes.** The case study states closely follow policy changes implemented by Medicare. These include use of code modifiers, different work expense RVUs associated with services provided in clinic or outpatient facilities in comparison to a private office, and claims editing procedures. In many cases, the Medicare methodology is adopted for the Medicaid fee schedule, but may lag the Medicare implementation timeframe.

None of the states have done a formal assessment of the impact of implementing a Medicaid fee schedule based on RBRVS, such as tracking changes in the number of physicians that participate in the Medicaid program. Anecdotally, the state representatives reported that the RBRVS system is well understood by physicians and is well accepted as a reimbursement methodology.

The ongoing administration and updating of a RBRVS payment system is not difficult, but policy decisions must be made regarding frequency of updates and cost. As California and other states evaluate whether to benchmark the Medicaid physician fee schedule to the Medicare RBRVS, they must consider to what extent they will adopt all the components of the Medicare RBRVS system. States that annually update the RVU component will have a reimbursement system that recognizes new technology and evaluates the comparative cost and resources needed to provide services. The decision to adopt the other features of the Medicare physician payment methodology, including use of geographic factors, calculation of the conversion factor(s), policy changes, and claims adjudication procedures will determine how closely the Medicaid physician reimbursement system resembles Medicare’s RBRVS system.
Appendices

A. Summary of 50 State Survey
B. Survey Tool
C. State Medicaid Agency Contacts
## Medicaid Program Use of Medicare RBRVS

<table>
<thead>
<tr>
<th>State Name</th>
<th>Medicaid Population</th>
<th>Medicaid Managed Care</th>
<th>Year RBRVS Adopted</th>
<th>Extent of RBRVS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>513,863</td>
<td>73.55%</td>
<td>n/a</td>
<td>Partial</td>
</tr>
<tr>
<td>Alaska</td>
<td>70,764</td>
<td>0.00%</td>
<td>n/a</td>
<td>Full</td>
</tr>
<tr>
<td>Arizona</td>
<td>401,066</td>
<td>90.67%</td>
<td>1992</td>
<td>Partial</td>
</tr>
<tr>
<td>Arkansas</td>
<td>388,048</td>
<td>59.82%</td>
<td>1994</td>
<td>New Codes</td>
</tr>
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<td>California</td>
<td>4,972,673</td>
<td>51.10%</td>
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<td>-</td>
</tr>
<tr>
<td>Colorado</td>
<td>234,753</td>
<td>92.16%</td>
<td>n/a</td>
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<tr>
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<td>322,181</td>
<td>71.46%</td>
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</tr>
<tr>
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<td>88,186</td>
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<td>1994</td>
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</tr>
<tr>
<td>Florida</td>
<td>1,512,216</td>
<td>60.31%</td>
<td>1995</td>
<td>Full</td>
</tr>
<tr>
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<td>848,618</td>
<td>75.19%</td>
<td>1992</td>
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<tr>
<td>Hawaii</td>
<td>152,757</td>
<td>78.72%</td>
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<td>-</td>
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<td>87,203</td>
<td>35.76%</td>
<td>-</td>
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<td>1,312,599</td>
<td>12.10%</td>
<td>-</td>
<td>-</td>
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<td>500,671</td>
<td>66.18%</td>
<td>1994</td>
<td>Full</td>
</tr>
<tr>
<td>Iowa</td>
<td>206,822</td>
<td>85.33%</td>
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<td>-</td>
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<td>Minnesota</td>
<td>438,133</td>
<td>61.25%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Mississippi</td>
<td>485,716</td>
<td>41.25%</td>
<td>1992</td>
<td>Partial</td>
</tr>
<tr>
<td>Missouri</td>
<td>714,392</td>
<td>38.72%</td>
<td>n/a</td>
<td>New Codes</td>
</tr>
<tr>
<td>Montana</td>
<td>69,738</td>
<td>100.00%</td>
<td>n/a</td>
<td>Full</td>
</tr>
<tr>
<td>Nebraska</td>
<td>171,723</td>
<td>71.05%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Nevada</td>
<td>92,996</td>
<td>39.73%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>71,407</td>
<td>8.14%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>New Jersey</td>
<td>611,589</td>
<td>58.37%</td>
<td>1994</td>
<td>Partial</td>
</tr>
<tr>
<td>New Mexico</td>
<td>284,705</td>
<td>73.24%</td>
<td>n/a</td>
<td>Partial</td>
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<td>New York</td>
<td>2,255,694</td>
<td>29.24%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>North Carolina</td>
<td>831,708</td>
<td>82.85%</td>
<td>1993</td>
<td>Full</td>
</tr>
<tr>
<td>North Dakota</td>
<td>43,389</td>
<td>55.05%</td>
<td>1995</td>
<td>New Codes</td>
</tr>
<tr>
<td>Ohio</td>
<td>975,415</td>
<td>25.11%</td>
<td>-</td>
<td>-</td>
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<td>Oklahoma</td>
<td>372,501</td>
<td>52.05%</td>
<td>1992</td>
<td>Full</td>
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<td>Oregon</td>
<td>378,894</td>
<td>81.50%</td>
<td>1993</td>
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<tr>
<td>Pennsylvania</td>
<td>1,304,427</td>
<td>77.01%</td>
<td>n/a</td>
<td>New Codes</td>
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<tr>
<td>Rhode Island</td>
<td>134,018</td>
<td>64.10%</td>
<td>1993</td>
<td>n/a</td>
</tr>
<tr>
<td>South Carolina</td>
<td>498,147</td>
<td>4.65%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>South Dakota</td>
<td>68,195</td>
<td>73.64%</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Tennessee</td>
<td>1,312,969</td>
<td>100.00%</td>
<td>1992</td>
<td>Partial</td>
</tr>
<tr>
<td>Texas</td>
<td>1,788,569</td>
<td>19.68%</td>
<td>1992</td>
<td>Partial</td>
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<td>Utah</td>
<td>132,566</td>
<td>89.47%</td>
<td>1994</td>
<td>Full</td>
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<tr>
<td>Vermont</td>
<td>113,925</td>
<td>57.66%</td>
<td>n/a</td>
<td>Full</td>
</tr>
<tr>
<td>Virginia</td>
<td>460,373</td>
<td>63.47%</td>
<td>n/a</td>
<td>Full</td>
</tr>
<tr>
<td>Washington</td>
<td>707,245</td>
<td>99.85%</td>
<td>1993</td>
<td>Full</td>
</tr>
<tr>
<td>West Virginia</td>
<td>256,869</td>
<td>43.42%</td>
<td>1994</td>
<td>Partial</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>395,336</td>
<td>47.44%</td>
<td>n/a</td>
<td>Partial</td>
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<tr>
<td>Wyoming</td>
<td>34,825</td>
<td>0.00%</td>
<td>n/a</td>
<td>Partial</td>
</tr>
</tbody>
</table>

**Notes:**
- **Full**: State uses RVRS RVUs for all or most CPT codes
- **n/a**: Data not available
- **-**: State does not use RBRVS
- **Partial**: State uses some aspects of the Medicare RBRVS; usually not applied to all procedure codes
- **Partial %**: State sets rates at a percentage of the Medicare RBRVS payment value
- **New Codes**: State adopts Medicare RBRVS payment for new codes only
Appendix B. PricewaterhouseCoopers RBRVS State Survey For the Medi-Cal Policy Institute

1. Prior Method of Medicaid Physician Payment
What was the state method of setting payment levels for physician services prior to the implementation of RBRVS?

2. Planning and Evaluation for Implementation of Medicaid RBRVS
(This is a series of questions relating to the planning and policy analysis that preceded the implementation of the Medicaid RBRVS.)

2a. What prompted the State to adopt RBRVS as the Medicaid physician payment method?

2b. Was a planning or review committee established to evaluate the idea? (Please check one that applies)

Yes _______  No _______

If Yes, Continue with the following questions:

2b.1 When was the committee established?  Year _______

2b.2 Who or what organization(s) established the committee?

(Please check all that apply)

Legislature  _______
Dept of Health Services  _______
Medicaid Advisory Committee  _______
Other State Agency or Dept  _______
State Medical Society  _______
Other  _______

2b.3 What was the composition of the committee?

Number of Total Members  _______

# Representatives from the following departments:

(Please list individual department/office names and numbers, if applicable):

Dept of Health Services
Dept of Finance
Other State Agency or Dept
State Medical Society
Other
2b.4 How long did the committee meet? How often did the committee meet?
(# months/time period / frequency and duration)

2b.5 What types of analyses were done as part of the planning and evaluation?

2b.6 What were the results and findings of the analyses?

2b.7 Did the committee issue a formal report? (Please check one that applies)
Yes _______  No _______

If Yes, when was the report issued? Year ______
If Yes, how can I obtain a copy of the report?

3. Objectives for Implementation of Medicaid RBRVS
3a. What were the major reasons and objectives for adopting the RBRVS for Medicaid physician payment?

3b. Was the RBRVS implemented with the intent of increasing Medicaid physician payment? If yes, please explain.

4. Implementation and Administration of Medicaid RBRVS
(This is a series of questions about the implementation and administration of the Medicaid RBRVS. Their purpose is to determine how similar your state Medicaid RBRVS is to the administration of the Medicare RBRVS. Some of these questions are general, while others cater toward specific technical aspects of RBRVS.)

4a. When was the Medicaid physician RBRVS implemented?
Date/Year ______________________

4a.1 Was the implementation done on a single effective date or as a phase-in?
(Please check one that applies)
Single Effective Date ____________  Phase-In __________
4a.2 If Phase-In, how was the phase-in structured? ____________________________________________

4a.3 If Phase-In, indicate the Beginning and End dates of the Phase-In.

Begin Date _______________       End Date __________ of Phase-In

Please explain the features that were phased-in: ____________________________________________

4b. What state agency/department/division is responsible for policy decision-making and rate-setting regarding the physician payment methodology?

4c. What contractor or state agency/department/division is responsible for claims payment under the physician payment methodology?

(The following are questions about the Relative Value Unit (RVU) component of the RBRVS.)

4d. Has your state adopted RBRVS payment for all of the CPT/HCPCS codes with a RVU value? (Please check one that applies)

Yes ____

No ____ If No, please explain: __________________________________________________________

4e. What version (year) of RBRVS is currently used for the Medicaid physician payment?

Date/Year ____________ If Year 2001, what was the previous version used? __________

4f. How are the RVU values updated? (Please check one that applies and explain, if applicable)

Annual Medicare RVU updates _____

Lag current Medicare RVU Updates _____ By a standard amount of time? __________

Selective Medicare RVU Updates _____ Please explain: _____________________________

Irregular RVU Updates _____ Please explain: _____________________________

Other _____ Please explain: _____________________________

______________________________________________________________________________
4g. Do you use the Medicare geographic adjuster(s)? (Please check one that applies)

Yes _______ No _______

4g.1. Are there multiple factors or a single statewide geographic factor?

(Please indicate factor)
No Geographic Adjuster _______
(National Average Value)
Medicare Geographic Adjusters that vary w/in the State _______
Medicare Geographic Adjuster, single statewide value _______

If Yes, for single factor AND state is Florida, Mass, Michigan, Texas or Washington:

4g.2 How was the single statewide geographic adjuster determined/calculated?

4h. Is your state using the separate Medicare Site of Service Facility/Non-Facility RVUs?

Yes _______ No _______ If No, please explain:

4h.1 Does the state use Medicare claims adjudication guidelines in processing payments?

Yes _______
No _______ Please explain

4h.2 Do any of the following Medicare practices apply?

Reduction for multiple surgery Yes_____ No_____
Use of modifiers Yes_____ No_____
Correct Coding Initiative (CCI) (This has to do with allowable “bundling” and whether the provider is permitted to bill other codes in conjunction with a particular CPT code) Yes______ No____

(These are questions about the Conversion Factor (CF) component of the RBRVS.)
4i. Overall, what is your estimate of how the Medicaid RBRVS payment level compares to the Medicare RBRVS method in your state? (Provide as an average percentage of Medicare)

Percent of Medicare

Varies by Service Category/Specialty

Please explain:

Other

4j. Does the program use a single conversion factor or multiple conversion factors (CF)?

Single CF

Multiple CF

Please explain:

4j.1 What are the categories of the different conversion factors (CF)?

4j.2 How are anesthesia services paid?

If a CF is used, what is the value of the CF? What is the relationship of the anesthesia CF to the surgical CF?

4k. What is the current dollar value of the conversion factor(s)?

Single CF

Multiple:

<table>
<thead>
<tr>
<th>Conversion Factor Descriptor</th>
<th>Dollar Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4l. How is the conversion factor value(s) updated?

Linked to annual Medicare updates _______
Annual state budget targets _______
Irregular updates _______
Other ______________________________________________

5. Outcomes and Impact of Implementation of Medicaid RBRVS

(This is a series of questions about the outcomes and impact of the implementation of the Medicaid RBRVS.)

Budget/ Physician expenditures

5a. What was the financial impact of the implementation of RBRVS?

(Please check situation that applies)
Increased all/most payment amounts for physician services _______
Increased within a budget target that allowed for increase in fee levels _______
**Budget Neutral**: Increased within expected trend _______
Decreased physician expenditures relative to expected trend _______

Please provide more detailed explanation of the fiscal impact: ____________________________

Other Policy Objectives

5b. Have the other policy objectives been achieved (refer to answer in Question 3a)?

5c. How are you measuring whether the objectives have been achieved? Which ones have been successfully achieved? (ie. Problems, Unintended Effects, Program Modifications)

5d. What problems did you experience during the implementation? Were they successfully resolved? If yes, how?
5e. Have you made modifications to the RBRVS program since the initial implementation? If yes, please describe.

5f. What are your plans for implementing/adopting the Medicare refinements to the RVUs?

5g. Are there other issues that are likely to require modification to your RBRVS payment methodology? If yes, please explain.

6. Other Questions Regarding Medicaid RBRVS

6a. How do you set payment levels for physician services not covered by Medicare/that do not have a RVU value?

6b. Does your state use the Medicare payment methodology for other Medicaid services?

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient DRGs</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Outpatient/APG</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Clinical Lab</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Amb Surgery Centers</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If other, please explain

6c. Does your state use the RBRVS payment methodology for other state health programs? (Please check answer that applies)

<table>
<thead>
<tr>
<th>Program</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Employees</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Workers Comp</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>SCHIP</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Is your S-CHIP program a Medicaid expansion?</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

If other, please explain
7. Conclusion

Thank you for taking the time to answer these questions.

Contact Information

PricewaterhouseCoopers
Healthcare Consulting Practice
199 Fremont Street
San Francisco, CA 94105

Susan Maerki  415/498-5394  susan.maerki@us.pwcglobal.com
Janice Fang  415/498-5460  janice.s.fang@us.pwcglobal.com
Fax: 415/498-5108
### Appendix C. State Medicaid Agency Contacts

<table>
<thead>
<tr>
<th>State</th>
<th>Contact Person(s)</th>
<th>Title(s)</th>
<th>Agency/Division</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Massachusetts</td>
<td>Linda Brown</td>
<td>Pricing Policy Analyst</td>
<td>Executive Office of Health and Human Services</td>
<td>2 Boylston Street, Boston, MA 02116</td>
</tr>
<tr>
<td></td>
<td>Howard Bond</td>
<td>Policy Analyst</td>
<td>Executive Office of Health and Human Services</td>
<td>2 Boylston Street, Boston, MA 02116</td>
</tr>
<tr>
<td>Texas</td>
<td>Jeffery Phelps</td>
<td>Program Analyst</td>
<td>Texas Health &amp; Human Services Commission</td>
<td>4900 N. Lamar, Austin, TX 78711-3247</td>
</tr>
<tr>
<td></td>
<td>Dr. Millard Howard</td>
<td>RBRVS Coordinator</td>
<td>Agency for Health Care Administration</td>
<td>2727 Mahan Drive, Tallahassee, FL 32308</td>
</tr>
<tr>
<td>Michigan</td>
<td>Linda McCardel</td>
<td>Policy Analyst</td>
<td>Medical Services Administration</td>
<td>400 South Pine, Lansing, MI 48913</td>
</tr>
<tr>
<td></td>
<td>Dan McCandless</td>
<td>Policy Analyst</td>
<td>Medical Services Administration</td>
<td>400 South Pine, Lansing, MI 48913</td>
</tr>
<tr>
<td>Iowa</td>
<td>Marty Swartz</td>
<td>Policy Specialist</td>
<td>Department of Human Services Division of Medical Services</td>
<td>5th Floor, Des Moines, IA 50319</td>
</tr>
<tr>
<td></td>
<td>Carol Gable, Director</td>
<td>Director</td>
<td>Indiana Family and Social Services Administration Office of Medicaid Policy and Planning</td>
<td>Room W382, MS 07, Indianapolis, IN 46204</td>
</tr>
<tr>
<td>Washington</td>
<td>Mary Wendt</td>
<td>Rates Analyst</td>
<td>Washington State Department of Social and Health Services Professional Reimbursement Agency</td>
<td>PO Box 45510, Olympia, WA 98504-5510</td>
</tr>
</tbody>
</table>

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Notes


3 2000 Annual Reports of the Board of Trustees of the Hospital Insurance and Supplementary Insurance Trust Funds


8 The Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, March 1999

9 42 CFR Parts 410 and 414 [HCFA- 1120-FC] “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2001.”

10 IBID


16 Personal Communication, Provider Payment Unit.


