

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICAID HASSLE: STATE RESPONSES  
TO PHYSICIAN COMPLAINTS**



**Richard P. Kusserow  
INSPECTOR GENERAL**

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**OEI-01-92-00100**

# EXECUTIVE SUMMARY

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## PURPOSE

This study describes approaches that States have taken in response to concerns about Medicaid's administrative burden on physicians.

## BACKGROUND

Physicians contend that the "hassle factor"--administrative red tape associated with participating in Medicaid--discourages many doctors from treating patients who are covered by Medicaid. The perceived hassle compounds other factors contributing to low physician participation, most notably low fees relative to other payers. When physicians refer to the administrative burden, they generally mean such problems as

- ▶ Slow payments;
- ▶ Rejection of claims because the billing form was completed incorrectly;
- ▶ Difficulties in correcting claims that contain errors;
- ▶ Inability to verify recipients' Medicaid eligibility, leading to claim denials;
- ▶ Frequent changes in policies, covered procedures, and required documentation;
- ▶ Obtuse provider manuals that do not meet the needs of program providers.

We identified States that are working to reduce Medicaid hassle through interviews with officials of national and State medical societies, staff of the Health Care Financing Administration, policy analysts familiar with State health issues, and a review of the literature on Medicaid physician participation. We then interviewed staff from the Medicaid program, fiscal agent, and medical society in these States, and reviewed available written material. We also examined data from an OIG survey of State Medicaid electronic claims management capacity, conducted in spring 1991.

## FINDINGS

*We identified nine approaches that States have found to be responsive to physician complaints about Medicaid's administrative burden. They respond to criticisms about claims processing, communication between physicians and Medicaid agencies, and provider manuals.*

### Improving Claims Processing

- ▶ At least 28 States accept electronic claims for physician services.
- ▶ At least 21 States use automated systems to answer physician inquiries about claims status, recipient eligibility, and other routine matters.

- ▶ Maryland and Florida give physicians written guides that provide clear instructions on how to correct problem claims.
- ▶ Michigan and Florida use specialized programs and instructors to train physician office staff about Medicaid billing and policy.

### **Improving Communication between Physicians and Medicaid**

- ▶ Washington, Alabama, and Missouri established joint Medicaid-physician task forces to identify and resolve administrative obstacles to physician participation.
- ▶ Florida uses its district Medicaid offices as provider relations units and participates in activities of State and local medical societies.
- ▶ Maryland employs a team of consultant nurses to enroll physicians for pediatric care and to assist them with administrative issues.

### **Simplifying Provider Manuals**

- ▶ Michigan is revising its provider manuals to make them more understandable to physicians and their staffs.
- ▶ Maryland distributes manuals for pediatric screening services that simplify the billing process and explain recommended screening schedules and tests.

## **CONCLUSIONS**

On the basis of the reports from State government and State medical society officials, each of these approaches appears to have potential as a constructive response to physician complaints about Medicaid hassle. In weighing the potential impact of these approaches and their applicability elsewhere, it is important to take the following three considerations into account:

- ▶ State and Federal requirements for financial accountability mean that some tension between Medicaid's administrative requirements and what providers perceive as hassle is unavoidable.
- ▶ Other policy initiatives, such as higher fees and development of managed care systems, often accompany efforts to reduce Medicaid's administrative burden.
- ▶ Fiscal constraints facing State governments limit the extent to which Medicaid programs can implement strategies to reduce the administrative burden.

# TABLE OF CONTENTS

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	PAGE
EXECUTIVE SUMMARY	
INTRODUCTION .....	1
FINDINGS .....	4
Improving Claims Processing .....	4
Improving Communication .....	8
Simplifying Provider Manuals .....	11
CONCLUSIONS .....	13
APPENDIX A: Methodology .....	A-1
APPENDIX B: Notes .....	B-1

# INTRODUCTION

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## PURPOSE

This study describes strategies that States have adopted in response to concerns about Medicaid's administrative burden on physicians. It responds to a request from the House Energy and Commerce Subcommittee on Oversight and Investigations, which asked that the Office of Inspector General provide information on State efforts to streamline Medicaid administrative processes for physicians.

## BACKGROUND

### *Defining Medicaid's Administrative Burden*

Physicians contend that the "hassle factor"--administrative red tape associated with participating in Medicaid--discourages many doctors from treating patients who are covered by Medicaid. When providers refer to the administrative burden, they generally mean such problems as:

- ▶ Slow payments;
- ▶ Rejection of claims because the billing form was completed incorrectly;
- ▶ Difficulties in correcting claims that contain errors;
- ▶ Inability to verify recipients' Medicaid eligibility, leading to claim denials;
- ▶ Frequent changes in policies, covered procedures, and required documentation;
- ▶ Obtuse provider manuals that do not meet the needs of program providers.

Pediatricians' "reasons for limiting participation include (1) unpredictable payments, (2) complex Medicaid program regulations, (3) payment delays, and (4) restrictions on health care services covered by Medicaid."<sup>1</sup> Primary care physicians have concluded that "covering more optional services and reducing complicated benefit limitations and requirements for prior authorization might encourage more participation."<sup>2</sup>

### *Issues in Medicaid Physician Participation*

Although the administrative burden appears to be an important factor in physician dissatisfaction with Medicaid, it is critical to recognize that easing that burden alone will not necessarily lead to higher participation rates. Other factors--most notably a low level of reimbursement relative to Medicare or private insurance--also contribute to low Medicaid provider participation rates.<sup>3</sup>

The Physician Payment Review Commission (PPRC) found that 38 State Medicaid agencies ranked low fees as one of the two most important factors for physician nonparticipation in Medicaid, while 14 agencies cited complex billing, and 6 ranked payment delays as one of the two most important factors. Indeed, the PPRC cautions that simply reducing Medicaid's administrative hassle without also increasing fees is

unlikely to induce more physician participation.<sup>4</sup> The National Governors' Association has found that low fee levels and malpractice costs outpace administrative problems as explanations for low participation among perinatal providers in Medicaid.<sup>5</sup>

Some physician complaints about Medicaid hassle may be due to misconceptions. The American College of Obstetricians and Gynecologists (ACOG) cites examples from two States. A New Hampshire physician task force concluded that Medicaid "billing is pretty much like it is for other third-party payers." In North Carolina, perceptions of the "problems with claims processing . . . carried over from the 1970's, before the state had initiated automated claims processing."<sup>6</sup> Florida's Medicaid director explains the consequences of these perceptions: "We sometimes find an entire practice that will not accept Medicaid, because the senior partners didn't get paid in 1978. They told the new partners in 1983, 'Don't bill Medicaid because you won't get paid at all and if you do get paid, it's a pittance.' Then they told the next group the same thing, and we find three generations of physicians biased against us for things that happened more than a decade ago. It's very hard to get these people back in our system."<sup>7</sup>

#### *Federal Efforts to Reduce the Administrative Burden on Physicians*

The Secretary of Health and Human Services has committed to reducing "the administrative burden of Federal health care programs on patients and providers."<sup>8</sup> The Health Care Financing Administration (HCFA) has engaged the issue of administrative burden on physicians who participate in Medicare. In February 1991, HCFA announced the establishment of an Advisory Committee on Medicare-Physician Relationships. That committee's role is to advise the Secretary on Medicare policies that directly relate to physicians' provision of services to Medicare beneficiaries and the "cost and administrative burden the Medicare program places on physicians."<sup>9</sup> The scope of that advisory committee does not extend to Medicaid. Nevertheless, senior staff in HCFA's Medicaid Bureau have expressed support for State efforts to reduce the administrative burden on physicians.



## SCOPE AND METHODOLOGY

We designed this study to provide information on approaches that a limited number of States have taken to address Medicaid's administrative burden on physicians. This study does not comprehensively review and evaluate these State initiatives. Rather, we highlight what some States are doing to address complaints from physicians about the administrative hassle that Medicaid participation imposes.

We identified States that are working to reduce Medicaid hassle on physicians through interviews with officials of State medical societies, the American Medical Association, staff of the Health Care Financing Administration, and policy analysts familiar with State health issues.

Our interviews with medical association staff members in 13 States provided additional information on physician complaints about Medicaid hassle. In this report, we include quotations from these interviews to give examples of their complaints.

We obtained information on a particular State's approach to reducing the administrative burden from interviews with Medicaid, fiscal agent, and medical society staff, and by reviewing written material provided by the Medicaid agency.

We also examined data gathered between May and July 1991, for a prior Office of Inspector General study of State Medicaid electronic claims management capacity.<sup>10</sup>

Our review was conducted in accordance with the *Interim Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

Appendix A provides additional information on our methodology.

# FINDINGS

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**WE IDENTIFIED NINE APPROACHES THAT STATES HAVE FOUND TO BE RESPONSIVE TO PHYSICIAN COMPLAINTS ABOUT MEDICAID'S ADMINISTRATIVE BURDEN. THEY RESPOND TO CRITICISMS ABOUT CLAIMS PROCESSING, COMMUNICATION BETWEEN PHYSICIANS AND MEDICAID AGENCIES, AND PROVIDER MANUALS.**

## *IMPROVING CLAIMS PROCESSING*

### **PHYSICIAN COMPLAINTS ABOUT MEDICAID CLAIMS PROCESSING**

"When a claim goes sour, it is like a conspiracy against the doctor. Even the most intelligent neurosurgeon gets hung up on what needs to be done."

"Physicians aren't given an explanation for rejected claims. It is the doctor's responsibility to track the claim and find out why it was denied, which takes extra staff time and financial resources."

"We'll do whatever it takes to get a claim approved--we just can't figure it out."

"We can't get through to the inquiry office due to the overloaded telephone system."

### *At least 28 States accept electronic claims for physician services.*

The development of billing software for personal computers means that even physician practices with a small volume of Medicaid patients can submit their bills electronically. In our prior survey of Medicaid programs' electronic claims management capacity, 28 States reported the proportion of physician claims that are submitted electronically, ranging from 3 percent in North Dakota to 66 percent in Georgia.<sup>11</sup>

Florida is one State that has made a significant commitment to increasing electronic claims processing among physicians. In conjunction with its fiscal agent, Florida Medicaid has developed software that enables any provider to submit claims electronically. The software is available free of charge to providers. They may also submit claims through private firms that offer electronic claims submission services for a per-claim fee. Fiscal agent staff report that in 1991, 47 percent of physician claims were submitted on electronic media.<sup>12</sup>

Florida's electronic billing software, entitled ASAP (Accelerated Submission and Processing), is based on the HCFA-1500 physician billing form.<sup>13</sup> Physicians can tailor the software to meet their particular needs when it is installed. For example, some information, such as the physician's name and address and the date of the claim, may be automatically inserted each time a claim is prepared. In addition, physicians can define up to 10 common diagnoses and procedures which, with their billing codes, can be inserted with single keystrokes. Automated insertion of this routine information is likely to reduce errors, with a commensurate decrease in problem claims.

Staff at other State Medicaid agencies we spoke with stressed their commitment to electronic claims submission. As one person said, "We are really pushing electronic claims submission as having great benefit. . . . It speeds processing, eliminates keying errors, and claims come in cleaner." Our 1991 survey of Medicaid agencies also suggests that electronic claims submission is less expensive.<sup>14</sup> Additional advantages cited for using electronic claims submission include:

- ▶ Faster payment compared to submission of paper claims.<sup>15</sup> The claim can be read directly by the Medicaid computer and, if no errors are found, can be paid in the next batch of payments.
- ▶ Decreased likelihood of errors:
  - o Built-in safeguards and edits in the computer software identify errors prior to actually filing the claim
  - o Paper claims do not have to be reentered into electronic format by fiscal agent staff, thereby reducing keypunch errors
- ▶ Reduced cost to the provider for clerical services, as paperwork is decreased and the physician's signature is not required on each claim.

Despite the advantages of electronic claims processing, most physician claims are still submitted on paper. Some of the reasons relate to Medicaid system requirements. For example, Medicaid may require paper documentation that is not easily sent electronically, such as prior authorization or sterilization consent forms<sup>16</sup>. Other barriers to electronic processing of physician claims relate to slow developments in the state of the art. The most widely used physician claim form--the HCFA 1500--did not have a standard electronic format until July 1991.<sup>17</sup>

In addition to these barriers, many physicians' offices simply do not have available the computer hardware necessary for electronic submission of claims. In fact, medical society staff in one State estimated that fewer than 20 percent of physicians in private practice have the computer capability necessary for computer submission of claims.

*At least 21 States use automated systems to answer physician inquiries about claims status, recipient eligibility, and other routine matters.*

Determining whether a patient is eligible on a given day may well mean the difference between a physician's being paid for providing a service and having that claim rejected. At other times a physician simply may need information on the status of bills that had been submitted during the prior month. In at least 21 States, Medicaid programs have established automated systems that can help providers address these questions.<sup>18</sup>

Alabama's fiscal agent estimates that 75 percent of telephone calls to the Medicaid information number were questions about recipient benefit limits or eligibility, or the status of submitted claims. To address this situation, Alabama established an automated voice response system (AVRS) in June 1991. This system, which operates 7 days per week for 18 hours per day, allows physicians to obtain information on these routine types of questions using a touch-tone phone.

In North Carolina, where a similar system operates, the fiscal agent estimates that the AVRS handles 1,000 calls per day, even without an eligibility verification component. By establishing an automated voice response system to answer these routine telephone inquiries, Medicaid staff are able to deal with more complex calls.

Maryland updated its eligibility verification system in November 1991. That system, which operates 24 hours per day, 7 days a week, was enhanced to permit providers to verify past dates of eligibility for services rendered up to 1 year previously. In addition, even if a recipient does not have his or her Medicaid card, the physician can use the recipient's Social Security number to obtain the current Medicaid identification number.

*Maryland and Florida give physicians written guides that provide clear instructions on how to correct problem claims.*

Maryland sends all providers, including physicians, a Turn-Around Document (TAD) whenever a claim is delayed. The TAD includes an error code, a description of the error, and an explanation of how to correct that error. Providers must resubmit the corrected TAD to Medicaid within 45 days. At that point, Medicaid will enter the changes and corrections into the computer system, and the claim will be processed. The TAD and corrective explanations were created with input from the various provider groups.

Florida has developed a "Trouble Shooting Guide for Medicaid Physician Providers" to help physicians understand and correct the most common billing errors.<sup>19</sup> Physicians receive this guide upon enrolling as a Medicaid provider, as well as periodic updates when needed.

When a physician receives a remittance voucher listing claims that are not being paid, the voucher contains a code explaining the reason for the delay. Although the remittance voucher translates each code, it does not specify how to correct the problem. For each problem, the Trouble Shooting Guide explains why the error occurred and how to correct it. In addition, the guide references the appropriate page of the Medicaid provider handbook in case the physician wants more information.

*Michigan and Florida use specialized programs and instructors to train physician office staff about Medicaid billing and policy.*

Michigan's four-person seminar unit holds training sessions throughout the State on Medicaid policy issues, coverage, and billing procedures. The seminar instructors spend more than half their time in the field; the balance is spent preparing, editing, and updating training materials. In 1990, the training staff sponsored 152 seminars, reaching more than 4,000 providers. Medicaid staff estimate that more than half of those attending were from physicians' offices.

In addition, two field representatives visit providers in their offices to help resolve billing problems, policy interpretations, and similar issues. In 1990, according to Medicaid staff, the field representatives visited over 1,700 providers on-site.

Florida conducts training through a joint effort that involves the regional and central Medicaid offices and the fiscal agent. Each plays a different role in the training program. The district office establishes district-specific guidelines for contacts with providers. The central office provides information on policy issues, such as eligibility criteria. The fiscal agent conducts training on billing procedures, problems, and solutions; remittance vouchers; and electronic billing. During the first six months of 1991, Florida conducted training seminars in 17 cities for more than 2,600 individuals.

## ***IMPROVING COMMUNICATIONS BETWEEN PHYSICIANS AND MEDICAID***

### **PHYSICIAN COMPLAINTS ABOUT HOW MEDICAID COMMUNICATES WITH PHYSICIANS**

"Medicaid policy is made with little input from practicing physicians."

"Medicaid's press releases have a negative tone regarding providers."

"Medicaid doesn't utilize publications of the medical and dental organizations for positive statements about the Medicaid program."

***Washington, Alabama, and Missouri established joint Medicaid-physician task forces to identify and resolve administrative obstacles to physician participation.***

Involving the physician community in solving Medicaid red-tape problems can yield mutual benefits. Medicaid program staff can gain a better understanding of the "real world" in which physicians practice. This should enhance the staff's appreciation of the impact that administrative processes have on provider views of the program. At the same time, the State can use such an effort to educate the physician community about the constraints under which the Medicaid program operates. These constraints may include inherent aspects of the program (*e.g.*, the need to verify recipient eligibility), State fiscal problems that limit the availability of funds, or Federal requirements over which States have no control.

We interviewed officials in three States--**Washington, Alabama, and Missouri**--that had established physician task forces to try to increase physician participation in Medicaid. They described concrete steps that emerged from these task forces. As the director of one State Medical Society told us, the task force "is the best thing to come out of Medicaid in years. It has really been a boon."

As a result of **Washington's "Red Tape Task Force,"** established in 1989, Medicaid

- ▶ clarified definitions of emergency and nonemergency procedures and distributed their corresponding procedure and diagnosis codes to physicians and hospitals;
- ▶ established field units to give technical assistance to physicians; and
- ▶ identified acceptable documents to confirm that a recipient lacks private third party coverage.

**Alabama's Physician Task Force,** established in 1990, led to

- ▶ an automated voice response system;

- ▶ increased time limits for claims submission from 180 to 365 days;
- ▶ assignment of Medicaid eligibility numbers to infants before birth, to make them eligible for Medicaid at birth; and
- ▶ shortened screening forms for the Early Periodic Screening, Diagnosis, and Testing (EPSDT) program.

Missouri's physician task force, established in 1989, implemented

- ▶ a toll-free telephone number for eligibility verification and provider information (previously, a toll call paid for by the physician); and
- ▶ an increase in the number of errors that can be identified during the initial claims processing run, so that the same claim is not rejected multiple times.

*Florida uses its district Medicaid offices as provider relations units and participates in activities of State and local medical societies.*

Florida has restructured its 11 district Medicaid offices. Previously, these local offices had been providers of health services such as transportation and EPSDT. In their new configuration, the district offices are an information and access point for consumers and providers. Provider-focused activities include:

- ▶ recruiting new providers to the program;
- ▶ resolving some claims payment problems, such as filing limits and eligibility issues; and
- ▶ maintaining and updating provider records.

In addition, Florida Medicaid has begun to participate actively in State and local medical society activities. This participation includes attending meetings of physicians and their billing administrators. The director of the program notes, "We staff a booth at the annual medical society conventions, and try to sell ourselves, just like any other vendor."

Florida Medicaid and the State medical and osteopathic societies mailed recruitment material to every nonparticipating physician in the state. These materials included a new pamphlet entitled "Medicaid Now Pays," explaining improvements in program fees and operations.

*Maryland employs a team of consultant nurses to enroll physicians for pediatric care and to assist them with administrative issues.*

Maryland combines active recruitment and administrative simplification to attract providers to Medicaid's EPSDT program, Healthy Kids. Seven nurse consultants

recruit providers for Healthy Kids, maintain ongoing relations with them--including assistance with Medicaid billing and administrative issues--and conduct annual quality assurance visits. Each nurse consultant covers a different area of the State. Recruitment efforts focus on physicians who treat children--pediatricians, family practitioners, and general practitioners. When a physician agrees to enroll, the nurse consultant helps obtain a Medicaid provider number, addresses programmatic issues, and answers questions about working with Medicaid.

One key nurse consultant role is explaining administrative and billing processes, focusing on exactly what an EPSDT provider must do in order to be paid. According to the director of the program, "The payment system is very comprehensive--it is just not very useful. We go in and tell the providers exactly what they need to do to make the [billing] forms work for them . . . what boxes to fill in, what doesn't need to be completed, what doesn't apply to them."

The nurse consultant also provides an ongoing contact for EPSDT providers who have questions or problems with Medicaid billing or other issues. This continuing relationship between health care professionals appears to be an important element of provider satisfaction. Providers apparently prefer to deal with a professional colleague whom they know rather than a "faceless entity at the other end of the telephone."

Program staff estimate that the number of EPSDT providers has grown from 375 in early 1990 to more than 900 today, as a result of these outreach and recruitment efforts.



## ***SIMPLIFYING PROVIDER MANUALS***

### **PHYSICIAN COMPLAINTS ABOUT GETTING INFORMATION ON MEDICAID**

"The program is so complicated. There are always new regulations, new drugs that will or won't be covered, new procedures that must be followed. It is difficult for physicians to learn the nuances."

"The rules and regulations often are very different from Medicare or private carriers, and the front office staff have trouble trying to keep them straight."

"Physician office staff aren't kept abreast of changes in Medicaid policy to keep up with appropriate billing methods and policies."

***Michigan is revising its provider manuals to make them more understandable to physicians and their staffs.***

**Michigan** has begun to simplify its Medicaid manuals with an emphasis on graphics, reference indexes, and simple language. The revisions are based on surveys and discussions with billing staff in physicians' offices. In addition to making the manual simpler to understand and use, staff hope that the revised format will make it easier to distribute policy changes to providers.

Another objective of the Manual Makeover Project is improving Medicaid's image among providers. Medicaid staff told us that their revisions have been widely accepted within the department, and "every doc on our Medical Society liaison committee loved it." In a pretest of the draft manual, providers particularly liked its simplicity. They were not sure, however, that the claims processing system would actually work as the new manual describes. To address this concern, project staff continue to work with the claims payment component of the Medicaid agency to coordinate necessary changes.

Budget constraints have slowed the manual makeover process. A new manual has been finalized for durable medical equipment suppliers only. Medicaid staff note that although the revised physician manual is temporarily on hold, they are committed to proceeding.

*Maryland distributes manuals for pediatric screening services that simplify the billing process and explain recommended screening schedules and tests.*

**Maryland** has developed two manuals for providers in its Healthy Kids initiative. A billing manual illustrates exactly how to complete the billing form. The document also contains procedure, immunization, and laboratory service codes and explains how to refer children for additional treatment under EPSDT.

The Screening Provider Manual contains information on current preventive child health standards and practices, as well as State and Federal regulations. Based on recommendations of the American Academy of Pediatrics, the manual includes optional guidelines for pediatric interval screening. These guidelines include forms that can be used to document screening results for each age interval.

## CONCLUSIONS

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Based on reports from State Medicaid agencies and medical society staff, each of the approaches described in this report appears to have potential as a constructive response to physician complaints about Medicaid hassle. Other States may wish to examine these initiatives in more detail to determine if they might work in their situation.

In weighing the potential impact of these approaches and their applicability elsewhere, it is important to take into account three considerations:

*Federal and State requirements for financial accountability mean that some tension between Medicaid's administrative requirements and what providers perceive as hassle is unavoidable.*

To some degree, the burden that physicians and other providers perceive as a hassle is a function of Medicaid's public nature and the need to monitor the expenditure of public funds. As the director of one Medicaid program told us, "If Medicaid receives a claim that is wrong, it goes back to the doctor. Every claim is considered a bill against the State and it's illegal for us to fix it on our own. Just because other payers give away money doesn't mean that we do."

Medicaid pays for services for eligible individuals only. Yet Medicaid eligibility is much less stable than for persons with Medicare or private insurance coverage. Whether or not someone is actually eligible for Medicaid coverage depends on such factors as income, marital status, and family makeup. Changes in any of these factors may affect a recipient's status. Although verifying whether someone is eligible for coverage on the date of treatment is a hassle, it is necessary to ensure payment.

Several States also informed us that some of the hassle results from Federal requirements. For example, physicians and patients must complete and maintain special documentation for sterilizations, hysterectomies, and abortions.

Although empirical evidence is limited, hassle is not unique to Medicaid or public payers. The Texas Medical Association (TMA) has been keeping a "hassle factor log" to compile complaints from members. As of October 1991, TMA had received fewer complaints for Medicaid (17 complaints) than for Workers' Compensation (52), Medicare (44), or Aetna Insurance (22).

*Other policy initiatives, such as higher fees and development of managed care systems, often accompany efforts to reduce Medicaid's administrative burden.*

State efforts to decrease Medicaid hassle for physicians do not take place in isolation. Florida, for example, raised physician fees over a four-year period to at least the 50th

percentile of Medicare fees. Maryland and Missouri increased fees for obstetricians to improve prenatal care.

Many of the efforts to reduce Medicaid hassle focus on traditional fee-for-service medicine. At the same time, many State Medicaid programs are encouraging the development of managed care systems for Medicaid recipients. Although we did not gather data on managed care programs, Maryland, Florida, and Michigan informed us that they are actively working toward this goal.

In addition, hassle factor reduction may affect providers other than physicians. For example, pharmacists and hospitals are more likely to submit claims electronically than are physicians. Manuals can be simplified and made easier to understand for all Medicaid providers.

***Fiscal constraints facing State governments limit the extent to which Medicaid programs can implement strategies to reduce the administrative burden.***

Although some States have raised physician fees as part of their strategy to improve physician participation, the fiscal climate surrounding State budgets makes it unlikely that fee increases will be widespread. State fiscal difficulties also may affect efforts to reduce the administrative burden of Medicaid. We discovered two specific examples of how these fiscal problems can affect attempts to reduce Medicaid hassle. In Michigan, the Medicaid Manual Makeover project has been delayed, because of the resources required to design, publish, and coordinate a new set of manuals. Likewise, in Missouri, we were told that the physician task force has been inactive over the past year because of the State's fiscal problems.

Even in light of these fiscal constraints, the State responses to Medicaid's hassle appear to reflect an awareness that physician concerns have some legitimacy and should be addressed. A staff person from one program summarized the comments of several others when she told us that "Medicaid has changed its philosophy to improve customer service. If we can't increase fees, at least we can make it as easy as possible to do business with us."

# APPENDIX A

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## METHODOLOGY

We conducted this study in two stages:

1. To identify State initiatives, we reviewed available literature and interviewed staff from:

- ▶ Physician organizations: The American Medical Association, the American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics. We interviewed State medical society staff in Alabama, Arkansas, California, Georgia, Florida, Illinois, Iowa, Michigan, Missouri, New York, Ohio, Pennsylvania, and Texas.
- ▶ State organizations: National Governors' Association, National Conference of State Legislatures, American Public Welfare Association, and Intergovernmental Health Policy Project.
- ▶ Health Care Financing Administration, Medicaid Bureau.
- ▶ Physician Payment Review Commission.

2. To obtain information on a particular State's approach to reducing the administrative burden we interviewed staff from the Medicaid program, the fiscal agent, and medical society in these States. We also reviewed written material provided by the Medicaid agency.

We examined data gathered in two surveys for an OIG study of State Medicaid electronic claims management capacity (OEI-01-91-00820, "Point-of-Service Claims Management Systems for Medicaid," Draft Report, January 1992; OEI-01-91-00821, "Electronic Funds Transfer for Medicaid Providers," Draft Report, January 1992). These surveys were:

- ▶ A mail survey of Medicaid programs, conducted from May to July 1991, to which 45 States responded. We received at least partial responses from every State except Alaska, Arizona, Arkansas, Delaware, and Ohio.
- ▶ Telephone interviews with Medicaid claims management staff in 49 States (all except West Virginia) and the District of Columbia.

## APPENDIX B

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### NOTES

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3. Anne Schwartz, David C. Colby, and Anne Lenhard Reisinger, "Variation in Medicaid Physician Fees," *Health Affairs* 10, no. 1 (Spring 1991): 131-39.
4. Physician Payment Review Commission, *Annual Report to Congress 1991*, p. 308.
5. Deborah Lewis-Idema *Increasing Provider Participation: Strategies for Improving State Perinatal Programs*, The National Governors' Association, 1988. This study addresses provider participation in both Medicaid and Maternal-Child Health Programs. The author notes that Medicaid agencies tend to place more emphasis on low reimbursement as the primary reason for low participation.
6. American College of Obstetricians and Gynecologists, *Improving Access to Maternity Care: Obstetric Provider Participation in Medicaid*, Washington, D.C., 1991, pp. 14-15.
7. "Making Florida's Medicaid Program 'Provider Friendly,'" *State Health Notes*, October 21, 1991.
8. Statement by Louis W. Sullivan, Secretary of Health and Human Services on behalf of the Forum on Administrative Costs, November 5, 1991.
9. 56 *FR* 8353, February 28, 1991.
10. These surveys provide information for two Office of Inspector General studies: "Point-of-Service Claims Management Systems for Medicaid," OEI-01-91-00820, Draft Report, January 1992, and "Electronic Funds Transfer for Medicaid Providers," OEI-01-91-00821, Draft Report, January 1992. In the notes to this study, we refer to the survey documents as "OIG Telephone Survey" for the telephone interviews conducted with Medicaid claims management staff, and "OIG mail survey" to describe the mail survey of Medicaid programs.

11. OIG mail survey. The following States were able to provide data on the percentage of physicians' claims that was submitted electronically: Alabama, California, Colorado, Connecticut, District of Columbia, Florida, Georgia, Idaho, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Minnesota, Mississippi, Montana, North Carolina, North Dakota, New Jersey, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Utah, Washington, and Wisconsin. It is likely that some other States also accept physician claims electronically, but were unable to break out the proportion. Only four States--Nevada, Rhode Island, South Dakota, and Wyoming--indicated affirmatively that they did not receive electronically submitted physician claims.

12. This figure compares with 87 percent of pharmacy claims, 81 percent of hospital claims, and 41 percent of dental claims. The 47 percent figure for physician claims does not mean that 47 percent of Medicaid physician providers are using electronic media. One would expect that large-volume Medicaid providers account for a disproportionate share of electronically submitted claims.

13. The HCFA-1500 is identical to the American Medical Society's Universal Billing Form. According to the American Public Welfare Association, 33 States use this form for physician claims submitted on paper. (*Medicaid Management Information Systems--Provider Participation, Cost Containment Initiatives: State Characteristics*, Summer 1991.)

14. OIG mail survey. Twenty States provided usable information on the cost per claim and the percent submitted electronically. The mean cost per physician claim was \$.83. The cost and percent were highly negatively correlated ( $r = -.57$ ), that is the higher the percent of claims submitted electronically, the lower the cost per claim.

15. Office of Inspector General, "Point-of-Service Claims Management Systems for Medicaid," Draft Report, OEI-01-91-00820, January 1992. In 47 States responding to this question, the mean payment time for electronic claims is 10 days, compared to 17 days for paper claims.

16. In our telephone survey, we found that three States--Kansas, Montana, and New York--are working on ways to automate prior authorization, although none is operational yet.

17. "Point-of-Service Claims Management Systems for Medicaid," p. 11.

18. OIG telephone survey. Nineteen States indicated in that survey that they had telephone automated voice response systems to verify eligibility: Alaska, California, District of Columbia, Florida, Georgia, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, New York, North Dakota, Ohio, Oregon, Texas, and Wisconsin. In addition, we learned through subsequent interviews that Alabama implemented such a system in June 1991, and North Carolina has an automated voice response system for general questions, but not eligibility verification.

19. Florida has prepared similar guides for other Medicaid providers, including hospitals, durable medical equipment and hearing aid suppliers, and nursing homes.