Access to Medicaid Services

February 1989

Program Evaluation Division
Office of the Legislative Auditor
State of Minnesota

Program Evaluation Division

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In July 1988 the Legislative Audit Commission directed the Program Evaluation Division to determine whether access to Medicaid services was a problem in Minnesota. Some people claimed that growing numbers of doctors and dentists were refusing to treat Medicaid patients--in part because reimbursement rates were not high enough.

We examined Medicaid billing data and surveyed providers, county officials, and social service advocates. We found that Medicaid recipients in some areas of Minnesota do have difficulty finding health care providers willing to accept Medicaid patients. While this is not currently a crisis, providers' negative attitudes about Medicaid reimbursement levels and administrative problems may cause more to limit their participation in the future.

Apart from simply raising Medicaid reimbursement levels, the state can address this problem by correcting errors and inconsistencies in its current rates and by improving provider training and support.

We received the full cooperation of county social service officials, the Department of Human Services, the Minnesota Medical Association, the Minnesota Dental Association, and many individuals who work for social service advocacy organizations.

This report was researched and written by Tom Walstrom (project manager), Mary Guerriero, and Deborah Woodworth.

Sincerely yours,

James R. Nobles
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ACCESS TO MEDICAID SERVICES

Executive Summary

Medicaid is a federal/state program that pays doctors, dentists, and other health care providers for services furnished to the poor. Administered by county welfare departments and the state Department of Human Services (DHS), Minnesota's Medicaid program cost over $1.15 billion in fiscal year 1988.

In recent years many health care providers have claimed they would have to stop seeing public assistance recipients because Medicaid payments do not cover their costs of doing business. Providers have claimed that this would result in limited health care access in some parts of the state. In July 1988, the Legislative Audit Commission requested a study to answer the following questions:

- **Do Medicaid or GAMC recipients have difficulty finding needed health care? Is there a shortage of Medicaid health care providers in particular specialties or geographic areas? Is a problem developing for the future?**

- **If there is a Medicaid access problem, what factors contribute to it? If there are impediments to provider participation other than reimbursement rates, how might they be eased?**

We examined these questions through surveys of 87 county welfare agencies, 726 dentists, and 515 physicians around the state. We also interviewed representatives of 41 groups serving Medicaid recipients, 21 medical clinic administrators, 12 providers who have withdrawn from the program, and many state Medicaid administrators.

Access to dental services is difficult in some parts of the state.

We found that access to some services is difficult for Medicaid patients in certain parts of the state because there are too few participating providers. In particular, we found that some dentists are withdrawing from the program and others are limiting the number of Medicaid patients they see. Physicians seem more reluctant to deny service to Medicaid patients, but a number of them have also limited their Medicaid participation.

ACCESS TO HEALTH SERVICES IN MINNESOTA

32 counties reported it was fairly or very difficult to find dentists willing to see public assistance recipients. No counties reported recipients went without care.

Our surveys of county welfare agencies and welfare advocates revealed a widespread perception that dentists and some doctors are dropping Medicaid patients or limiting the number they will see. Officials in 14 counties said that dentists willing to serve Medicaid or GAMC patients are very difficult to find and those in 18 counties said they were fairly difficult to find. Access to dentists for GAMC recipients is especially difficult. Only two counties reported that finding physicians willing to serve Medicaid patients was very difficult.

However, no counties reported that Medicaid recipients went without care. In most cases where access is reported as difficult, recipients have to travel farther to receive care. County welfare agencies and recipient group advocates are concerned that some recipients may be deferring care because of difficulty finding dentists.

To see whether county reports were accurate, we examined the number of medical and dental procedures performed per Medicaid recipient in counties reporting very difficult access. We found that there had generally been a decrease in the number of procedures per recipient in those counties. This tends to support the idea that dentists are limiting Medicaid patients in a few areas of the state, and that recipients are going outside the county to receive care.

Counties reported much less difficulty finding physicians willing to participate in Medicaid, although there are shortages in a few areas of the state. In particular, access was reported as very difficult in Anoka County.

In general, we found that:

- **Medicaid recipients have more difficulty finding willing dental providers than finding willing medical providers.**

The most important reason dentists and some physicians decline to see Medicaid patients is their perception that Medicaid reimbursement rates are too low. The second important reason providers limit the number of Medicaid patients they see is the difficulty in dealing with what they call the Medicaid "bureaucracy" to get their bills paid.

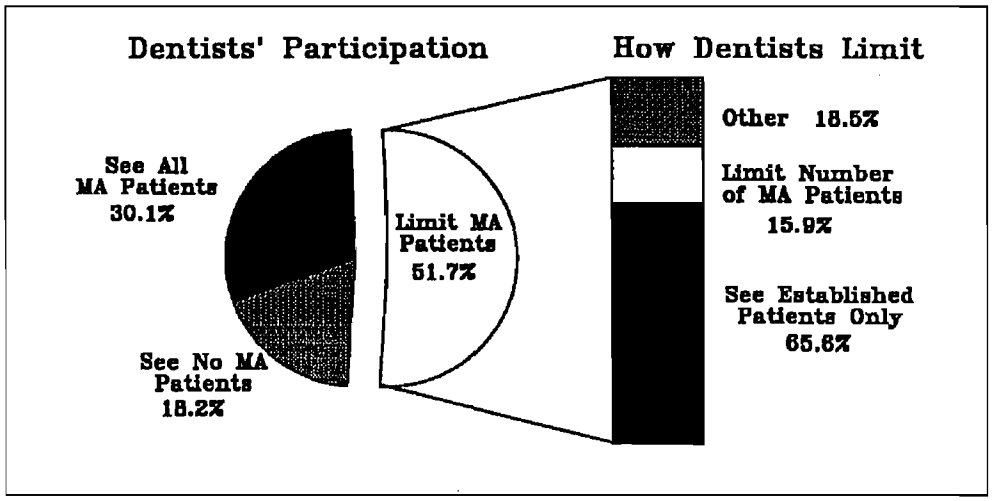
DENTISTS' PARTICIPATION

We explored dentists' attitudes about Medicaid through a mailed survey and through numerous direct conversations with individual dentists. We mailed surveys to a random sample of 1,020 dentists and received 726 replies, for a response rate of 71 percent. We found that about 82 percent of Minnesota dentists participate in the Medicaid program. However, almost two-thirds of participating dentists limit the number of Medicaid patients they see. This means that:

Less than one-third of dentists see all Medicaid recipients.

- **About 30 percent of dentists see all Medicaid patients (full-participants), 52 percent see some (limiters), and 18 percent see none.**

The most frequent way dentists limit Medicaid patients is to see no new patients.



Extent of Dentists' Participation in Medicaid

Nineteen percent of all dentists said they would end Medicaid participation in 1989, and 34 percent reported they would continue to accept new patients as time allowed. If this actually occurs, dental access will become more difficult. It would mean that over 26 percent of all dentists would accept no Medicaid patients, 50 percent would accept some, and only 24 percent would continue to see all Medicaid patients.

Dentists say their overhead costs are 60 percent of charges. Medicaid paid 72 percent of charges in 1987.

Dentists' most persistent complaint is Medicaid's payment rates. Over 87 percent of dentists said that Medicaid did not pay enough to cover their overhead costs. The Minnesota Dental Association estimates that an average dentist's office overhead (all costs except the dentist's salary) is about 60 percent of submitted charges. There is no way to know how accurate this cost estimate is or how much dentists' efficiency affects costs. Nonetheless, because dentists seem to be making participation decisions on this basis, we compared dentists' estimate of overhead costs to the percentage of dentists' submitted charges that Medicaid paid. We found that:

- **Medicaid paid an average of 72 percent of dentists' submitted charges in 1987.**

Because Medicaid rates have not gone up, we expect that the percent of dentists charges Medicaid paid in 1988 will be lower. Still, on average, Medicaid paid more than dentists said their overhead costs were.

We found that metro-area dentists on average received a lower percentage (67 percent) of their charges than non-metro dentists (76 percent). Most likely, metro dentists are charging more than non-metro dentists. However, Medicaid reimbursement is the same across the state.

Average Percent of Charges Paid	Number of Dental Billing Sources							
	1984		1985		1986		1987	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0-50%	83	3.5%	133	5.6%	40	1.8%	74	3.4%
50-60	397	16.9	457	19.4	122	5.4	187	8.5
60-70	910	38.8	891	37.8	445	19.7	598	27.2
70-80	582	24.8	529	22.4	799	35.4	756	34.4
80-90	192	8.2	171	7.2	570	25.2	391	17.8
90-100	119	5.1	113	4.8	222	9.8	146	6.7
100	64	2.7	66	2.8	62	2.7	43	2.0
Total	2,347	100.0%	2,360	100.0%	2,260	100.0%	2,195	100.0%

Overall Average	66.4%	65.7%	74.7%	71.6%
Metro Average	63.5	62.1	70.6	67.0
Non-Metro Average	69.5	69.2	78.6	75.5
Out-of-State	71.1	68.2	74.6	69.2

Percent of Dentists' Submitted Charges Paid by Medicaid

Although on average Medicaid payments apparently cover dentists' overhead costs, and contribute to paying dentists' salaries, there are some for whom this may not be true. About 12 percent of dentists were paid less than 60 percent of their charges in 1987.

The Department of Human Services analyzed how Medicaid reimbursement rates compared to those from private dental insurers in 1987. The department's analysis shows that on average insurers pay about 29 percent more than Medicaid.

Dentists complain about reimbursement rates, claims processing, and difficult patients.

The second biggest reason that dentists refuse to see Medicaid patients is because of problems with paperwork and claims handling, provider relations, and Medicaid policies. For example:

- **54 percent of dentists said Medicaid invoices are difficult to fill out correctly.**
- **Only 40 percent of dentists said payments are usually received within 30 days.**
- **Only 35 percent of dentists thought that Medicaid administrative requirements are generally reasonable compared to other payors.**
- **About 46 percent of dentists thought program requirements are communicated well.**

Many dentists commented that the department was unresponsive in dealing with problems in claims processing and in prior authorizations.

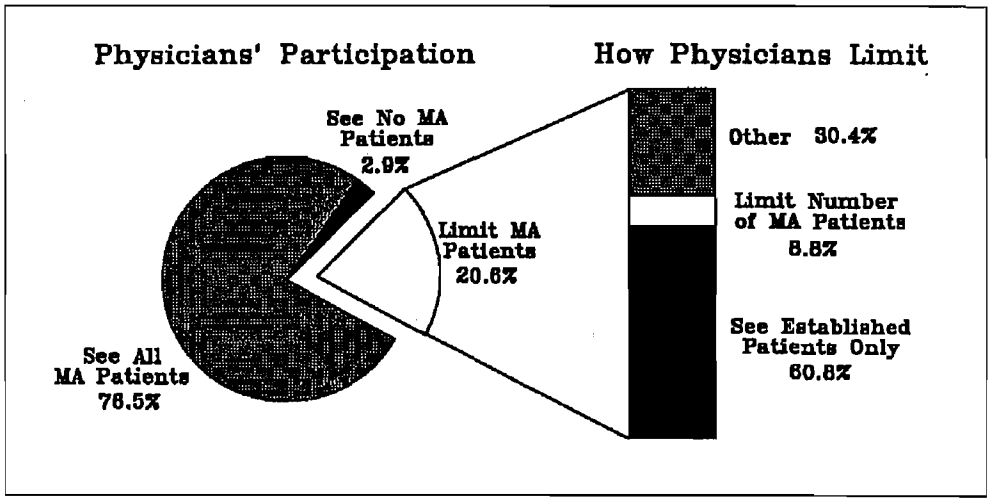
Dentists also have problems with Medicaid patients. Almost 93 percent said Medicaid patients failed to keep appointments more often than other patients. Some Medicaid patients also have disabilities that make them more difficult and expensive to treat, according to the dentists.

PHYSICIANS' PARTICIPATION

We also surveyed physicians to examine their attitudes about Medicaid. Out of a random sample of 975 office-based primary care physicians, 515 responded for a response rate of 53 percent. We found that:

- **Almost all physicians (97 percent) participate, with 76 percent seeing all patients, and about 21 percent somehow limiting the Medicaid patients they see.**

Almost all physicians participate but 21 percent limit the number of MA patients they see.



Extent of Physicians' Participation in Medicaid

We asked physicians about their plans for 1989 given current reimbursement levels. Seventy-eight percent said they would continue to accept new patients as time permits, 20 percent would continue to treat current patients but accept no new patients, and 1.5 percent would terminate participation.

Based on our survey responses, we conclude:

- **Most physicians are reluctant to completely stop seeing Medicaid patients.**

Like dentists, physicians perceived problems with the program's reimbursement levels, with the timeliness and ease of payment, and with the Medicaid patients themselves. Over 87 percent of physicians said that Medicaid reimbursement amounts did not cover their costs, and over 95 percent disagreed that reimbursement rates are reasonable overall. In particular, physicians and medical clinic administrators mentioned that reimbursement levels are poor

for obstetric services. Many physicians also complained that they were paid less than their costs for injectable drugs and immunizations.

Physicians say their costs are 50 to 55 percent of charges. Medicaid paid 65 percent of charges in 1987.

Physicians reported that their overhead costs, not including the physician's salary, were in the range of 50 to 55 percent of submitted charges. Again, there is no way to verify what physician overhead costs are, or how and why physician costs vary. Nonetheless, since physicians said Medicaid did not cover their overhead costs, we examined DHS computer files to determine what percent of submitted charges Medicaid did pay. We found that:

- **On average, Medicaid paid physicians about 65 percent of their submitted charges in 1987. However, there is considerable variation among providers in the percent of charges Medicaid pays.**

	Physician Billing Sources							
Average Percent of Charges Paid	1984		1985		1986		1987	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0-50%	1,134	15.6%	1,219	15.8%	484	6.2%	678	8.8%
50-60	1,898	26.1	2,225	28.9	1,138	14.5	1,651	21.5
60-70	2,360	32.4	2,377	30.9	2,473	31.5	2,717	35.3
70-80	1,217	16.7	1,160	15.1	2,265	28.9	1,640	21.3
80-90	409	5.6	420	5.5	934	11.9	640	8.3
90-100	137	1.9	146	1.9	337	4.3	222	2.9
100	120	1.6	153	2.0	208	2.7	139	1.8
Total	7,275	99.9%*	7,700	100.1%*	7,839	100.0%	7,687	99.9%*
Overall Average	61.9%		62.9%		69.2%		65.3%	
Metro Average	61.2		62.2		67.9		63.7	
Non-Metro Average	63.2		69.2		71.7		67.9	
Out-of-State	59.9		68.2		67.1		64.1	

*Does not total 100 due to rounding.

Percent of Physicians' Submitted Charges Paid by Medicaid

This means that, if the physicians' overhead cost estimates are correct, on average Medicaid contributes to paying the physicians' salaries. However, there are some physicians for whom this may not be true. Almost 9 percent of physicians were paid less than 50 percent of their submitted charges, and an additional 21 percent were paid between 50 and 60 percent of their submitted charges.

These differences are attributable to several factors. First, providers charge different amounts for the same services. This is because some are more efficient, some have higher or lower cost structures for other reasons, and some have higher income expectations than others.

Physicians' Medicaid payments also vary as a percent of their charges because of billing practices. Depending on billing practice, there can be large differences in Medicaid payments. This is because:

- **There are very serious problems with the department's list of Medicaid rates -- the so-called reference file.**

Medicaid's list of rates contains mistakes and inconsistencies.

Many of the 15,000 procedures and rates listed in the reference file have not been updated regularly, and there are many inconsistencies in pricing between similar procedures. For example, it is possible to bill for the same service in different ways and to be paid different amounts. Also, if providers bill with procedure codes that are infrequently used, it is almost certain they are paid a smaller percent of charges, because Medicaid's rates for many of these codes have not been updated regularly (some are still based on 1979 rates). Likewise, we found that Medicaid rates for immunizations and injectable drugs are a minimum of $1.50 lower than they should be, and they are based on 1985 instead of current prices.

A related problem causing inconsistencies is that there has been little control in the past over reference file changes. Although the department now has better internal controls over changes, the inconsistencies introduced by past *ad hoc* changes remain.

Physicians also complained about long delays in claims processing and the difficulties they had trying to resolve problems on claims. We found that Medicaid paid a claim with no errors in an average of 21.5 days. However, the average time between when the service is provided and when Medicaid pays is about 75 days. This is because some claims are suspended from processing or rejected for errors, and because it takes providers time to submit their claims to the department. The department has steadily improved its claims processing performance, but many providers still consider it unacceptable.

Physicians are also upset with some Medicaid recipients' overuse of services. Although our survey did not ask any questions about this, half of physicians commenting noted problems with some Medicaid recipients' overuse of emergency rooms and other services, or suggested co-payments or case management approaches to curb service overuse.

CONCLUSIONS AND RECOMMENDATIONS

Some providers are dropping out of the program or limiting services to Medicaid recipients.

This study confirms anecdotal accounts that some health providers are dropping out of the Medicaid program, or limiting services to Medicaid recipients. Although we do not believe there is currently an access crisis, it is becoming increasingly difficult to find willing providers in some parts of the state.

Some providers, particularly dentists, are eliminating or limiting Medicaid services because they perceive reimbursement is below their costs. We confirmed what providers told us -- that Medicaid payments were low as a percent of their billings. However, we found that on average Medicaid reimbursement levels were above what dentists and doctors said their overhead costs are. While this is true in general, our analysis also shows that some dentists and physicians receive Medicaid reimbursements that are less than 60 percent of their submitted charges.

DHS should correct inconsistencies and problems with its reimbursement rates.

We believe some of this variation is due to errors and inconsistencies in the Department of Human Service's reference file of Medicaid rates. Keeping the reference file current as medical and dental practices change is a complex job that has sometimes received little attention from the department. While DHS has made some efforts to correct known reference file problems, the department reports inadequate staffing to systematically correct the problems.

DHS's job is complicated by the fact that, in all cases, they do not technically have authority to change reimbursement rates, although in individual cases they have made changes. In our opinion, it is reasonable for the department to have the authority to make technical and administrative changes in Medicaid rates where necessary. However, the department's actions should be disclosed to the Department of Finance and to the House Appropriations and Senate Finance Committees.

We believe the problems with the reference file are serious enough that they demand immediate attention. Therefore, we recommend:

- **DHS should systematically review and correct problems with its Medicaid rates. This may require additional staff, at least temporarily.**

- **The Legislature should amend *Minn. Stat.* §256B to allow the department the authority to make necessary administrative changes to Medicaid rates. The department should be required to report such changes to the Department of Finance and appropriate legislative committees.**

Systematically reviewing rates and making them consistent where necessary would help to rationalize provider payments. We believe it will also ease some of the department's provider relations problems.

DHS should be more proactive in provider relations.

We also believe that the department should take a more proactive role in provider relations. Many problems for providers and the department are created because of miscommunication and a lack of provider training. The department has taken some steps to improve communication with providers, but it says it is hampered by a lack of staff. Other third party payors we contacted all had staff devoted to provider training and relations. We believe that provider relations staff would pay a dividend to the state by encouraging provider participation in the program and reducing problems in the department's claims processing. Therefore, we recommend:

- **The department should establish a Medicaid provider support and training function. This, too, may require additional staffing.**

Consistent Medicaid rates and better provider support will be the lowest cost strategy to ensure sufficient numbers of Medicaid providers.

We believe that the state will have to maintain a consistently higher level of reimbursement to ensure provider participation if administrative problems are not remedied. We believe that pursuing a policy of consistent, timely, and fair provider payment will encourage more providers to participate in the Medicaid program at any given level of reimbursement.

We believe that consistent Medicaid rates and better provider support will be the lowest cost strategy for the state to ensure an adequate supply of Medicaid providers.

INTRODUCTION

The Medical Assistance (MA) program is intended to pay for health services for poor people. Recently, Minnesota health care providers have complained about reimbursement levels and other problems with the program, and some have withdrawn or limited their participation. As a consequence, legislators have become concerned about the availability of services for public assistance recipients.

At the request of the Legislative Audit Commission we studied the following questions:

- **Do Medicaid or GAMC clients have difficulty finding needed health care? Is there a shortage of health care providers in particular specialties or geographic areas? Is a problem developing for the future?**

- **If there is a Medicaid access problem, what factors contribute to it? If there are impediments to provider participation other than reimbursement rates, how might they be eased?**

To answer these questions we talked to many groups who work with Medical Assistance clients, including county MA financial supervisors, state Medicaid administrators, dentists, physicians, advocacy groups, clinic managers, and providers who have withdrawn from the Medical Assistance program. We also examined claims information collected by the Department of Human Services.

Chapter 1 examines Minnesota's Medical Assistance program and the issue of access to health services. Chapter 2 reports the conclusions of county Medicaid supervisors and recipient advocacy groups about access problems in Minnesota. Chapters 3 and 4 examine the comments of dentists, physicians, and clinics about their perceptions of the MA program and their plans for future participation. In Chapter 5 we discuss our findings and make several recommendations.

BACKGROUND

Chapter 1

In this chapter, we briefly describe the Minnesota Medicaid and General Assistance Medical Care programs, review the national literature on health care access, and discuss Minnesota access issues.

THE MEDICAID AND GENERAL ASSISTANCE MEDICAL CARE PROGRAMS

Medicaid

Medicaid (Medical Assistance or MA) is a joint state-federal program authorized by Congress in 1965 by Title XIX of the Social Security Act and implemented by the Minnesota Legislature in 1967. MA pays for health care services provided to recipients of public assistance. The program's main aim is to improve access to health services for persons who would not otherwise be able to afford such care.

Costs

Minnesota's Medicaid program cost over $1.1 billion in 1988.

Medicaid is supported by both state and federal funding. As of October 1, 1988, the federal funding share was 53 percent and Minnesota's share was 47 percent (of which the state pays 90 percent and counties pay 10 percent). As shown in Table 1.1, total expenditures amounted to about $1.15 billion in fiscal year 1988. Most of MA expenditures were for institutional services, with nursing homes alone costing the program over $550 million in fiscal year 1988. Non-institutional provider expenditures totalled approximately $175 million or about 15 percent of total Medicaid expenditures. Although small as a proportion of Medicaid expenditures, payments to office-based providers are still large in comparison with expenditures for many other Minnesota state programs.

Eligibility

Minnesota Medical Assistance covers both the "categorically needy" and the "medically needy." The categorically needy includes those who qualify for Aid to Families with Dependent Children or Supplemental Security Income, as well as children in foster care or subsidized adoption, and recent refugees.

Category of Service	FY 1988 Expenditures
Mandatory Services (subtotal)	$604,766,452
Inpatient Hospital, General	184,270,092
Outpatient Hospital, General	25,776,126
Nursing Home, Skilled	327,766,668
Independent Lab/X-Ray	808,580
Family Planning Service	3,260,164
EPSDT	1,469,211
Physician/Osteopathic Service	61,415,611
Optional Services (subtotal)	$567,167,322
Inpatient Hospital, T.B.	0
Inpatient Hospital, Mental	40
Crippled Children's Hospital/Convalescent	0
Mental Health Service	5,619,196
HMO	30,653,437
Rehabilitation Service	9,102,469
Nursing Home, T.B.	0
Nursing Home, ICF-MR	132,054,529
Nursing Home, ICF-I	109,248,224
Nursing Home, ICF-II	13,982,590
P.T., O.T., S.T., & Aud. in Nursing Homes	13,308,204
Home Health Service	8,515,998
Crippled Child Service	59,356
Buy-In/Health Insurance	5,506,336
Public Health Clinic Service	557,147
Recipient Recovery	(16,801,067)
State Institution, MR (ICF)	106,258,543
State Institution, MI-CD (Mental Hospital)	12,624,417
Prescribed Drugs	50,822,774
Medical Supplies	11,900,217
Ambulance Service/Medical Transportation	9,374,059
Dental Services	13,807,403
Optometric Services	1,954,537
Psychology	6,298,502
Nursing Services	8,591,292
Physical Therapy	395,173
Speech Therapy	121,296
Occupational Therapy	0
Podiatrist Service	362,092
Chiropractor Service	1,833,294
Audiologist	74,661
Osteopathic Service (Non-M.D.)	0
Waivered Services (MR)	26,144,854
Waivered Services (Elderly)	4,711,573
Other Services	86,176
All Services (Grand Total)	$1,171,933,774

Table 1.1: Medical Assistance Expenditures

Minnesota Medicaid also covers pregnant women with incomes up to 185 percent of the federal poverty level. Although not required by federal law, Minnesota also chooses to cover the medically needy, a group whose income dips below MA eligibility limits after deducting medical expenses.

As Table 1.2 shows, in fiscal year 1987, Hennepin County had by far the largest average number of eligible persons (64,081). The seven-county metro area had an average of 124,702, or about 46 percent of those eligible in the entire state. In contrast, Cook County had the smallest monthly average (224).

Minnesota has a generous Medicaid program.

Services

Minnesota has a generous Medicaid program compared with most other states. Measured from the perspective of poor persons on several dimensions, Minnesota's Medicaid program was rated the best in the country by a recent study.[1] Minnesota has the second highest number of services covered (after New York).

The federal Medicaid law requires each state to cover certain services. In addition, Minnesota chooses to cover virtually all optional services.

Services Required by the Federal Government:

- early periodic screening, diagnosis, and treatment for children,
- family planning and nurse midwives,
- physicians,
- inpatient and outpatient hospital services,
- laboratory services and x-rays,
- home health care, including medical supplies and equipment,
- rural health clinics, and
- skilled nursing facilities.

Optional Services Provided in Minnesota:

- dentists,
- psychologists,
- clinics,
- intermediate care facilities, including care for mentally retarded persons,
- audiologists, chiropractors, and physical and speech therapy,
- home and community-based waiver services,
- medical transportation,
- pharmacies,
- prosthetics,
- personal care assistant and private duty nursing,
- public health nursing,
- rehabilitation agencies, and
- skilled nursing facilities for individuals under age 21.

Figure 1.1: Required and Optional Health Services Under Medical Assistance

General Assistance Medical Care

Funded entirely by the state, General Assistance Medical Care (GAMC) finances medical services for low-income persons who are ineligible for Medicaid. As shown in Table 1.3, expenditures for the GAMC program during fiscal year 1988 totaled about $80 million. Office-based provider ex-

1 Karen Erdman and Sidney M. Wolfe, *Poor Health Care for Poor Americans: A Ranking of State Medicaid Programs* (Washington, D.C.: Public Citizen Health Research Group, 1987).

County	MA Average	GAMC Average	County	MA Average	GAMC Average
Aitkin	1,342	189	Martin	1,284	134
Anoka	8,440	756	Meeker	1,231	96
Becker	2,974	365	Mille Lacs	1,837	166
Beltrami	4,785	439	Morrison	2,199	256
Benton	1,741	159	Mower	2,711	353
Big Stone	502	48	Murray	616	73
Blue Earth	3,263	343	Nicollet	1,122	98
Brown	1,260	141	Nobles	1,254	136
Carlton	2,705	381	Norman	513	40
Carver	1,131	114	Olmsted	4,357	586
Cass	2,963	322	Otter Tail	3,551	464
Chippewa	769	62	Pennington	1,164	130
Chisago	1,600	142	Pine	1,994	267
Clay	3,418	393	Pipestone	667	46
Clearwater	1,280	173	Polk	3,325	330
Cook	224	41	Pope	826	81
Cottonwood	746	103	Ramsey	38,498	4,486
Crow Wing	4,055	517	Red Lake	357	43
Dakota	7,105	520	Redwood	915	78
Dodge	754	54	Renville	942	106
Douglas	1,827	157	Rice	2,043	207
Faribault	1,127	108	Rock	433	40
Fillmore	1,383	108	Roseau	670	65
Freeborn	2,060	148	St. Louis	22,772	4,115
Goodhue	1,909	182	Scott	1,411	95
Grant	403	31	Sherburne	1,506	104
Hennepin	64,081	12,646	Sibley	646	46
Houston	945	124	Stearns	5,119	412
Hubbard	1581	139	Steele	1,121	117
Isanti	1,560	130	Stevens	588	87
Itasca	5,010	771	Swift	852	76
Jackson	986	196	Todd	2,150	248
Kannabec	1,043	128	Traverse	345	39
Kandiyohi	3,103	378	Wabasha	1,015	67
Kittson	427	21	Wadena	1,621	182
Koochiching	1,693	323	Waseca	1,006	96
Lac Qui Parle	491	50	Washington	4,036	277
Lake	771	168	Watonwan	741	87
Lake of the Woods	275	39	Wilkin	522	34
LeSueur	1,288	98	Winona	2,379	279
Lincoln	481	31	Wright	2,840	231
Lyon	1,641	151	Yellow Medicine	731	68
McLeod	1,212	99			
Mahnomen	738	100	Total*	271,617	36,573
Marshall	619	47			

Source: Department of Human Services

*Columns may not sum exactly due to rounding.

Table 1.2: Average Number of Persons Eligible Per Month for Medicaid and General Assistance Medical Care, Fiscal Year 1987

Category of Service	FY 1988 Expenditures
Inpatient Hospital Services	$39,981,666
Skilled Nursing Home Care	20,371
Intermediate Care	203
Physician Services	12,115,288
Outpatient Hospital or Clinic	6,065,418
Home Health Care	186
Nursing Services	0
P.T., O.T., S.T., & Rehab Services	51,219
Dental Services	3,154,452
Independent Lab and X-Ray	212,084
Prescribed Drugs	4,427,330
Optometric Services	494,903
Family Planning	284,159
Mental Health/Psychology	400,850
Medical Supplies	737,427
Diagnostic Screening Services	0
Ambulance and Other Medical Transportation	1,103,570
Other Practitioners	525,523
Health Insurance/HMO	10,504,785
Other Services	(484,701)
Grand Total	$79,594,733

Table 1.3: General Assistance Medical Care Expenditures

penditures were about $17 million, approximately 21 percent of all GAMC expenditures.

GAMC generally offers lower payments to providers and covers fewer services than Medicaid. GAMC covers:

- chiropractors, podiatrists, and vision care,
- day treatment for the mentally ill provided by Community Mental Health Centers,
- dentists,
- equipment necessary for diabetics to administer insulin and monitor blood sugar levels,
- family planning supplies,
- hearing aids and services,
- independent laboratories,
- inpatient and outpatient hospital services,

- medical transportation,
- Medicare-certified rehabilitation agencies,
- physicians,
- prescribed drugs, and
- prosthetics.

About half of those who are eligible for GAMC live in or around the Twin Cities area. The seven-county metro area, which had a monthly average of 18,894 persons eligible in 1987, accounts for about 52 percent of all those eligible in the state. And, like MA, the number varies dramatically from county to county. As shown in Table 1.2, Hennepin County averaged 12,646 eligible persons per month in 1987 while Kittson County averaged only 21.

ACCESS TO HEALTH SERVICES

In this section we review what national studies say about access to health services. Specifically, we asked:

- **What is access? How is it defined?**
- **What are the most common barriers to access? What keeps patients from getting the care they need?**
- **Why do some providers decide not to participate in public assistance medical care programs?**

What is Access?

Unwilling providers can limit access.

Reasonable access to health services means that patients can (1) find care when they need it, (2) afford the care that they need, and (3) obtain quality care.[2] Whether MA recipients can find care when they need it is the primary focus of this study. Some providers in Minnesota and throughout the nation maintain that, because of low provider reimbursement levels and other problems with Medicaid, they will not treat all or most public assistance clients. Minnesota dentists, in particular, assert that provider withdrawals will increase access problems for MA recipients seeking care in the future. Therefore, the availability of health care providers in Minnesota is an important issue that we will discuss in later chapters.

2 Duncan Clark, "Dimensions of the Concept of Access to Health Care," *Bulletin of the New York Academy of Medicine*, 59: 5-8.

The second aspect of access, the ability to afford care, is a difficult problem for the uninsured. However, it is not a problem for Medicaid recipients because MA pays for a wide variety of health services.

The third aspect of access, quality of care, is an important issue, but we do not address it directly in this report. It is nevertheless worth reporting that in conversations with program administrators and recipient advocacy groups we did not hear that the quality of care provided to Medicaid recipients is a serious problem.

Barriers to Access

There are three major barriers to health care access:

- An unequal geographic distribution of physicians and/or dentists.
- The unique needs and characteristics of those seeking care.
- The unwillingness of providers to treat patients on public assistance.

These problems affect the entire nation, including Minnesota.

The Geographic Distribution of Providers

Providers are unequally distributed around the state.

In many rural areas across the nation, physicians and dentists are in short supply. Specialists cluster in urban areas, while rural areas have higher proportions of general practitioners, trained before the emphasis on specialization emerged.[3] Therefore, rural areas may suffer from limited numbers of practitioners, a lack of specialists, and an aging physician population. As we discuss later, we found there is a shortage of providers, particularly specialists, in some rural Minnesota counties.

When providers are widely dispersed, transportation can be a serious problem for patients. Public assistance recipients are often the least capable of obtaining transportation.[4] Medicaid and GAMC reimburse transportation that is necessary for the recipient to obtain medical services. Counties are responsible for 50 percent of these transportation costs and the other 50 percent is covered by the federal government. The state requires counties to have a detailed plan for recipient transportation. The most common procedure is to reimburse clients for mileage and parking.

Group Characteristics

Some groups may have difficulty finding health care services because of their unique needs and characteristics. For example, recent refugees who do not

3 John E. Kushman, "Physician Participation in Medicaid," *Western Journal of Agricultural Economics* 2 (1977): 21-33.

4 One study of West Virginia found that 10 percent of that state's population lived more than a 30-minute drive from hospital care. The most isolated individuals were also the poorest and most in need of accessible care. Edward M. Bosanac, Rosalind C. Parkinson, and David S. Hall, "Geographic Access to Hospital Care: A 30-Minute Travel Time Standard," *Medical Care* 14 (1976): 616-624.

speak English may have trouble understanding and utilizing the health care system. We explore this issue specifically for Minnesota MA recipients in Chapter 2.

Provider Participation

MA and GAMC recipients will experience problems finding care if enough providers in their area decide to limit their treatment of public assistance clients. Over the past fifteen years, numerous national studies have shown an increase in the proportion of Medicaid providers who limit the number of MA patients they will treat.[5] As we will see in Chapter 3, many Minnesota dentists limit their MA participation or decline to participate at all. Though virtually all Minnesota physicians treat MA patients, they, too, sometimes limit the number they will see.

A number of national studies show that two major factors influence the decision to withdraw from or limit participation in the Medicaid program. These factors are:

- Low reimbursement levels for services provided.
- Difficulties encountered during the claims payment process.

Reimbursement Levels

National studies show that provider reimbursement levels can affect participation.

National studies show that low provider reimbursement is the most frequent explanation for limiting participation. As we will see in Chapters 3 and 4, our survey of Minnesota dentists and physicians confirms this finding.

According to national studies, states with higher reimbursement levels also have higher provider participation rates. However, reimbursement levels of other third party payors also affect participation.[6] National studies have found that (1) provider participation is lower when private insurance reimbursements are higher, and (2) while reimbursement increases can raise physician participation rates, a relative raise in private insurance rates can counteract this increase.[7] Providers may perceive MA reimbursement rates to be more attractive when they are similar to private insurance rates and less attractive when private insurance rates increase.

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5 See, for example, Janet Mitchell, "Medicaid Participation by Medical and Surgical Specialists," *Medical Care* 21 (1983): 929-938; Mitchell and Schurman, "Access to Private Obstetrics/Gynecology Services Under Medicaid," 1984; Sloan, *et. al.*, "Physician Participation in State Medicaid Programs," 1978.

6 Mitchell, "Medicaid Participation by Medical and Surgical Specialists," 1983. Mitchell studied a large national sample of physicians from 15 specialties.

7 Frank Sloan, Janet Mitchell, and Jerry Cromwell, "Physician Participation in State Medicaid Programs," *The Journal of Human Resources* 13 (1978): 211-245; Janet Mitchell and Rachel Schurman, "Access to Private Obstetrics/Gynecology Services Under Medicaid," *Medical Care* 22 (1984): 1026-1037.

The Claims Process

Problems with claims can also affect provider participation.

After reimbursement levels, providers' most frequent complaint is about the administrative difficulties they encounter when filing Medicaid claims. National studies identify the following specific problems: (1) cumbersome claims forms and procedures, (2) slow turnaround time for reimbursement, (3) forms returned frequently for changes or minor errors, (4) unpredictable payment, and (5) brusque public employees. We found these factors to be significant in our survey of Minnesota providers as well. Compared to other third party payors across the nation, state Medicaid programs have a poor record for time required to complete forms, forms being returned, and payment turnaround time.[8] In fact, one study found that collection difficulties actually cancelled the positive effect of generous reimbursement levels on provider participation.[9]

Other Influences on Provider Participation

Though less powerful as deterrents, other factors affect a provider's decision to participate in Medicaid programs. Abuse of the Medicaid program by recipients is at least an irritant to some providers. A study of physician participation in the Mississippi MA program found many physicians who felt that patients overused or inappropriately used the program.[10] Other research points out that Medicaid clients often do not keep their appointments.[11]

Several national studies show that characteristics of the providers and their environment can influence their Medicaid participation rates. Providers who participate more in MA programs tend to:

- be general practitioners or belong to certain specialties, such as pediatrics,[12]
- have foreign medical degrees,[13]
- be younger and have spent fewer years in practice,[14] and

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8 Sloan, *et. al.*, "Physician Participation in State Medicaid Programs," 1978.

9 Mitchell and Schurman, "Access to Private Obstetrics-Gynecology Services Under Medicaid," 1984.

10 Dewey D. Garner, Winston C. Liao, and Thomas R. Sharpe, "Factors Affecting Physician Participation in a State Medicaid Program," *Medical Care* 17 (1979): 43-58.

11 For example, see Stephen M. Davidson, "Physician Participation in Medicaid: Background and Issues," *Journal of Health Politics, Policy and Law* 6 (1982): 703-717.

12 Sloan, et al., "Physician Participation in State Medicaid Programs," 1978.

13 Janet D. Perloff, Phillip R. Kletke, and Kathryn M. Neckerman, "Physicians' Decisions to Limit Medicaid Participation: Determinants and Policy Implications," *Journal of Health Politics, Policy and Law* 12 (1987): 221-251; Sloan, *et al.*, "Physician Participation in State Medicaid Programs," 1978.

14 W. Paul Lang and Jane A. Weintraub, "Comparison of Medicaid and Non-Medicaid Dental Providers," *Journal of Public Health Dentistry* 46(1986): 207-211.

- practice in nonmetropolitan or low income areas.[15]

For the most part, studies find that specialists tend to participate less than nonspecialists, such as general practitioners. The reason may be that specialty fields usually require more training and command higher fees, but Medicaid does not pay specialists more.

Some research has found that internists, obstetrician-gynecologists, and cardiologists have lower-than-average participation rates. For obstetricians, participation is lower because of high insurance rates and the difficulties of collecting reimbursement for lengthy treatments, such as prenatal care.[16] Pediatricians often participate at higher levels, perhaps because children's health is generally considered to be high priority.

According to national studies, physicians tend to participate more in Medicaid in non-metro and lower income areas with higher proportions of persons eligible for Medicaid.

SUMMARY

The Medicaid program is a joint state-federal program that pays for health care services provided to persons who would not otherwise be able to afford such care. The General Assistance Medical Care program is state funded and pays for a more restricted list of services provided to low-income persons who are not eligible for Medicaid.

The success of such medical care programs depends on the availability of health care providers who are willing to treat recipients. National studies indicate a trend among some types of providers toward limiting their MA participation or even declining to treat any MA patients. Providers cite low reimbursements and problems with program administration as the principal reasons for their withdrawal. In later chapters, we examine whether these factors limit access to MA in Minnesota.

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15 Kushman, "Physician Participation in Medicaid," 1977; Mitchell, "Medicaid Participation," 1983; Janet D. Perloff, Phillip R. Kletke, and Kathryn Neckerman, "Recent Trends in Pediatrician Participation in Medicaid," *Medical Care* 24 (1986): 749-760; and Perloff, *et al.*, "Physicians' Decisions to Limit Medicaid Participation," 1987.

16 Mitchell, "Medicaid Participation," 1983; Mitchell and Schurman, "Access to Private Obstetrics-Gynecology Services," 1984.

GENERAL ACCESS TO MEDICAL CARE

Chapter 2

Minnesota's Medical Assistance (MA or Medicaid) and General Assistance Medical Care (GAMC) programs paid for health services for over 450,000 people in fiscal year 1988. In this chapter, we examine access to Medicaid services around the state. We asked:

- **Do Medicaid recipients have difficulty finding needed health care services? If so, what types of access problems exist and how serious are they?**
- **Does access to health services for Medicaid recipients vary by location around the state?**
- **Do some groups have more difficulty than others getting health services under Medicaid?**

To address these questions, we conducted a survey of county MA financial supervisors as well as a survey of 41 persons providing services to MA recipients.

Briefly, there is no evidence that MA recipients are not receiving needed care. However, counties and advocacy groups report that some MA recipients have difficulty getting health care in some areas of the state. This is primarily due to a shortage of willing Medicaid providers. In particular, they reported it was difficult for MA and GAMC recipients to obtain dental services. Most of the people we talked to reported that some dentists are limiting or terminating their Medicaid participation because of dissatisfaction with reimbursement levels and with program administration.

ACCESS TO HEALTH SERVICES IN MINNESOTA

All hospitals in the state currently participate in the Medical Assistance program. As a result, MA recipients have access to emergency services through hospital emergency rooms. But the distribution of hospitals throughout the state may affect MA recipients' access to health care. Likewise, the distribution of willing office-based care providers is an important factor in access to daily health care. We discuss problems finding both hospital and office-based care below.

Rural Health Care

Medical resources are unevenly distributed in Minnesota.

Medical resources in Minnesota, as in the nation as a whole, are unevenly distributed. For example, there are about four times as many physicians per patient in Minnesota Standard Metropolitan Statistical Areas (SMSAs) as in non-SMSA counties.[1] Moreover, the situation is not improving. The number of primary care physicians per capita in rural areas decreased two percent between 1965 and 1985. Some rural counties, such as Wadena and Lake of the Woods, told us that they have too few providers, particularly specialists. The Medicaid program does not cause such shortages, but the shortages limit services for Medicaid patients as well as everyone else in the affected areas.

With recent hospital closings in some rural areas, health care resources are likely to concentrate in urban areas even further. Figure 2.1 shows that hospitals are sparsely distributed in some parts of the state. Cass County, for example, has no hospitals, and several other counties have only one.

Travel time required to reach the nearest hospital is an important aspect of access to emergency room care. Some researchers and health planners have proposed a standard of 30 minutes travel time as being reasonable access to hospitals.[2] From Figure 2.1, it appears that residents in a few areas may need to drive for more than 30 minutes to reach a hospital.

Several recent studies have noted problems for rural Minnesotans in getting access to needed health care.[3] The Department of Health is currently conducting a study of access to acute care services in rural Minnesota.

Access to Office-Based Care

We surveyed county Medicaid financial supervisors and asked whether MA recipients were able to receive needed health care. Officials from all 87 counties responded.

We also interviewed 41 advocates or others who serve Medical Assistance recipients. These individuals included legal and social advocates, health care providers, directors of public human service organizations, representatives of private social service organizations, and researchers. (See list in Appendix A.)

Overall:

- **Fifteen county welfare agencies report that public assistance recipients have serious difficulties finding willing providers of one or more health services.**

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1 Terry Dennis, "Changes in the Distribution of Physicians in Rural Areas of Minnesota, 1965-1985," *American Journal of Public Health* 78, No. 12 (December 1988), 1577.

2 Bosanac, et al., "Geographic Access to Hospital Care: A 30-Minute Travel Time Standard," 1976.

3 For example, Dave Giel and Michael Scandrett, *Report of the Minnesota Senate Task Force on Rural Health Care* (St. Paul, January 1988), and *Averting a Crisis in Rural Health Care* (St. Paul: Minnesota Medical Association, 1986.)

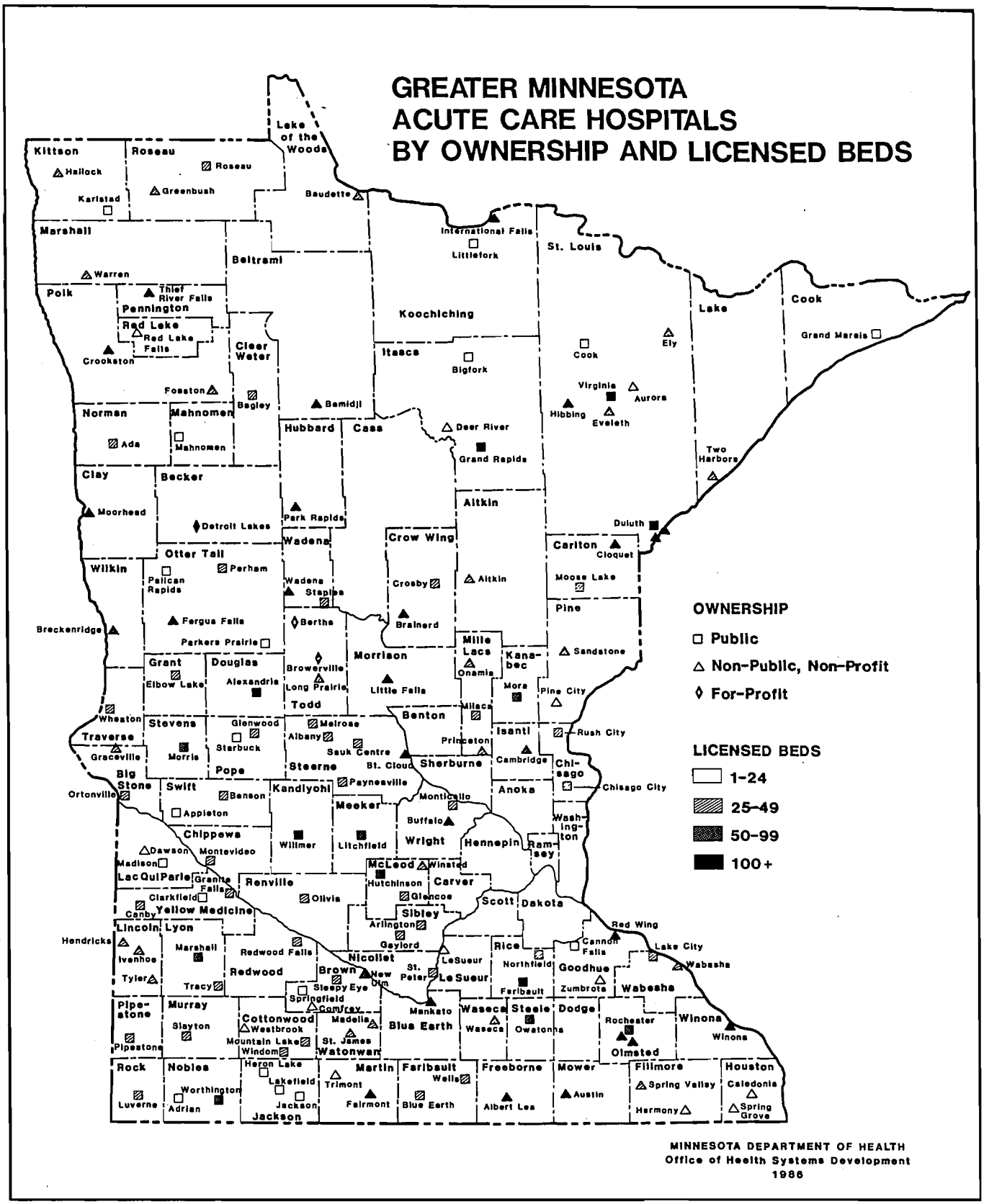
GREATER MINNESOTA
ACUTE CARE HOSPITALS
BY OWNERSHIP AND LICENSED BEDS
OWNERSHIP
Public
Non-Public, Non-Profit
For-Profit
LICENSED BEDS
1-24
25-49
50-99
100+
MINNESOTA DEPARTMENT OF HEALTH
Office of Health Systems Development
1986

Figure 2.1

- **More than a third of county agencies report that providers are either leaving or limiting their Medicaid participation.**

Some counties and advocacy groups report difficulties finding willing Medicaid providers.

Some county staff and advocates report that finding providers who will treat Medicaid recipients is difficult, and sometimes extra travel time is required. Counties and others gave examples of difficult access, including:

- A Hennepin County social worker receives calls almost daily from MA clients unable to find a dentist.
- A foster mother in Chisago County is unable to find a local dentist so she must drive 30 miles to St. Paul for her children's routine dental care.
- The Anoka County Community Health Department says it sometimes requires many phone calls to get prenatal services for pregnant women on Medicaid.
- A Hennepin County women's health clinic reported two recent cases of delayed prenatal care because the patients had trouble locating providers who would treat them. The same clinic reported MA patients whose prenatal care was interrupted when physicians at other clinics stopped treating them.

Despite these examples:

- **We found no evidence that recipients are unable to receive needed care.**

Access may be difficult, but recipients are able to receive care.

Currently, access in some cases may be difficult, but care is not impossible to find. However, many of those we interviewed believed that:

- **Finding Medicaid providers, particularly dentists, is becoming increasingly difficult.**

We asked counties reporting access problems how long they have existed. Fifteen counties reporting access problems said the problems have existed for two years or less. It appears that providers in some areas are terminating or limiting service in increasing numbers. Some respondents believe this decline in available providers is making it increasingly difficult for MA clients to find care.

GEOGRAPHIC AREAS REPORTING ACCESS PROBLEMS

County staff and recipient group advocates report that finding willing providers is difficult for MA recipients in three areas:

- The Twin Cities metro area.

- Northwestern Minnesota.
- A few southern Minnesota counties.

Almost all of the reported difficulty was in finding dental providers.

We found that almost all of the reported difficulty was in finding dental providers. Fourteen counties told us that dentists willing to serve Medicaid patients are very difficult to find. Six of those mentioned that GAMC patients, especially, have a hard time finding dental care. Eighteen other counties said dental care is fairly difficult to find. As shown in Figure 2.2, five metro area counties (Anoka, Carver, Chisago, Scott, and Washington) reported access to dental services as very difficult. Scott County officials said dentists are limiting the number of MA, and especially GAMC, patients they see. Sherburne County also reported very difficult access to dental care.

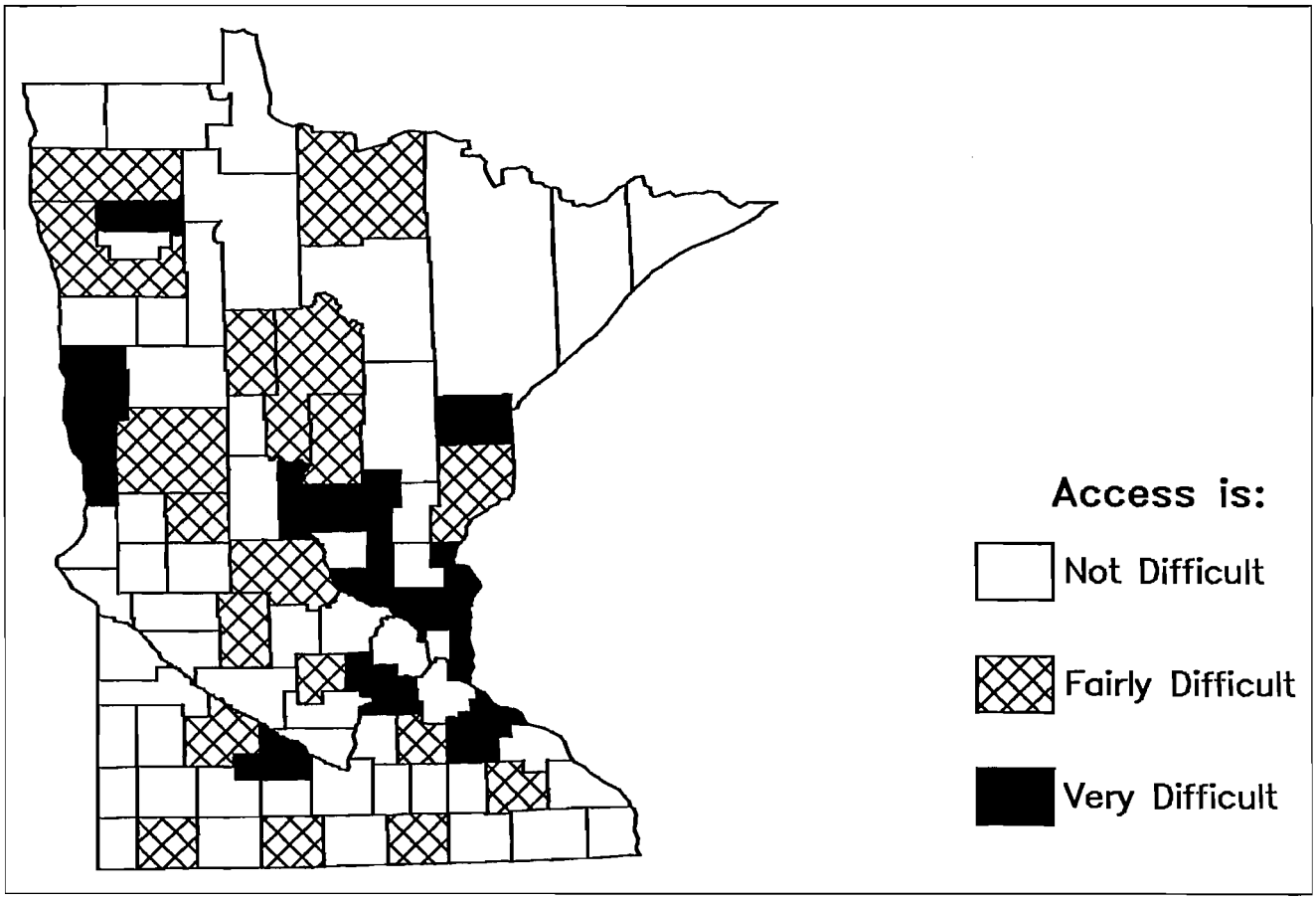

Figure 2.2: Access to Dental Care

Several counties in northwestern Minnesota reported difficult health care access, particularly for dentists. Polk, Clay, and Wilkin Counties all reported fairly serious problems finding dentists, and Pennington County reports a very serious problem. Wilkin, Clay, and Pennington Counties reported that providers are dissatisfied with Medicaid and GAMC and are terminating or limiting their participation. According to Wilkin County staff, only one den-

tist in Breckenridge takes GAMC and new MA patients, so some recipients must travel 25 miles to see a dentist.

Several recipient advocates and county administrators reported that access to dental services is a problem in certain areas of southern Minnesota, such as Freeborn County. They believe there are insufficient numbers of dentists in these areas to begin with and some will not see Medicaid or GAMC recipients.

Many of the advocates we talked to said that they have received increasing numbers of calls from Medicaid recipients seeking dental care. Many dentists will treat only established MA patients, and will not take GAMC patients at all. Several recipient advocates also suspect that dental access difficulties are underreported because, unlike much medical care, dental care can often be delayed, so clients may simply give up trying to locate a dentist who will treat them.

COUNTIES REPORTING VERY DIFFICULT DENTAL ACCESS

- Anoka
- Brown
- Carlton
- Carver
- Chisago
- Clay - GAMC only
- Goodhue - GAMC only
- Mille Lacs - GAMC only
- Morrison - GAMC only
- Pennington
- Scott - GAMC only
- Sherburne
- Washington
- Wilkin - GAMC only

COUNTIES REPORTING FAIRLY DIFFICULT DENTAL ACCESS

- Cass
- Crow Wing
- Douglas - GAMC only
- Freeborn - GAMC only
- Hubbard - GAMC only
- Kandiyohi
- Koochiching - GAMC only
- McLeod - GAMC only
- Marshall
- Martin
- Nobles
- Olmsted
- Otter Tail - GAMC only
- Pine
- Polk - GAMC only
- Redwood
- Rice
- Stearns

County officials, except in Anoka County, report little difficulty finding willing medical providers.

County officials reported much less difficulty finding access to other medical providers. However, Anoka County reported severe problems with access to virtually all types of providers. Recipient group advocates agree with this perception. The Anoka Community Health Department reported that several large clinics have either withdrawn from the MA program or are limiting their acceptance of new MA clients. A few clinics accept MA clients up to a maximum number and then refuse to see more. Apparently Anoka County recipients who cannot find care in Anoka County are going to clinics and providers in Hennepin County.

Sherburne County reported serious problems with access to family practitioners, obstetrician/gynecologists, and pediatricians, in addition to dentists.[4] Mille Lacs staff stated that access to pharmacies is a problem for GAMC recipients, and Lake County reported difficulties with mental health practitioners and chiropractors.

4 According to the AMA, as of December 31, 1985, Sherburne County had only one family practitioner and no OB/GYNs or pediatricians. The county is reportedly affected by several clinics in Anoka County limiting access.

RECIPIENT GROUPS AND ACCESS PROBLEMS

Many recipients have disabilities that complicate access.

We wanted to know if particular groups of public assistance recipients had unusual access problems because of provisions of the Medicaid or GAMC programs. We questioned county staff and recipient group advocates specifically about GAMC recipients, developmentally disabled, seniors, Southeast Asians, American Indians, mentally ill, physically disabled, and the homeless. Virtually every recipient group we asked about has a disability or a characteristic that complicates access to health services. In most cases, this disability or characteristic is also the reason the recipients qualify for Medical Assistance. If providers are unwilling to participate in Medical Assistance, it worsens a pre-existing access problem.

Developmentally disabled patients may have behavioral problems that discourage providers from treating them. Other groups, such as seniors and children covered by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, generally have fewer problems obtaining care, yet some advocates maintain that provider withdrawals endanger access for these groups as well. Homeless persons reportedly move frequently and have trouble finding medical, dental, and mental health care providers who will serve new MA and GAMC patients.[5]

We found that few of these groups experience problems directly caused by Medicaid or GAMC, although they may be compounded by a lack of willing providers. However, there are two groups that have experienced problems. GAMC recipients have problems finding providers because reimbursement rates are low, and mentally ill recipients reportedly have problems because of restrictions on program coverage.

Counties say access is more difficult for GAMC recipients.

According to our survey, General Assistance Medical Care recipients have problems getting the care they need. Twenty-one counties report access problems for particular groups. Of these 21 counties, 18 maintain that some dentists do not accept GAMC recipients because of GAMC's low reimbursement rates.[6] Several counties report that GAMC clients must go outside the county to find dental care.

According to some advocacy groups, mentally ill recipients face special difficulties obtaining mental health services. Many need long-term treatment,

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5 A February 1988 Wilder Research Center survey conducted in Minneapolis and St. Paul shelters confirms homeless people's dental problems. The survey found 48 percent of the homeless on MA said they needed dental treatment, and 43 percent of those who needed care had tried unsuccessfully to obtain it. Fewer (9 percent) reported that they had not been able to see a physician. Figures for the total sample are published in Greg Owen and Judith A. Williams, *Results of the Twin City Survey of Emergency Shelter Residents*, February 25, 1988 (St. Paul: Wilder Research Center, 1988).

6 GAMC reimbursement rates are the same as for Medicaid, but they are affected by various ratable reductions. Currently, mental health, chemical dependency, inpatient and outpatient hospitals have a 15 percent reduction, and most other providers have a five percent reduction from Medicaid rates.

and some psychiatrists are reportedly unwilling to take Medicaid patients because of the program's limits on outpatient treatment. Community clinic treatment, an alternative to private care, can involve long waiting periods.

EMERGENCY ROOMS AS OFFICE CARE SUBSTITUTES

Research studies have shown that when office-based services are difficult to find, patients may turn to hospital emergency rooms as substitutes.[7] We asked counties if, in their perception, Medical Assistance clients are using hospital emergency rooms as substitutes for office-based care.

Some county officials believe recipients misuse emergency rooms.

- **Officials in thirty-seven counties (44 percent) believed that Medical Assistance recipients in their county were using emergency rooms as substitutes for office care.**

About half of these counties (19) responded that the practice is at least somewhat widespread, though only four thought it is very widespread. As we will see in Chapter 4, Minnesota physicians believe this phenomenon is fairly widespread and a number offered suggestions to curb hospital emergency room misuse.

SUMMARY

In this chapter we examined Medical Assistance access problems reported by two groups: county MA supervisors and recipient group advocates. The two sources agreed on several points. Dental access is perceived to be difficult, though not impossible, in 32 counties, because many dentists are leaving or limiting their participation in the MA and GAMC programs. GAMC clients have a particularly hard time finding dental services. Counties and advocates also agree that access to physician services is less problematic, though prenatal care can be difficult to obtain.

Anoka County is perceived to have the most severe access problems, followed by other counties in and around the Twin Cities, Freeborn County in the south, and a few northwestern counties. The rural counties have shortages of providers, especially specialists, in addition to some problems with providers no longer seeing Medicaid patients.

According to recipient group advocates, access to health services is more difficult for disabled MA recipients, not because of Medical Assistance, but because they have conditions that impede access to health services. GAMC recipients and the mentally ill appear to have access problems more related to the design of the programs.

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7 See Stephen M. Davidson, "Understanding the Growth of Emergency Department Utilization," *Medical Care* 16, no. 2 (February 1978): 122-132.

DENTISTS' PARTICIPATION

Chapter 3

As we saw in Chapter 2, county welfare workers believe that it is sometimes difficult to find willing dental care providers in some parts of Minnesota. They believe this is, in part, because dentists are dropping out of the program or limiting the number of Medicaid patients they will see. In this chapter we examine in more detail dentists' participation in the Medical Assistance program. Specifically, we ask:

- **To what extent do dentists participate in the program, and how is dentists' participation level changing?**
- **What complaints do dentists have about the Medical Assistance program, and are their complaints justified?**
- **What reasons do dentists give for withdrawing from the program? What would encourage more dentists to participate?**

To answer these questions we surveyed a random sample of 726 dentists, examined the Department of Human Services claims processing computer files, and conducted telephone interviews with several dentists who had stopped accepting Medicaid patients. The survey methodology is described in the next section and the survey results are summarized in Appendix B.

HOW MANY DENTISTS PARTICIPATE?

Dentists' Participation

There are currently a total of about 2830 practicing dentists in the state. Unfortunately, there is no readily available source of information to determine how many dentists provide services under the Medicaid program. The Department of Human Services keeps track of the number of dental providers enrolled to participate in the program, but some enrolled dentists do not accept Medicaid clients, or in some way limit the number they will see.

Nonetheless, billing information is a rough gauge of the number of dentists participating around the state. Table 3.1 shows the number of dentists and dental clinics in each county that had billed the program for services between 1984 and 1987.

County	1984	1985	1986	1987
Aitkin	4	4	4	4
Anoka	72	76	74	68
Becker	7	7	8	8
Beltrami	13	12	11	11
Benton	9	8	8	8
Big Stone	4	4	3	2
Blue Earth	34	35	39	40
Brown	15	15	14	14
Carlton	17	18	17	17
Carver	15	16	16	15
Cass	8	8	8	8
Chippewa	6	6	6	6
Chisago	11	10	10	12
Clay	25	25	25	23
Clearwater	2	2	2	2
Cook	1	1	1	1
Cottonwood	6	8	7	8
Crow Wing	28	27	26	26
Dakota	93	96	99	98
Dodge	4	5	4	4
Douglas	17	19	18	17
Faribault	10	9	9	9
Fillmore	10	10	10	9
Freeborn	17	14	14	13
Goodhue	20	20	20	20
Grant	2	1	2	2
Hennepin	627	633	589	571
Houston	9	9	8	8
Hubbard	5	5	5	5
Isanti	7	8	8	7
Itasca	21	21	23	23
Jackson	3	4	4	4
Kanabec	7	7	8	8
Kandiyohi	24	25	24	24
Kittson	3	3	3	3
Koochiching	8	7	7	7
Lac Qui Parle	6	6	6	6
Lake	5	5	5	5
Lake of the Woods	1	1	1	0
LeSueur	12	11	11	12

Table 3.1: Number of Dentists and Dental Clinics Billing Medicaid, 1984-1987

County	1984	1985	1986	1987
Lincoln	3	4	4	4
Lyon	13	12	13	11
McLeod	17	17	19	18
Mahnomen	1	1	1	1
Marshall	2	2	2	1
Martin	11	11	9	9
Meeker	8	7	7	7
Mille Lacs	12	12	12	12
Morrison	9	9	10	10
Mower	21	20	18	21
Murray	3	3	3	3
Nicollet	11	12	10	11
Nobles	5	7	8	8
Norman	4	2	2	2
Olmsted	43	43	40	44
Ottertail	28	26	28	26
Pennington	10	9	9	9
Pine	7	7	7	7
Pipestone	6	6	6	6
Polk	16	14	14	15
Pope	3	4	4	4
Ramsey	285	289	264	254
Red Lake	4	4	4	4
Redwood	8	7	7	7
Renville	7	7	7	7
Rice	21	20	21	20
Rock	5	4	4	4
Roseau	4	4	4	6
Saint Louis	139	136	129	123
Scott	23	22	21	21
Sherburne	6	8	6	7
Sibley	6	6	6	7
Stearns	69	65	64	61
Steele	15	16	14	13
Stevens	5	5	5	4
Swift	6	6	6	6
Todd	8	7	7	7
Traverse	4	4	3	3
Wabasha	8	9	9	11
Wadena	8	7	7	7
Waseca	9	10	9	9
Washington	47	51	49	46
Watonwan	8	8	8	8
Wilkins	3	3	3	3
Winona	23	23	22	23
Wright	25	25	26	27
Yellow Medicine	6	6	7	7
Total	2,173	2,181	2,095	2,052

Table 3.1: Number of Dentists and Dental Clinics Billing Medicaid, 1984-1987, (continued)

According to DHS information, dentists' participation in the Medical Assistance program appears to have declined somewhat since the early 1980s. The decline in number of enrolled dentists occurred while the number of persons eligible for Medicaid has increased. As Figure 3.1 shows, this has increased the average number of eligible persons per dental provider. Whether or not the changes in the number of dentists has affected access is arguable, but it is worth noting that the trend in dentist participation is downward.

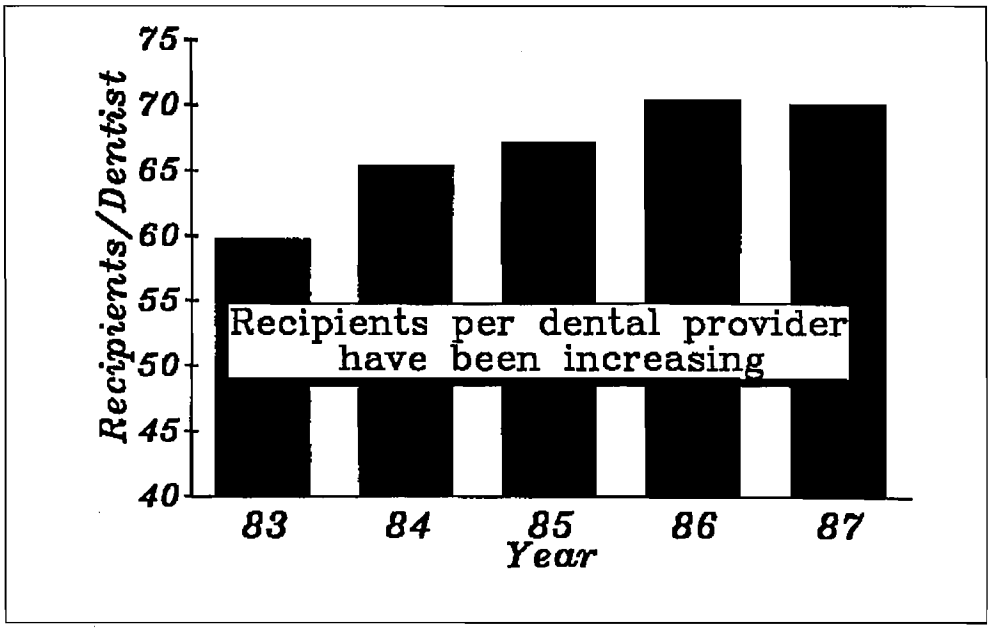

Figure 3.1: Increases in Recipients Per Dental Provider

Billing information suggests dentists may be limiting Medicaid services.

We also examined dental procedures paid by Medicaid to determine whether there had been noticeable changes over time. Table 3.2 shows how the number of billed procedures and the number of billed procedures per eligible recipient have changed over time.[1] In several counties fewer dental procedures are being billed to Medicaid, suggesting that in some areas dentists are limiting the services they provide and the numbers of MA patients they will see. The trend in the number of billed procedures is up in some other counties, suggesting that Medicaid recipients may be traveling to other counties to receive dental care.

In most of the counties reporting dental access problems to us the number of billed procedures per recipient went down between 1985 and 1987. For example, procedures per recipient went down 11.4 percent in Anoka County, 15.2 percent in Brown County, 8.4 percent in Carver County, 31.5 percent in Chisago County, and 18.9 percent in Washington County. In Sherburne and Pennington counties the number of procedures per recipient went up between 1985 and 1987 (1.8 percent in Sherburne and 13.2 percent in Pen-

1 The number of billed procedures does not include Medicare-crossover claims. Also, there are usually several billed procedures on each invoice submitted to DHS. The number of procedures billed in 1987 is approximately 98.4 percent of the total in-state procedures that will eventually be paid. Dentists have one year to bill Medicaid and not all claims attributable to 1987 had been paid at the time these calculations were made.

County	Number of Billed Procedures 1985	Average Recipients 1985	Procedures Per Recipient 1985	Number of Billed Procedures 1986	Average Recipients 1986	Procedures Per Recipient 1986	Number of Billed Procedures 1987	Average Recipients 1987	Procedures Per Recipient 1987	Percent Change Procedures Per Recipient 1985-1987
Aitkin	3,702	1,419	2.6	4,078	1,355	3.0	3,840	1,338	2.9	10.0%
Anoka	28,435	8,428	3.4	26,577	8,488	3.1	25,309	8,470	3.0	-11.4
Becker	6,329	2,970	2.1	7,613	2,947	2.6	7,851	3,106	2.5	18.6
Beltrami	11,033	4,398	2.5	12,532	4,678	2.7	12,963	4,946	2.6	4.5
Benton	4,188	1,722	2.4	4,372	1,737	2.5	3,637	1,763	2.1	-15.2
Big Stone	1,401	512	2.7	1,495	495	3.0	1,682	522	3.2	17.8
Blue Earth	14,683	2,813	5.2	17,448	3,254	5.4	19,114	3,284	5.8	11.5
Brown	3,697	1,222	3.0	3,389	1,254	2.7	3,329	1,298	2.6	-15.2
Carlton	11,718	2,862	4.1	12,167	2,761	4.4	10,894	2,650	4.1	0.4
Carver	3,124	1,071	2.9	3,316	1,122	3.0	3,091	1,157	2.7	-8.4
Cass	6,102	3,013	2.0	6,198	3,011	2.1	5,606	2,959	1.9	-6.5
Chippewa	2,229	751	3.0	2,261	756	3.0	2,381	798	3.0	0.5
Chisago	4,136	1,575	2.6	4,280	1,594	2.7	2,826	1,570	1.8	-31.5
Clay	12,441	3,205	3.9	15,149	3,358	4.5	14,933	3,260	4.6	18.0
Clearwater	2,802	1,323	2.1	2,826	1,294	2.2	3,523	1,323	2.7	25.7
Cook	68	249	0.3	55	234	0.2	78	222	0.4	28.7
Cottonwood	3,054	724	4.2	4,074	758	5.4	3,603	768	4.7	11.2
Crow Wing	13,071	4,123	3.2	14,648	4,093	3.6	16,002	4,150	3.9	21.6
Dakota*	25,308	6,570	NA	20,188	7,022	NA	12,593	7,378	NA	NA
Dodge	1,479	750	2.0	1,709	761	2.2	1,734	741	2.3	18.7
Douglas	7,579	1,679	4.5	10,376	1,818	5.7	10,009	1,832	5.5	21.0
Faribault	4,648	1,163	4.0	5,054	1,154	4.4	4,961	1,126	4.4	10.2
Fillmore	3,071	1,388	2.2	3,429	1,438	2.4	4,108	1,348	3.0	37.7
Freeborn	6,294	2,129	3.0	6,784	2,108	3.2	6,100	2,084	2.9	-1.0
Goodhue	5,104	1,919	2.7	5,112	1,940	2.6	6,120	1,924	3.2	19.6
Grant	678	402	1.7	859	409	2.1	834	421	2.0	17.5
Hennepin*	225,854	61,326	NA	216,003	63,854	NA	189,878	65,080	NA	NA
Houston	2,806	940	3.0	3,083	946	3.3	2,182	948	2.3	-22.9
Hubbard	3,480	1,675	2.1	3,439	1,487	2.3	3,356	1,627	2.1	-0.7
Isanti	4,691	1,569	3.0	5,678	1,630	3.5	5,283	1,593	3.3	10.9
Itasca*	12,139	4,912	NA	4,802	4,948	NA	5,869	5,450	NA	NA
Jackson	1,828	778	2.3	2,296	936	2.5	3,124	1,106	2.8	20.2
Kanabec	3,397	931	3.6	4,430	1,029	4.3	4,197	1,108	3.8	3.8
Kandiyohi	13,695	2,860	4.8	15,950	3,063	5.2	16,170	3,504	4.6	-3.6
Kittson	913	450	2.0	867	440	2.0	823	460	1.8	-11.8
Koochiching	4,791	1,627	2.9	5,771	1,679	3.4	5,394	1,848	2.9	-0.9
Lac Qui Parle	1,369	470	2.9	1,598	485	3.3	1,515	534	2.8	-2.6
Lake	2,057	895	2.3	2,007	827	2.4	1,819	808	2.3	-2.0
Lake of the Woods	65	299	0.2	11	294	0.0		311	0.0	-100.0
LeSueur	3,638	1,266	2.9	4,246	1,317	3.2	3,457	1,391	2.5	-13.5
Lincoln	887	472	1.9	1,145	482	2.4	1,118	538	2.1	10.6
Lyon	4,424	1,589	2.8	4,932	1,608	3.1	5,161	1,792	2.9	3.4
McLeod	4,480	1,230	3.6	4,305	1,232	3.5	4,369	1,327	3.3	-9.6
Mahnomen	899	769	1.2	711	784	0.9	946	770	1.2	5.1
Marshall	385	637	0.6	420	624	0.7	396	667	0.6	-1.8
Martin	3,485	1,216	2.9	3,331	1,266	2.6	3,636	1,468	2.5	-13.6
Meeker	2,375	1,187	2.0	2,764	1,227	2.3	2,653	1,358	2.0	-2.4
Mille Lacs	5,291	1,680	3.1	5,950	1,810	3.3	5,536	1,960	2.8	-10.3

*There is a lower number of billed procedures in 1986 and 1987 because the county participated in the Medicaid Prepaid Demonstration Project.

Table 3.2: Number of Dental Procedures, Average Recipients, Average Dental Procedures per Recipient, 1985-1987

County	Number of Billed Procedures 1985	Average Recipients 1985	Procedures Per Recipient 1985	Number of Billed Procedures 1986	Average Recipients 1986	Procedures Per Recipient 1986	Number of Billed Procedures 1987	Average Recipients 1987	Procedures Per Recipient 1987	Percent Change Procedures Per Recipient 1985-1987
Morrison	7,421	2,533	2.9	6,992	2,344	3.0	7,300	2,351	3.1	6.0%
Mower	12,002	2,603	4.6	12,350	2,734	4.5	14,223	2,944	4.8	4.8
Murray	1,123	652	1.7	1,295	681	1.9	1,006	628	1.6	-7.0
Nicollet	4,967	1,070	4.6	5,563	1,086	5.1	4,748	1,266	3.8	-19.2
Nobles	2,784	1,227	2.3	3,456	1,263	2.7	3,346	1,345	2.5	9.6
Norman	1,262	543	2.3	1,434	537	2.7	1,128	562	2.0	-13.6
Olmsted	18,252	3,858	4.7	18,531	4,258	4.4	20,586	4,892	4.2	-11.1
Ottertail	12,600	3,416	3.7	12,789	3,526	3.6	14,264	3,871	3.7	-0.1
Pennington	5,000	1,076	4.6	7,274	1,175	6.2	6,599	1,255	5.3	13.2
Pine	4,856	2,048	2.4	5,487	1,996	2.7	4,776	2,229	2.1	-9.6
Pipestone	2,250	618	3.6	2,389	647	3.7	1,956	746	2.6	-28.0
Polk	6,995	3,177	2.2	7,710	3,285	2.3	8,462	3,742	2.3	2.7
Pope	1,874	736	2.5	2,937	822	3.6	2,799	884	3.2	24.4
Ramsey	152,499	37,633	4.1	144,195	38,206	3.8	134,756	42,157	3.2	-21.1
Red Lake	1,694	332	5.1	2,059	356	5.8	2,294	396	5.8	13.5
Redwood	2,826	892	3.2	2,922	922	3.2	2,814	971	2.9	-8.5
Renville	1,879	920	2.0	1,896	955	2.0	2,129	1,055	2.0	-1.2
Rice	5,580	2,016	2.8	5,651	2,032	2.8	5,218	2,229	2.3	-15.4
Rock	861	384	2.2	952	431	2.2	1,079	476	2.3	1.1
Roseau	1,464	661	2.2	2,054	675	3.0	2,203	725	3.0	37.2
St. Louis	86,658	22,976	3.8	91,264	23,015	4.0	89,063	23,921	3.7	-1.3
Scott	6,405	1,456	4.4	6,138	1,467	4.2	5,727	1,493	3.8	-12.8
Sherburne	3,514	1,719	2.0	3,584	1,583	2.3	3,411	1,639	2.1	1.8
Sibley	1,409	673	2.1	1,658	680	2.4	1,367	687	2.0	-5.0
Stearns	31,802	5,170	6.2	32,023	5,225	6.1	31,148	5,539	5.6	-8.6
Steele	5,396	1,095	4.9	5,861	1,117	5.2	5,439	1,226	4.4	-10.0
Stevens	2,095	499	4.2	1,824	583	3.1	1,705	655	2.6	-38.0
Swift	3,032	854	3.6	3,472	870	4.0	3,278	955	3.4	-3.3
Todd	9,423	2,160	4.4	9,352	2,159	4.3	10,890	2,330	4.7	7.1
Traverse	2,453	327	7.5	2,582	346	7.5	2,367	385	6.1	-18.0
Wabasha	4,549	1,107	4.1	4,143	1,519	2.7	3,842	1,102	3.5	-15.2
Wadena	8,310	1,538	5.4	9,851	1,635	6.0	10,192	1,785	5.7	5.7
Waseca	2,787	972	2.9	2,761	1,048	2.6	3,029	1,070	2.8	-1.3
Washington	13,147	3,960	3.3	13,819	4,040	3.4	12,137	4,509	2.7	-18.9
Watonwan	2,856	649	4.4	3,235	742	4.4	3,126	797	3.9	-10.9
Wilkin	145	521	0.3	220	518	0.4	249	565	0.4	58.4
Winona	10,615	2,428	4.4	10,143	2,487	4.1	9,399	2,519	3.7	-14.7
Wright	9,868	2,864	3.4	8,254	2,864	2.9	8,430	3,097	2.7	-21.0
Yellow Medicine	2,771	706	3.9	3,092	736	4.2	3,364	854	3.9	0.4
MINNESOTA	944,747	265,227	3.6	950,940	272,372	3.5	903,852	285,938	3.3	-7.6%
North Dakota	4,461			4,156			3,723			
South Dakota	603			743			926			
Iowa	489			452			650			
Wisconsin	2,415						2,604			
East of Mississippi	533						12			
West of Mississippi	1,649						96			
Total	954,897	265,227	3.6	956,291	272,372	3.5	950,940	285,938	3.3	-7.6%

Table 3.2: Number of Dental Procedures, Average Recipients, Average Dental Procedures per Recipient, 1985-1987, (continued)

nington), although the trend was down in both counties between 1986 and 1987.

We conclude:

- **Dentists' participation in the Medicaid program has declined.**

Extent of Participation

We surveyed a representative sample of 726 dentists to find out more about the extent of their participation and about problems they perceive with the program.[2] We asked dentists if they participated in the Medicaid program. We found:

- **82 percent of dentists said they were currently participating in the program.**
- **15 percent of dentists said they used to participate in the program but have dropped out.**
- **3 percent of dentists said they have never participated in the Medicaid program.**

Since we wanted to know the extent of dentists' participation, we asked the 82 percent who saw some Medicaid patients if they limited their participation in any way. We found:

Only 30 percent of dentists see all Medicaid patients.

- **Almost two-thirds of the dentists who see some Medicaid patients said that they limit the number they see.**

As Figure 3.2 shows, this means that of all dentists surveyed only about 30 percent see all Medicaid patients desiring services (*full participants*), 52 percent see some (*limiters*), and 18 percent see none.

2 We sent surveys to 1,020 dentists selected at random from a list of 2,832 dentists the Minnesota Board of Dentistry believed to be actively practicing in Minnesota. We stratified the list by zip code so dentists around the state received surveys in proportion to the number licensed in each geographic area. We received 726 useable responses for a response rate of 71 percent. There is one chance in 20 that the sample is not representative of licensed dentists actively practicing in the state. We are 95 percent confident that the survey results accurately reflect dentists' opinions on a statewide basis within 4 percentage points of the reported numbers. We excluded "do not know" responses in calculating the percentages reported in this chapter. Raw totals of responses and percentages are reported in Appendix B.

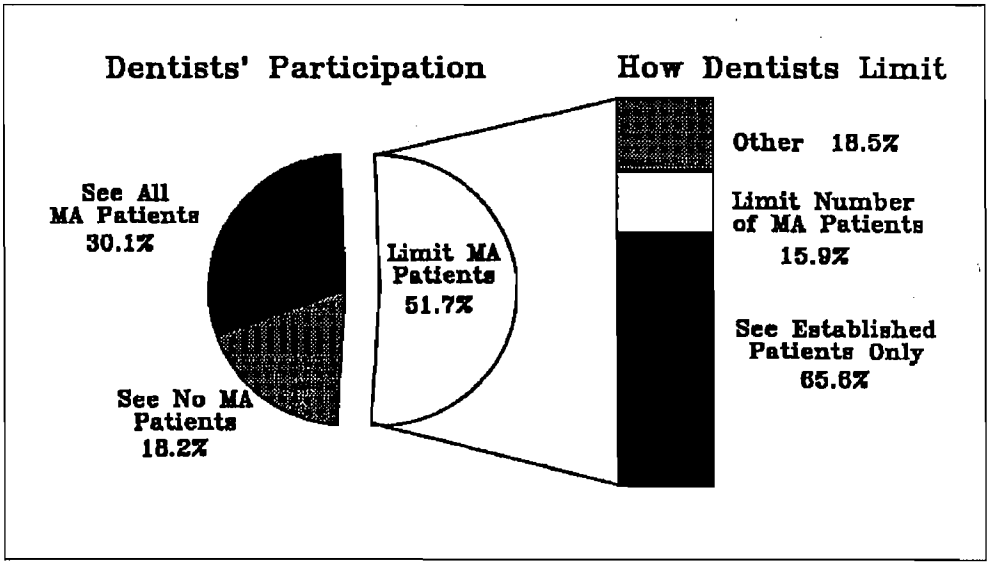

Figure 3.2: Extent of Dentists' Participation in Medicaid

Dentists most frequently limit services by seeing only established patients. (See Figure 3.2) These *limiters* refer new Medicaid patients elsewhere, although they could see them.[3] Over 86 percent of dentists reported receiving phone calls from patients turned away by other providers. Over 96 percent of dentists reported that their practices were not at capacity and that they could accept new patients. So, it appears that dental providers drop or limit Medicaid patients even though they do not have other patients to replace the Medicaid business they turn down. This implies that a significant number of dentists believe problems with the Medicaid program or with Medicaid patients outweigh the benefit to be gained from a larger practice.

Overall, Medicaid patients made up about nine percent of the patients seen by dentists surveyed. The number of Medicaid patients in dental practices varies as one might expect. *Fully participating* dentists estimated that about 13 percent of their patients were Medicaid recipients, and *limiters* estimated that about 6 percent of their patients received Medicaid. Dental specialists estimated that about nine percent of their patients received Medicaid.

We asked dentists about their plans for Medicaid participation in 1989. Overall, about 50 percent of dentists said they would like to see fewer Medicaid patients, 44 percent said they would like to see about the same number, and 6 percent said they would like to see more. As Table 3.3 shows, the responses parallel dentists' current attitudes about the program. Limiting dentists were more likely to say they would like to see fewer Medicaid patients in the future (58 percent), compared with dentists who now see all Medicaid patients (40 percent).

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3 The Department of Human Services points out that MA providers' right to limit services is not absolute. *Minn. Rules* Part 9505.0195 states in part: "A provider shall not place restrictions or criteria on the services it will make available, the type of health conditions it will accept, or the persons it will accept for care or treatment, unless the provider applies those restrictions to all individuals seeking the provider's services."

Like to Change Number of MA Patients Seen*	All Dentists		Full Participants		Limiters	
	Number	Percent	Number	Percent	Number	Percent**
No - same number	250	43.5%	106	50.2%	138	38.8%
Yes - fewer	291	50.6	84	39.8	205	57.6
Yes - More	34	5.9	21	10.0	13	3.7

*The exact survey question read "Would you like to change the number of Medical Assistance patients you see?"

**Does not total 100 due to rounding.

Table 3.3: Number of Medicaid Patients Dentists Would Like to See

As Table 3.4 shows, *limiting* dentists were far more likely to say they would end participation in the program in 1989, or only treat current patients, compared with dentists who now accept all Medicaid patients. Metro area dentists were also more likely than non-metro area dentists to say they would end participation (24 percent metro vs. 13 percent non-metro) and less likely to say they would see new patients (27 percent metro vs. 42 percent non-metro).

- **Significantly, 19 percent of all dentists said they would end Medicaid participation in 1989, and only 34 percent reported they would continue to accept new patients as time allowed.**

Practice Plans for 1989	All Dentists		Full Participation		Limiters		Metro		Non-Metro	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent*	Number	Percent
Accept new patients as time permits	220	33.9%	166	79.8%	47	12.9%	96	27.3%	119	42.5%
Treat current patients, but not new patients	304	46.8	30	14.4	256	70.1	172	48.9	124	44.3
Terminate participation	125	19.3	12	5.8	62	17.0	84	23.9	37	13.2

*Does not total 100 due to rounding.

Table 3.4: Dentists' Medicaid Practice Plans for 1989

If this actually occurs, access to dental care for public assistance recipients would get more difficult. It would mean that 26 percent of all dentists would not accept any Medicaid patients, 50 percent would accept only some Medicaid patients, and only 24 percent would continue to see all Medicaid patients.

Reasons Dentists Withdraw

We asked those survey respondents who said they had quit the program to tell us the major factors that lead to their decision. Almost 83 percent blamed low

reimbursement, 23 percent mentioned the paperwork burden, and over 20 percent mentioned the nature of MA patients.[4]

Dentists quit because of pay, paperwork, and patients.

We also talked privately with several dentists about their reasons for withdrawing from Medicaid and what might make them re-enroll in the program. Most dropped out of the program primarily because of reimbursement levels. However, they said it would take more than slightly increased rates for them to re-enroll. These ex-providers also cited other problems such as claims red tape, slow payment, a lack of respect and cooperation from DHS, and unreliable and abusive patients.

DENTIST PERCEPTIONS OF MEDICAID

In this section we examine dentists' perceptions and complaints about the Medicaid program. Undoubtedly, dentists base their Medicaid participation decisions on their perceptions of the way Medicaid interacts with their dental practice.

We found that dentists are almost uniformly dissatisfied with the Medicaid program. Dentists' complaints fall into three general areas:

- reimbursement rates,
- administrative problems including payment, claims handling, and provider relations, and
- the Medicaid patients themselves.

Dentists Think Medicaid Payments are Too Low

Over 86 percent of dentists think Medicaid payments do not cover their costs.

The most persistent complaint of dentists and other providers is that the payment offered by the MA program is too low. Only three percent of the dentists we surveyed thought that reimbursement levels were reasonable overall. Over 90 percent agreed that payments were too low for certain procedures. As Figure 3.3 shows, over 86 percent disagreed that Medicaid payments generally covered their costs.

The most often cited reason dentists gave for not seeing Medicaid patients was that reimbursement levels were low. Dentists said that lower reimbursement amounts would make them see fewer or no Medicaid patients. Even dentists in the group that saw all Medicaid patients were critical of the reimbursement level, although less so than other dentists.

In comments written on the survey form, many dentists vented their anger about reimbursement levels. Over 83 percent of dentists who commented volunteered something about low payment amounts.

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4 Percentages do not total 100 because some dentists had more than one reason for quitting.

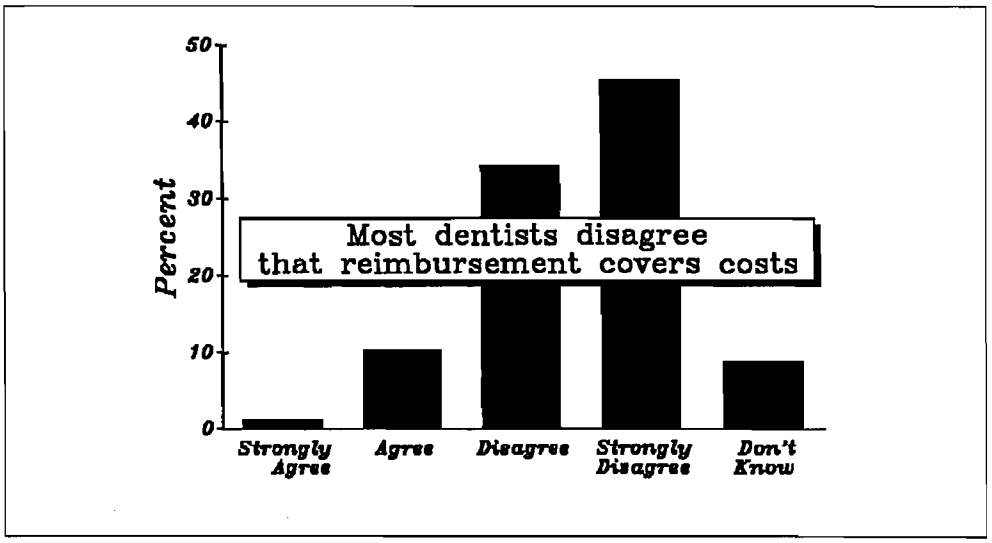

Figure 3.3: Dentists' Attitude Toward Medicaid Reimbursement

Some typical dentist comments were:

- "Health care providers are severely discriminated against compared to other recipients of welfare dollars - e.g., (those who sell) food, clothes, etc. Those providers don't discount their prices."
- "All taxpayers should pay the costs of the program. Don't expect the dental/medical provider to pay more."
- "Do you prior authorize grocery purchases, make the grocer sell at a price less than his purchase price, and then make him wait ... for payment?"

Many dentists proposed ways of dealing with the reimbursement question. A suggestion made by several was to set priorities for care, by the recipients of dental services (e.g., children and elderly) or by the types of services available (e.g., preventative and emergency) and to pay more. Others suggested alternative providers such as state or county-run clinics and the University of Minnesota dental school.

Dentists are Dissatisfied With Medicaid Administration

Most dentists are critical of the paperwork burden.

Most dentists we surveyed were critical of the way the Department of Human Services processed their claims for payment. Dentists' three main concerns were:

- Paperwork and claims handling.
- Provider relations.

- Medicaid dental policy.

Paperwork and Claims Handling

The Department of Human Services has a very difficult job processing the large number of requests for reimbursement. Dentists account for about 270,000 of the over 10 million claims paid by Medicaid each year. Many of the claims contain multiple procedures performed for a recipient.

We asked dentists several questions about Medicaid administration in our survey. When asked to make judgements about Medicaid compared to their experiences with other third party payors:

- **35 percent of dentists thought Medicaid administrative requirements were generally reasonable.**

- **40 percent of dentists said payments are usually received within 30 days of submitting an invoice.**

- **54 percent of dentists said that Medicaid invoices were difficult to fill out correctly.**

More than 27 percent of the written comments on the survey dealt with the efficiency of Medicaid's administrative process. Some typical comments were:

- "The MA ... administration treats us like dogs, makes us submit and resubmit for ridiculously low fees... harass us endlessly with petty paperwork details; is uncooperative and makes us wait 90-180 days for payment."

- "Payments sometimes take months to come back and are too often returned 'suspended'. Prior authorization takes too long. Patients are left hanging. ... Policies do not take into account that all dental problems do not fit a code number and sometimes require special handling."

- "One month we submitted claims on forms which you provided and they were then rejected for being the wrong color. Also, claims have been rejected when 1 number or letter is out of the box but perfectly legible. Also rejected if corrections are made on form. This is insane! If this happens again, you'll have one less provider in (this) county."

Provider Relations

Dentists complained about DHS's lack of responsiveness.

Many dentists complain about the lack of responsiveness from the Department of Human Services in dealing with problems encountered in claims processing and in prior authorizations. Dentists frequently commented that DHS shuffled their phone calls around the department, put them on hold for long periods, and often did not answer their questions. Some dentists complained about the unavailability of training and about the quality and clarity of the department's communication with them. Twelve percent of written com-

ments mentioned communications, instruction, and training. Some typical comments were:

- "When the current (administrative) changes came through, we were informed about them 2-3 months later."
- "It is very difficult to get a straight, concise answer from MA administration office on what is covered under the MA dental plans and what is not."

However, overall,

- **46 percent of dentists thought the state communicated program requirements well.**

Medicaid Policy Questions

The goal of Medicaid dental policies is to provide the least costly acceptable service for all medically necessary conditions. However, many dentists had problems with the department's policies on what types of services it will pay for. For example, many dentists objected to Medicaid not paying for many cast metal restorations such as crowns and bridges. Many dentists thought that the department's dental policies were not up-to-date with current dental practice. More than 24 percent of dentists' written comments addressed problems with prior authorization or treatment guidelines. Many also had difficulty with the department's dental advisors who review and decide on dental prior authorizations.

Some typical dentist comments were:

- "Drop prior authorization requirements for removable prosthodontics."
- "...cover more procedures that can enable recipients to maintain their level of oral health by today's standards."
- "...if periodontal treatment, such as scaling and root planing, was reimbursed at a level more in line with the...time needed to do a good treatment, more patients would recieve periodontal treatment and need less prosthetic treatment."
- "If MA approves orthodontic treatment it should pay all at once. Even if I agree to accept 60 percent of my usual fee for an MA patient, I can still be forced to accept even less when payment stops due to the patient becoming ineligible. Payment stops but the treatment must continue."

DHS has not been proactive in communicating with providers.

Many dentists also complained that Medicaid should cover the cost of sealants, apparently unaware that sealants have been covered since May 1988. This complaint and other similar ones suggest that the department has done a poor job in disseminating information about the dental coverages and policies of the program. In fact, the department acknowledges that it has not been

proactive in communicating with providers, and it is taking several steps to remedy the situation. The department has issued a new provider manual that pulls together all policies into one easy-to-update format. The department also plans to reactivate a dental advisory committee to help keep in better touch with the dental provider community and to gauge changes in dental practice.

Prior authorization is required for many dental procedures. Prior authorization requires that the dentist justify the medical necessity of performing the service in question. Overall:

- **55.1 percent thought that the list of services requiring prior authorization was reasonable.**
- **39.7 percent thought DHS processed the prior authorization requests promptly.**
- **44.7 percent thought that the criteria used for prior authorization were appropriate.**

Medicaid Patients

Dentists maintain that Medicaid patients are more costly and difficult to treat.

Dentists' attitudes about participating in the Medicaid program are flavored by characteristics of the Medicaid patients themselves. In particular, dentists consistently noted that Medicaid patients were more costly to serve. Almost 93 percent of dentists said that Medicaid patients fail to show up for appointments more often than others. More than 24 percent of dentists who wrote comments complained that MA patients were often abusive, unappreciative, and irresponsible. Many suggested tightening eligibility requirements, educating patients about oral hygiene and other responsibilities, and requiring patients to pay for missed appointments.

Over half of the dentists surveyed felt that Medicaid patients were more difficult to treat than other patients. These dentists felt that Medicaid patients had poorer oral health to begin with and did not follow instructions about proper oral health procedures. Some dentists also noted that certain Medicaid patients have disabilities that make treatment inherently more difficult and costly.

In summary, most dentists were critical of Medicaid payment levels. Many dentists also were critical of the department's administration of the program compared with their treatment by other third party payors. Those dentists who are full participants in the program (who see all MA patients) are more positive about the department's performance than those who have limited the number of MA clients or withdrawn from the program. Dentists also maintain that Medicaid recipients are more difficult and costly to serve than their other patients.

ARE DENTIST COMPLAINTS JUSTIFIED?

Dentists' most frequent and strongly felt opinion was that reimbursement rates were too low. The second area dentists consistently complained about was the Department of Human Services' administration of the program. In this section we examine the validity of these complaints.

Reimbursement Rates

The Legislature limited Medicaid reimbursement sharply during the 1981 legislative session. The base year for calculating rates was frozen at 1979 levels. Before this time Medicaid paid up to the previous year's median of all providers' charges for a particular procedure.

In 1985 the Legislature changed the base year for calculating reimbursement rates from 1979 to 1982, and it decreased rates five percent across the board in 1987. In 1988, the Legislature rescinded the five percent cut, and removed the usual and customary fee restriction as of July 1989.

What Percentage of Charges are Dentists Paid?

Dentists say their average overhead costs are 60 percent of charges.

We did not set out in this study to determine what the appropriate amount of payment for dentists should be. However, we did want to examine dentists' claims that Medicaid reimbursement did not cover their costs. The Minnesota Dental Association has estimated that the average cost of services (before the dentist's compensation) for most providers is about 60 percent of their charges. Several dentists have testified that their reimbursement from Medicaid was less than their overhead costs. Some providers have maintained that Medicaid payments are as low as 50 percent of their charges.

Figure 3.4 shows the percent of total charges paid over time by Medicaid for a group of frequently billed dental procedures. The figure shows the average

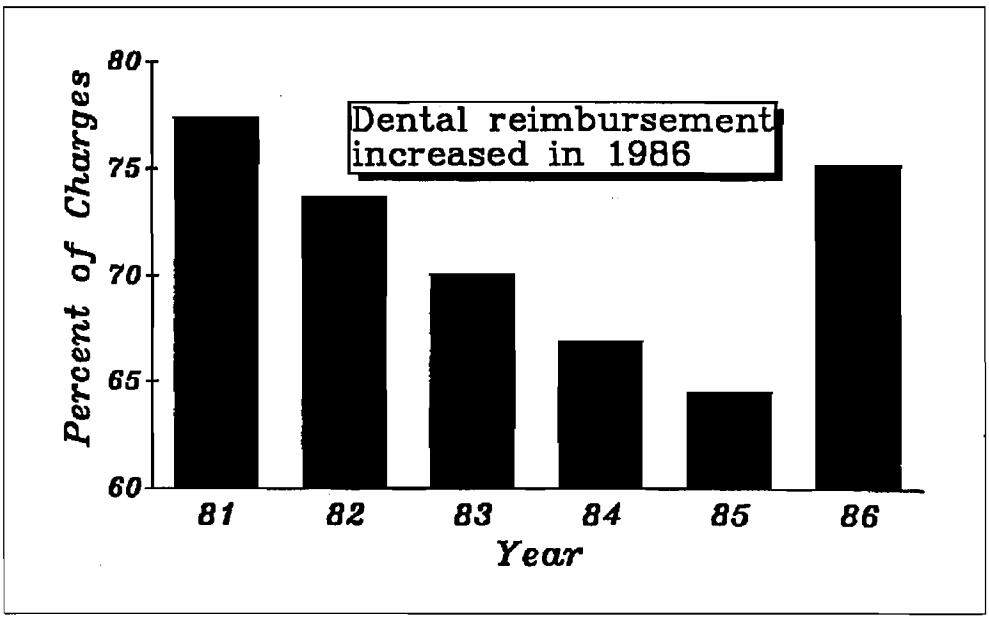

Figure 3.4: Change in Dental Reimbursement

payment-to-charge ratio declined between 1981 and 1985 because inflation drove up dental charges and Medicaid payment remained constant. Because of a November 1985 change in the base year for calculating rates, the percentage of dentists' submitted charges paid by Medicaid jumped to about 75 percent in 1986. It is worth noting that:

- **Dentists' Medicaid payments on average did not fall below what they report as their overhead costs.**

While this tells what the overall average is, it does not tell us the average level for a particular provider, or how much variation there is among providers.

Because dentists discuss reimbursement in terms of average overhead costs as a percentage of their charges, we also examined reimbursement in this way.[5] To determine how Medicaid reimbursement affects dental providers, we summarized all the non-Medicare dental claims paid by Medicaid for four years, and we calculated the average percent of individual dentists' charges paid.

Medicaid paid 71.6 percent of dentists' charges--more on average than what dentists said their overhead costs were.

Table 3.5 shows that, on average:

- **Medicaid paid dentists 71.6 percent of their submitted charges in 1987 -- more than the 60 percent of charges many dentists say is their office overhead.**

However, the table also shows there is a lot of variation in the percentage of charges that are paid. For example, Medicaid pays outstate dentists a higher percentage of their charges than dentists in the seven-county metro area. Most likely, dentists in the metropolitan area bill more for their services, but Medicaid pays them the same as their out-state peers.[6]

We also examined charges for the 12 percent of dentists whose average payment-to-charge ratio was less than 60 percent. We expected to find that many

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5 When providers talk about their overhead costs, they are invariably speaking about average costs. However, this is probably not the best way to analyze costs. In the short run, the relevant cost to consider for decision making is the marginal cost. That is, in the case of Medicaid patients, what additional costs are associated with serving Medicaid patients? Thus, from an economic standpoint, Medicaid providers (assuming they are not operating at capacity) should compare the marginal benefits (Medicaid payments) from serving Medicaid patients with the additional costs. If the marginal benefits are greater than the marginal costs, then Medicaid patients are contributing to paying the provider's fixed costs. Thus, from an economic point of view the provider should continue to serve MA patients. There are several complications in applying this analysis to medical providers serving Medicaid patients. First, many providers do not know the fixed and variable cost components of their practices. Therefore, they use the average cost as an estimate. Second, many providers claim Medicaid patients are more difficult and clostly to treat than other patients. As a result, they may feel less inclined to accept discounted reimbursement rates for these patients. Third, the higher the proportion of Medicaid patients in a provider's practice the closer the average and marginal costs. Thus, for providers seeing a higher percentage of Medicaid patients, there is less ability to pass on costs to their other patients.

6 It is possible that metro-area dentists perform a different mix of procedures than non-metro dentists.

Average Percent of Charges Paid	Number of Dental Billing Sources							
	1984		1985		1986		1987	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
0-50%	83	3.5%	133	5.6%	40	1.8%	74	3.4%
50-60	397	16.9	457	19.4	122	5.4	187	8.5
60-70	910	38.8	891	37.8	445	19.7	598	27.2
70-80	582	24.8	529	22.4	799	35.4	756	34.4
80-90	192	8.2	171	7.2	570	25.2	391	17.8
90-100	119	5.1	113	4.8	222	9.8	146	6.7
100	64	2.7	66	2.8	62	2.7	43	2.0
Total	2,347	100.0%	2,360	100.0%	2,260	100.0%	2,195	100.0%
Overall Average		66.4%		65.7%		74.7%		71.6%
Metro Average		63.5		62.1		70.6		67.0
Non-Metro Average		69.5		69.2		78.6		75.5
Out-of-State		71.1		68.2		74.6		69.2

Table 3.5: Percent of Dentists' Submitted Charges Paid by Medicaid

of those were affected by the usual and customary reduction.[7] However, we found no relationship between the percentage of submitted charges paid by Medicaid and the usual and customary reduction. In fact, the usual and customary reduction as a percent of total Medicaid payments tends to be higher outside the seven-county metro area where the average payment-to-submitted charge ratio is also higher. We do not know exactly why these dentists are paid a lower percentage of their charges. They could just be billing more than their peers for the same procedures, they could be reflecting higher costs in their rates, or their practices could be billing for procedures that Medicaid pays relatively less for. As we discuss in Chapter 5, we believe some of these anomalies are explained by problems with the department's list of allowable prices for services. This is clearly an issue that deserves further study.

How Do Private Insurance and Medicaid Payments Compare?

Dental insurance covers approximately 50 percent of Minnesota adults compared with approximately 90 percent covered by medical insurance.[8] Dental insurers, like medical insurers, pay bills at a discount from the submitted charge. Other Minnesotans without dental insurance generally pay the dentists' full charge for services performed. Because a larger proportion of

7 Payment for providers whose rates were below the 50th percentile of all providers in 1982 are restricted to their 1982 usual and customary rate. Since this is a reduction from the allowable rate, it is sometimes referred to as the usual and customary reduction. The Legislature has removed this limit effective July 1, 1989.

8 There is considerable uncertainty about the exact percentage covered by medical insurance. The State Planning Agency estimated in 1985 that 5.8 percent of the under-65 population was without medical insurance. A recent study of 720 Minnesota households by the Minnesota National Health Care Coalition estimates that 11.8 percent of this under-65 population is without insurance.

the population pays dental bills directly, dentists receive their full charge for services more often than physicians.

Nonetheless, it is of interest to know how dental insurer payments compare to Medicaid payments for the same services. The Department of Human Services compared Medicaid dental reimbursement rates with the rates offered in 1987 by several large Minnesota dental insurers representing almost 800,000 Minnesotans. The department compared Medicaid and insurer payment for 39 dental procedures representing about 80 percent of all Medicaid dental charges. The average Medicaid reimbursement for these 39 procedures was $19.56. The dental insurers' average payment in 1987 for this same group of procedures varied from $19.13 to $34.28, depending on the unique features of each plan. The most likely level of payment from the insurers was $25.33 or 29.5 percent higher than Medicaid average reimbursement.[9]

- **Private dental insurance plans pay an average of about 29 percent more than Medicaid.**

Administration

Claims Processing Performance

Dentists complained about how long DHS took to pay their bills. To see if dentists' complaints were reasonable we looked at all non-Medicare dental procedures paid during the last four years. We examined two measures:

- **How many days elapsed between the time when DHS received an error-free claim and when DHS paid the claim?**

- **How many days elapsed between the time the dentist performed the service and when DHS paid the claim?**

Dentists' error-free claims are paid in about 20 days.

Table 3.6 shows that the department's performance in paying claims has improved in each of the last two years. The department pays an error-free claim in an average of about 20 days. In comparison, other large third-party payors require between 5 and 45 days to pay claims.

The federal government requires DHS to pay 90 percent of error-free claims within 30 days of receipt. The department has consistently met this standard. In 1988, they paid 94 percent of such claims within 30 days.

We found that an average of 50 days elapse between the time when a dentist provides a service until Medicaid pays for it. The additional 30 days results from two sources. First, providers do not always submit claims in a timely manner and there is some time associated with mailing the claim to DHS. Second,

9 Depending on the plan, the actual level of payment from the insurer may be lower. The reported average reflects both the insured's copayment and the insurer's payment to the provider. In some cases dentists may try to recover a larger amount from the insured than the copayment.

Average Number of Days Between Service and Date Paid

	Number of Days		
Billing Source	1985	1986	1987
Dentist	55.7	56.7	46.6
Dental Clinic	64.6	60.1	50.7

Average Number of Days Between Receipt of Error-Free Claim and Date Paid

	Number of Days		
Billing Source	1985	1986	1987
Dentist	27.0	26.6	19.0
Dental Clinic	29.1	25.7	20.4

Table 3.6: How Quickly the Department of Human Services Pays Dentists

Dental claim processing times are within acceptable limits.

the 50 day average includes the time necessary to resubmit claims that are incorrect in some fashion.

Table 3.7 shows the distribution, for individual dentists, of the average time until Medicaid pays. As the data show, some dentists are much more efficient and effective than others in getting claims paid quickly.

After reviewing the actual claims processing times for dental claims, we conclude:

- **Overall dental claims processing times are within acceptable limits.**

Dentists also complained about problems with the department's forms and its use of a scanner for data entry. Minnesota uses an optical scanner to read most claims, supplemented with manual data entry for non-scannable claims.[10] One of the most frequent suggestions by dentists was to use the American Dental Association (ADA) standard insurance reimbursement form, used by several other insurers in the state. Unfortunately, the standard ADA form is not a scannable form, and so the dentists must use a DHS produced dental invoice that will work with the scanner. Other insurers in the state do not use a scanner to enter invoices into their computer systems, but instead employ large data entry staffs to manually enter the information.

Problems With Provider Relations

Many dentists complained about poor provider relations and the problem resolution process in the department. Provider complaints are probably justified. The Department of Human Services does not have a provider relations function to deal with problems associated with paying for Medicaid services. As a result, the department handles telephone calls and inquiries in a non-systematic way.

10 Invoices that cannot be scanned include hospital claims and handwritten claims. Many invoices also come to the department directly on magnetic tape.

Time Between Service and Date Paid

Average Number of Days	Dentist Billing Sources Number	Dentist Billing Sources Percent	Dental Clinic Billing Sources Number	Dental Clinic Billing Sources Percent
0-20	45	2.2%	2	1.0%
20-40	628	31.3	41	21.5
40-60	665	33.2	65	34.0
60-80	308	15.4	44	23.0
80-100	153	7.6	14	7.3
More Than 100	205	10.2	25	13.1
Total	2,004	99.9%*	191	99.9%*

Time Between Receipt of Error-Free Claim and Date Paid

Average Number of Days	Dentist Billing Sources Number	Dentist Billing Sources Percent	Dental Clinic Billing Sources Number	Dental Clinic Billing Sources Percent
0-20	1,426	71.2	117	61.3
20-40	485	24.2	64	33.5
40-60	83	4.1	9	4.7
60-80	8	0.4	1	0.5
80-100	0	0	0	0
More Than 100	2	0.1	0	0
Total	2,004	100.0%	191	100.0%

*Does not total 100 due to rounding.

Table 3.7: Payment of Dental Claims, 1987

DHS has no provider relations section and it handles inquiries non-systematically.

The department estimates it receives several hundred calls per day on Medicaid questions. The department transfers calls to whomever is available to take them, often a Medical Claims Technician. Although these personnel can answer some technical questions, there are many matters that they cannot handle. As a result, calls are often transferred around, callers are put on hold, and the problem is sometimes not resolved. In some cases providers write and call legislators in an effort to resolve problems. In many cases, the callers' questions reflect poor understanding of how to submit Medicaid claims for payment. This is at least partially because the department has no staff available to conduct provider training. The department creates problems for itself by not teaching providers to properly submit claims for payment. Rejected claims result in more work for the department and for providers.

Department staff are aware of this problem, and DHS has proposed a combined provider relations and training function several times. However, the Department of Finance and the Legislature have not approved this budget item. We believe that a provider relations function should be part of any large claims processing system, including the Minnesota Medicaid program. A

provider relations section would also help in dealing with dentists' many complaints and questions about prior authorization and treatment guidelines.

Other third-party payors have separate provider relations staff.

We called 11 other Minnesota third-party payors and found that all had personnel devoted to this function. Only two of those used data entry staff to answer phones in a customer service capacity. Most had separate trained staff in customer service and provider relations functions. For example, Blue Cross/Blue Shield has regional provider relations personnel to negotiate contracts and solve problems. They sponsor regional workshops annually to discuss proper coding, forms preparation, and rules and regulations.

SUMMARY AND CONCLUSIONS

Dentists are increasingly withdrawing from the Medicaid program or limiting participation. Only about 30 percent of dentists see all Medicaid patients, 52 percent see some patients, and 18 percent see no Medicaid patients. Examination of claim payment files indicates that the number of dental procedures performed in counties reporting dental access difficulty has declined in the last several years.

The reasons that dentists give for limiting participation are that Medicaid payments are too low, administration is poor, and the patients are more difficult to serve. We found that on average Medicaid paid dentists about 72 percent of their submitted charges in 1987, more than dentists said their overhead costs were. According to analysis done by DHS, Medicaid dental payments are about 29 percent less than payments from private dental insurers. Dentists believe Medicaid patients are more expensive to treat than others because of a higher rate of failed appointments. Many dentists also noted that some disabled Medicaid patients take longer and are more difficult to treat than other patients.

Despite many dentists' complaints, we found Medicaid pays dental claims in a reasonable amount of time. However, DHS has definite problems with dental provider relations because of disagreements about prior authorization and treatment policies, and other perceived administrative problems.

PHYSICIANS' PARTICIPATION

Chapter 4

Many physicians, like dentists, have complained in recent years about problems with the Medicaid program. Some medical clinics have dropped out or limited their Medicaid participation. In this chapter, we examine the extent of physicians' dissatisfaction with the Medicaid program and the degree to which they continue to participate. Specifically, we asked:

- **To what extent do physicians participate in Medicaid, and how is the participation level changing?**
- **What complaints do physicians have about the Medicaid program? Are their complaints justified?**
- **What reasons do physicians give for withdrawing from the program? What would encourage more doctors to participate?**

To answer these questions we surveyed a random sample of 515 physicians, examined Department of Human Services computer files, and conducted telephone interviews with 21 medical clinic administrators around the state. Our survey methodology is described in the next section and the survey results are summarized in Appendix C.

HOW MANY PHYSICIANS PARTICIPATE?

We found that for physicians, as for dentists, there is no perfect data source on how many participate in the Medicaid program. Table 4.1 shows the number of in-state physician billing sources that billed Medicaid from 1984 to 1987. The number of billing sources increased from 5,723 in 1984 to 6,162 in 1987, with almost all (85 percent) of the increase coming in the seven-county metro area. This table tells us the number of billing sources, but not how often they billed.

Table 4.2 shows the average number of recipients, the number of billed procedures, and the number of procedures per recipient between 1984 and 1987.[1]

1 These data are from a DHS database of Medicaid billed procedures. There may be more than one billed procedure on each invoice, so the figures reported are weighted by the number of procedures, not the number of claims. Data on Medicare crossover, EPSDT, or HMO procedures are not included in the database we examined.

County	1984	1985	1986	1987
Aitkin	7	8	12	16
Anoka	166	174	185	187
Becker	30	33	32	32
Beltrami	44	43	45	52
Benton	7	8	7	7
Big Stone	9	10	8	7
Blue Earth	80	84	80	81
Brown	31	31	29	28
Carlton	18	18	17	19
Carver	44	47	49	49
Cass	7	13	11	14
Chippewa	10	11	11	10
Chisago	16	19	17	18
Clay	32	34	37	36
Clearwater	10	11	5	5
Cook	4	4	5	5
Cottonwood	10	9	10	8
Crow Wing	56	60	57	57
Dakota	106	115	116	122
Dodge	3	3	3	3
Douglas	39	42	40	41
Faribault	15	14	11	9
Fillmore	16	18	16	10
Freeborn	40	37	39	39
Goodhue	44	44	45	47
Grant	5	4	4	4
Hennepin	2,352	2,477	2,546	2,574
Houston	3	3	5	5
Hubbard	13	16	15	16
Isanti	21	25	27	26
Itasca	37	36	36	37
Jackson	9	8	15	10
Kanabec	8	9	9	9
Kandiyohi	75	81	84	81
Kittson	7	8	7	5
Koochiching	18	19	17	13
Lac Qui Parle	5	5	5	2
Lake	8	9	10	10
Lake of the Woods	2	2	3	2
LeSueur	15	16	15	16
Lincoln	6	8	7	7
Lyon	20	23	23	24
McLeod	22	25	24	28
Mahnomen	2	3	5	3
Marshall	6	4	5	4

Table 4.1: Number of Medical Doctors and Clinics Billing Medicaid, 1984-1987

County	1984	1985	1986	1987
Martin	17	18	19	19
Meeker	14	16	18	18
Mille Lacs	19	23	21	18
Morrison	22	20	20	18
Mower	40	45	44	44
Murray	4	5	4	3
Nicollet	7	8	8	9
Nobles	26	27	26	23
Norman	3	3	4	4
Olmsted	80	84	85	85
Ottertail	54	56	51	48
Pennington	20	20	21	21
Pine	9	8	6	6
Pipestone	7	8	9	12
Polk	25	26	23	23
Pope	7	6	6	5
Ramsey	971	1,010	1,118	1,051
Red Lake	2	1	1	2
Redwood	5	5	4	4
Renville	10	10	10	10
Rice	34	36	33	38
Rock	11	9	11	11
Roseau	12	13	13	11
Saint Louis	376	390	391	406
Scott	34	31	34	32
Sherburne	4	6	5	5
Sibley	6	6	7	7
Stearns	166	165	177	175
Steele	21	25	25	26
Stevens	9	13	12	12
Swift	6	4	4	4
Todd	15	20	15	13
Traverse	5	5	5	5
Wabasha	13	15	14	14
Wadena	11	11	10	12
Waseca	10	10	9	8
Washington	64	70	70	71
Watonwan	6	6	6	7
Wilkins	8	9	8	8
Winona	49	49	47	45
Wright	32	40	43	44
Yellow Medicine	11	9	8	7
Total	5,723	6,012	6,094	6,162

Table 4.1: Number of Medical Doctors and Clinics Billing Medicaid, 1984-1987, continued

County	Number of Billed Procedures 1985	Average Recipients 1985	Procedures Per Recipient 1985	Number of Billed Procedures 1986	Average Recipients 1986	Procedures Per Recipient 1986	Number of Billed Procedures 1987	Average Recipients 1987	Procedures Per Recipient 1987	Percent Change Procedures Per Recipient 1985-1987
Aitkin	8,263	1,419	5.8	8,412	1,355	6.2	9,552	1,338	7.1	22.6%
Anoka	88,739	8,428	10.5	86,991	8,488	10.2	72,100	8,470	8.5	-19.2
Becker	29,043	2,970	9.8	30,366	2,947	10.3	30,234	3,106	9.7	-0.5
Beltrami	41,063	4,398	9.3	47,118	4,678	10.1	58,248	4,946	11.8	26.1
Benton	6,472	1,722	3.8	5,951	1,737	3.4	3,753	1,763	2.1	-43.4
Big Stone	4,928	512	9.6	5,105	495	10.3	6,785	522	13.0	35.0
Blue Earth	45,443	2,813	16.2	45,303	3,254	13.9	46,482	3,284	14.2	-12.4
Brown	10,649	1,222	8.7	11,277	1,254	9.0	11,845	1,298	9.1	4.7
Carlton	21,518	2,862	7.5	19,414	2,761	7.0	19,032	2,650	7.2	-4.5
Carver	15,538	1,071	14.5	18,150	1,122	16.2	17,089	1,157	14.8	1.8
Cass	6,257	3,013	2.1	8,574	3,011	2.8	10,091	2,959	3.4	64.2
Chippewa	4,864	751	6.5	5,689	756	7.5	5,232	798	6.6	1.2
Chisago	8,239	1,575	5.2	7,459	1,594	4.7	8,447	1,570	5.4	2.9
Clay	8,931	3,205	2.8	10,267	3,358	3.1	10,461	3,260	3.2	15.2
Clearwater	8,745	1,323	6.6	7,376	1,294	5.7	7,429	1,323	5.6	-15.0
Cook	1,897	249	7.6	2,201	234	9.4	1,708	222	7.7	1.0
Cottonwood	4,332	724	6.0	5,242	758	6.9	5,343	768	7.0	16.3
Crow Wing	48,668	4,123	11.8	50,336	4,093	12.3	52,717	4,150	12.7	7.6
Dakota*	81,402	6,570	NA	75,020	7,022	NA	40,002	7,378	NA	NA
Dodge	368	750	0.5	166	761	0.2	186	741	0.3	-48.8
Douglas	17,737	1,679	10.6	19,754	1,818	10.9	19,987	1,832	10.9	3.3
Faribault	6,032	1,163	5.2	5,978	1,154	5.2	5,914	1,126	5.3	1.3
Fillmore	4,204	1,388	3.0	4,631	1,438	3.2	5,790	1,348	4.3	41.8
Freeborn	18,082	2,129	8.5	16,693	2,108	7.9	19,117	2,084	9.2	8.0
Goodhue	14,273	1,919	7.4	14,377	1,940	7.4	13,695	1,924	7.1	-4.3
Grant	2,209	402	5.5	2,685	409	6.6	2,413	421	5.7	4.3
Hennepin*	1,082,232	61,326	NA	1,099,736	63,854	NA	1,035,122	65,080	NA	NA
Houston	998	940	1.1	1,135	946	1.2	1,590	948	1.7	58.0
Hubbard	17,398	1,675	10.4	17,973	1,487	12.1	18,183	1,627	11.2	7.6
Isanti	19,798	1,569	12.6	21,920	1,630	13.4	23,592	1,593	14.8	17.4
Itasca*	34,032	4,912	NA	15,230	4,948	NA	17,889	5,450	NA	NA
Jackson	3,628	778	4.7	5,753	936	6.1	7,698	1,106	7.0	49.3
Kanabec	11,503	931	12.4	13,633	1,029	13.2	13,206	1,108	11.9	-3.5
Kandiyohi	53,097	2,860	18.6	55,748	3,063	18.2	63,343	3,504	18.1	-2.6
Kittson	3,811	450	8.5	3,867	440	8.8	3,637	460	7.9	-6.6
Koochiching	21,239	1,627	13.1	19,681	1,679	11.7	19,475	1,848	10.5	-19.3
Lac Qui Parle	1,623	470	3.5	1,162	485	2.4	759	534	1.4	-58.8
Lake	4,625	895	5.2	4,906	827	5.9	5,474	808	6.8	31.1
Lake of the Woods	1,514	299	5.1	1,240	294	4.2	1,619	311	5.2	2.8
LeSueur	6,326	1,266	5.0	5,668	1,317	4.3	5,441	1,391	3.9	-21.7
Lincoln	3,572	472	7.6	4,265	482	8.8	4,784	538	8.9	17.5
Lyon	9.927	1,589	6.2	12,910	1,608	8.0	14,977	1,792	8.4	33.8
McLeod	10,841	1,230	8.8	11,134	1,232	9.0	11,123	1,327	8.4	-4.9
Mahnomen	2,926	769	3.8	1,836	784	2.3	5,199	770	6.8	77.5
Marshall	2,386	637	3.7	2,310	624	3.7	2,854	667	4.3	14.2
Martin	7,244	1,216	6.0	7,938	1,266	6.3	10,069	1,468	6.9	15.1
Meeker	4,908	1,187	4.1	5,991	,1227	4.9	7,733	1,358	5.7	37.7
Mille Lacs	15,365	1,680	9.1	18,146	1,810	10.0	21,433	1,960	10.9	19.6

*There is a lower number of billed procedures in 1986 and 1987 because the county participated in the Medicaid Prepaid Demonstration Project.

Table 4.2: Number of Medical Procedures, Average Recipients, Average Medical Procedures per Recipient, 1985-1987

County	Number of Billed Procedures 1985	Average Recipients 1985	Procedures Per Recipient 1985	Number of Billed Procedures 1986	Average Recipients 1986	Procedures Per Recipient 1986	Number of Billed Procedures 1987	Average Recipients 1987	Procedures Per Recipient 1987	Percent Change Procedures Per Recipient 1985-1987
Morrison	14,817	2,533	5.8	15,873	2,344	6.8	25,248	2,351	10.7	83.6
Mower	18,733	2,603	7.2	20,784	2,734	7.6	21,434	2,944	7.3	1.2
Murray	1,836	652	2.8	1,841	681	2.7	1,001	628	1.6	-43.4
Nicollet	4,170	1,070	3.9	3,965	1,086	3.7	4,912	1,266	3.9	-0.4
Nobles	16,259	1,227	13.3	16,755	1,263	13.3	14,693	1,345	10.9	-17.6
Norman	2,257	543	4.2	1,624	537	3.0	1,760	562	3.1	-24.7
Olmsted	131,918	3,858	34.2	137,024	4,258	32.2	108,015	4,892	22.1	-35.4
Ottertail	29,653	3,416	8.7	28,937	3,526	8.2	32,154	3,871	8.3	-4.3
Pennington	14,426	1,076	13.4	15,434	1,175	13.1	17,352	1,255	13.8	3.1
Pine	6,624	2,048	3.2	6,233	1,996	3.1	5,134	2,229	2.3	-28.8
Pipestone	4,717	618	7.6	5,588	647	8.6	6,420	746	8.6	12.8
Polk	17,842	3,177	5.6	15,845	3,285	4.8	17,996	3,742	4.8	-14.4
Pope	3,831	736	5.2	4,678	822	5.7	4,645	884	5.3	0.9
Ramsey	523,039	37,633	13.9	498,426	38,206	13.0	472,848	42,157	11.2	-19.3
Red Lake	934	332	2.8	823	356	2.3	920	396	2.3	-17.4
Redwood	1,604	892	1.8	1,795	922	1.9	1,856	971	1.9	6.3
Renville	3,978	920	4.3	3,687	955	3.9	4,214	1,055	4.0	-7.6
Rice	18,407	2,016	9.1	17,582	2,032	8.7	18,217	2,229	8.2	-10.5
Rock	2,979	384	7.8	2,932	431	6.8	3,059	476	6.4	-17.2
Roseau	8,140	661	12.3	10,759	675	15.9	9,250	725	12.8	3.6
St. Louis	300,523	22,976	13.1	310,662	23,015	13.5	312,842	23,921	13.1	0.0
Scott	13,356	1,456	9.2	12,728	1,467	8.7	11,434	1,493	7.7	-16.5
Sherburne	3,183	1,719	1.9	2,957	1,583	1.9	3,552	1,639	2.2	17.0
Sibley	2,096	673	3.1	2,947	680	4.3	3,121	687	4.5	45.9
Stearns	70,076	5,170	13.6	73,519	5,225	14.1	78,214	5,539	14.1	4.2
Steele	8,249	1,095	7.5	9,079	1,117	8.1	9,542	1,226	7.8	3.3
Stevens	4,451	499	8.9	6,138	583	10.5	5,635	655	8.6	-3.6
Swift	3,715	854	4.4	4,213	870	4.8	4,422	955	4.6	6.4
Todd	15,839	2,160	7.3	16,255	2,159	7.5	18,136	2,330	7.8	6.1
Traverse	2,147	327	6.6	2,550	346	7.4	2,428	385	6.3	-3.9
Wabasha	6,022	1,107	5.4	5,951	1,519	3.9	6,726	1,102	6.1	12.2
Wadena	17,791	1,538	11.6	22,142	1,635	13.5	21,642	1,785	12.1	4.8
Waseca	6,361	972	6.5	6,650	1,048	6.3	6,389	1,070	6.0	-8.8
Washington	31,029	3,960	7.8	27,930	4,040	6.9	26,913	4,509	6.0	-23.8
Watonwan	4,330	649	6.7	4,649	742	6.3	4,834	797	6.1	-9.1
Wilkin	2,673	521	5.1	3,042	518	5.9	2,920	565	5.2	0.7
Winona	18,487	2,428	7.6	18,172	2,487	7.3	16,280	2,519	6.5	-15.1
Wright	27,199	2,864	9.5	33,349	2,864	11.6	32,625	3,097	10.5	10.9
Yellow Medicine	6,462	706	9.2	5,937	736	8.1	5,818	854	6.8	-25.6
MINNESOTA	3,197,042	265,227	12.5	3,226,172	272,372	12.3	3,123,453	285,938	11.3	-9.0%
North Dakota	70,616			79,998			84,305			
South Dakota	5,223			6,239			6,620			
Iowa	1,806			2,105			2,110			
Wisconsin	19,067			19,149			18,413			
East of Mississippi	6,644			5,559			4,288			
West of Mississippi	5,940			4,189			3,672			
Total	3,306,343	265,227	12.5	3,343,439	272,372	12.3	3,242,865	285,938	11.3	-9.0%

Table 4.2: Number of Medical Procedures, Average Recipients, Average Medical Procedures per Recipient, 1985-1987 (continued)

Anoka County reports difficult access to all providers.

We saw in Chapter 2 that only a few counties reported serious problems with access to medical providers. Anoka County reported very difficult access for all types of providers. This is borne out by the 19 percent decrease in billed procedures per recipient in Anoka County between 1985 - 1987. Although not statistically repesentative, the sub-sample of Anoka physicians we surveyed were more likely to limit the number of Medicaid patients they saw. 85 percent of Anoka County respondents limited the Medicaid patients they saw compared with 21 percent of all physicians. Anoka County physicians said that Medicaid patients made up about 7.6 percent of their practices compared with 14 percent for all physicians. Also, 83 percent of Anoka County responding physicians reported receiving calls from Medicaid patients turned away by other providers.

Sherburne County also reported very difficult access to all primary care physicians, but this is not reflected in a decrease in procedures per recipient (up 17 percent between 1985 and 1987). Sherburne County reported that this was a recent problem so it may not be reflected in 1987 data.[2]

We surveyed 515 office-based physicians to find out the extent of their participation in the Medicaid program.[3] We mailed 975 surveys and 515 physicians responded for a response rate of 53 percent. We include a tabulation of the responses in Appendix C.

We asked physicians if they participated in the Medicaid program. We found:

- **Nearly all (97 percent) of physicians are currently billing Medicaid for some patients.**
- **Only 1.5 percent of physicians used to participate in Medicaid but have dropped out.**
- **Another 1.5 percent of physicians have never participated in Medicaid.**

Almost all physicians participate in the Medicaid program.

Since we wanted to know if physicians were fully participating, we asked participating physicians if they limited services to Medicaid patients in any way. As Figure 4.1 shows, 97 percent of physicians participate, about 76 percent

2 Sherburne County officials also reported Medicaid patients affected by limiting providers in Anoka County. It is probable that many Sherburne County residents travel to Stearns, Wright, and Anoka Counties for medical care.

3 The Minnesota Medical Association (MMA) supplied us with the list of names, addresses, and practice specialties of office-based general practice, family practice, pediatric, OB/GYN, and internal medicine physicians in Minnesota. We drew a systematic random sample after stratifying the list by county and practice specialty. Generally, we excluded responses from physicians at the University, the VA, staff model HMO's, and the Mayo clinic who were mistakenly included in the MMA list. In a few cases we did include responses if the physicians had direct contact with the Medicaid program in the last six months. The MMA and the Department of Human Services helped review the survey instrument.

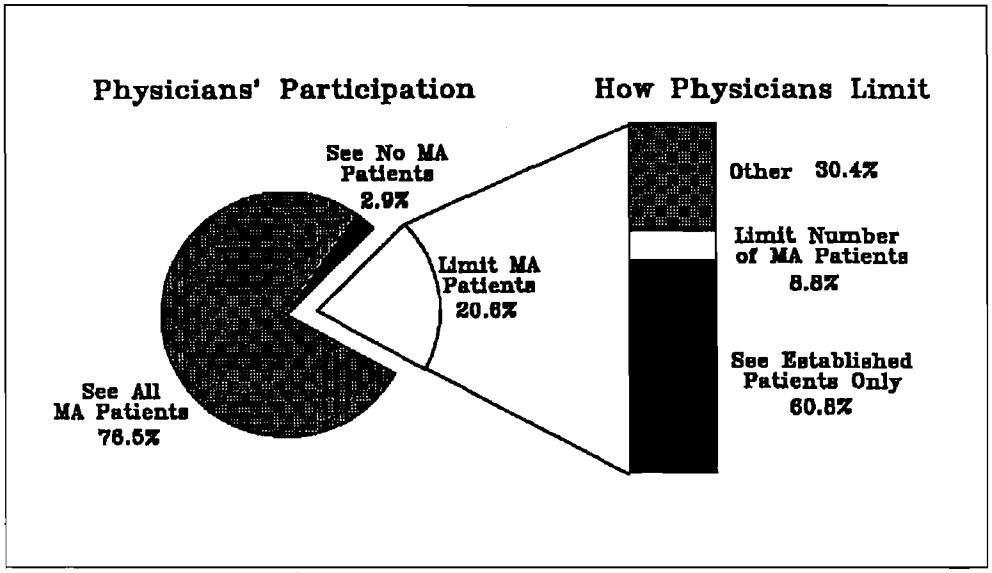

Figure 4.1: Extent of Physicians' Participation in Medicaid

About 21 percent of physicians limit the number of Medicaid patients they see.

see all patients (*full participants*), and about 21 percent somehow limit the Medicaid patients they see (*limiters*). The most frequent way (61 percent) that physicians limit services is to see only their established patients and not new Medicaid patients.[4] Physicians in the metro area are more likely (31 percent) than non-metro physicians (9 percent) to limit the number of Medicaid patients they see.

Physicians said that Medicaid patients make up about 14 percent of their practices. Non-metro area physicians saw a larger proportion of Medicaid patients (17 percent) compared with metro physicians (11 percent). *Full participants* reported about 16 percent of their practice is made up of Medicaid patients compared with 8 percent for *limiters*. In general, physicians who limit services to Medicaid patients do not replace them directly with other patients, they just see fewer patients.

We asked doctors two questions about their plans for future Medicaid participation. First, we asked physicians what number of Medicaid patients they would like to see? Overall, 59 percent of physicians said they would like to see the same number of Medicaid patients, 35 percent said they would like to see fewer, and six percent said they would like to see more. Non-metro doctors were more likely to say they would like to see fewer MA patients (46 percent) than metro area physicians (26 percent). This could be because over 30 percent of metro physicians already limit participation.

We also asked physicians about their practice plans for 1989 given current reimbursement levels. As Table 4.3 shows, 78 percent said they would continue to accept new patients as time permits, 20 percent would continue to

4 The Department of Human Services points out that MA providers' right to limit services is not absolute. *Minn. Rules* Part 9505.0195 states in part: "A provider shall not place restrictions or criteria on the services it will make available, the type of health conditions it will accept, or the persons it will accept for care or treatment, unless the provider applies those restrictions to all individuals seeking the provider's services."

Practice Plans for 1989	All Physicians		Full Participation		Limiters		Metro		Non-Metro	
	Number	Percent	Number	Percent	Number	Percent*	Number	Percent	Number	Percent*
Accept new patients as time permits	371	78.3%	341	92.9%	30	30.6%	187	70.6%	178	88.6%
Treat current patients, but not new patients	96	20.3	23	6.3	66	67.3	74	27.9	20	10.0
Terminate participation	7	1.5	3	.8	2	2.0	4	1.5	3	1.5

*Does not total 100 due to rounding.

Table 4.3: Physicians' Medicaid Practice Plans for 1989

treat current patients but accept no new patients, and only 1.5 percent would terminate participation. The same question asked one year earlier on a Minnesota Medical Association survey yielded similar responses, except that the number of doctors saying they will end participation in 1989 is smaller than in 1988 (1.5 percent in 1989 vs. 7 percent in 1988). We conclude that:

- **Although physicians are dissatisfied with the Medicaid program, they are reluctant to completely end participation.**

This observation is confirmed by a telephone survey we conducted of 21 medical clinic business managers from around the state.[5] Although all of these clinics participated in the Medicaid program, two clinics indicated they would not take new MA patients and one said they would not accept new Medicaid obstetric patients because of low reimbursement rates.

Overall, we conclude:

- **There is little difficulty finding physicians willing to treat Medicaid patients.**

In the next section we examine physicians' attitudes about the Medicaid program that lead some to limit their Medicaid participation.

PHYSICIAN PERCEPTIONS OF MEDICAID

Physicians are somewhat critical of the Medicaid program's administration and very critical of its reimbursement rates. Physicians also complain about some Medicaid recipients' overuse of emergency rooms and other services. However, judging from the comments written on our survey, physicians seem less willing than dentists to deny services to Medicaid patients who need them. As two physicians commented:

- "We see all patients because that's what I'm trained to do. Payment is important but it doesn't stop me from providing treatment."

5 We chose 20 clinics at random from a list supplied by the Minnesota Medical Association. In addition, we contacted the Mayo Clinic in Rochester.

- "My partners [and I] will continue seeing MA patients at a loss for humanitarian reasons."

This attitude was widespread and might account for a higher participation rate among physicians compared to dentists. In the next three sections we discuss physicians' perceptions of Medicaid reimbursement, Medicaid administration, and Medicaid patients.

Physicians Perceive Medicaid Reimbursement Is Low

Physicians maintain that Medicaid rates are below their costs.

Like dentists, physicians most commonly complained about low Medicaid payments. Many physicians maintain that reimbursement rates are below their costs for many procedures. Over 95 percent disagreed that reimbursement rates are reasonable overall, and over 84 percent agreed that payment was too low for certain procedures. Obstetric procedures were most frequently mentioned as poorly paid.

Only 13 percent of physicians agreed that Medicaid payments generally covered their costs of providing services. Physicians specifically mentioned that payment for immunizations and some other injectable drugs were below their supply costs.

Of physicians who commented, over 74 percent mentioned poor reimbursement levels. Typical physician comments were:

- "At the most recent evaluation of claims paid, we received 51 percent of charges. (This is the least by over 10 percent of any of our 3rd-party payors). This does not account for claims rejected. We lose money on the MA program."
- "My overhead is 57 percent -- I get less than half of my charges reimbursed."
- "At least increase reimbursement so it only means my time is given as a free item, but I can cover my costs of malpractice insurance, supplies, staff, etc."
- "Reimbursement (should be) increased to at least 60 percent of bills for office calls. (Our overhead, like most offices is between 50 and 55 percent)."

Clinic managers say obstetric rates are especially low.

In our survey of 21 medical clinic business managers around the state, low reimbursement rates were also the most frequent complaint. Like physicians, clinic managers specifically mentioned low rates for obstetric procedures. They reported that Medicaid paid them about 52 percent of their charges. No clinics reported that they did better than break-even on Medicaid business. Most clinic business managers reported that MA paid the least of all third party payors for all procedures. One said others pay 75 to 100 percent of charges while MA pays 50 percent. Another said that MA pays at least 50 percent less than other payors.

Physicians Perceive Problems With Medicaid Administration

Claims Processing

Physicians accounted for about 1.5 million of the roughly 10 million Medicaid claims in fiscal year 1988, which cost about $62 million. Our survey of physicians showed that they are dissatisfied with the way the state processes these invoices. We asked physicians several questions about Medicaid administration. Asked to compare their experiences with Medicaid to their experiences with other third party payors:

Physicians are dissatisfied with Medicaid administration.

- **36 percent of physicians agreed that Medicaid administrative requirements are reasonable.**
- **24 percent of physicians agreed that payments are usually received within 30 days of submitting an invoice.**
- **61 percent of physicians agreed that Medicaid invoices are difficult to fill out correctly.**

Physicians limiting Medicaid patients have more negative views than full participants. Full participants were more likely than limiters to say they received their payment within 30 days (27 percent vs. 13 percent for limiters), and less likely to say that invoices are difficult to complete correctly (58 percent vs. 76 percent for limiters).

Over 25 percent of physicians' comments addressed Medicaid's administrative efficiency. Some typical physician comments were:

- "Payments should be received within 30 days -- average now is 60 days."
- "Administrative processes are laborious and costly and will be the main factor if we terminate Medical Assistance patients."
- "...the amount of paperwork (is) excessive and the length of time until reimbursement is obtained is not acceptable... the rule is always greater than 150 days."
- "Use common sense in reading forms. They send them back for minor things such as one letter not in the white box, etc. That costs you and us extra postage."

In addition, physicians were concerned about the increasing paperwork associated with coordination of insurance benefits. A 1986 federal law change has placed more burden on physicans and clinic administrators to seek reimbursement from other potentially liable third parties.

Provider Relations

Physicians, like dentists, were critical of the department's responsiveness to special problems in claims processing. Many physicians mentioned difficulties getting questions answered over the phone.

Overall, 39 percent of physicians thought the department communicated Medicaid program requirements well. Some physicians complained about the lack of training and help in properly filling out invoices. Many physicians (over 25 percent of those commenting) noted that Medicaid forms were more difficult than forms used by other providers. Over 11 percent of physicians who commented addressed difficulties in claims processing. Typical physician comments were:

- "I would like to receive more assistance and training on all the ins and outs of how to bill Medical Assistance."
- "Hire at least a few competent people to handle questions and claims."
- "Disputes and questions are handled inefficiently and impersonally."
- "We used to have periodic sessions, both training and informational, in past years. Let's bring them back. It would help relationships."
- "[The Department of Human Services] needs a physician contact person."

Physician Perceptions of Medicaid Patients

Physicians' views split (52 percent agreed) on whether Medicaid recipients are more difficult to treat than other patients. However, 71 percent of physicians believed that Medicaid patients fail to keep appointments more often than other patients.

One of physicians' most common views about Medicaid recipients was written in the survey's comment section. Fifty percent of physicians commenting (168 of 339) mentioned that Medicaid patients overuse emergency rooms or other services. Many suggested a copayment or a physician gatekeeper to curb service overuse. Some typical and widely shared views are:

Physicians believe that MA patients misuse services.

- "Require a copayment on certain non-essential services and procedures."
- "Limit use of emergency room visits for MA patients. Costs are generally 3 times higher than office. I know of several patients that routinely use the ER as primary care... because they don't need an appointment or need to call ahead. Study the impact of a ... copay for ER visits."
- "'Gatekeeper' approach to cost-control (is needed) -- (we) need to prevent multiple physician visits and prescriptions."

- "A few patients should be restricted, to be able to see other doctors only on referral of a primary care physician."
- "Stop abuse of MA recipients who are doctor shopping and get multiple drugs from multiple sources."
- "Make medical assistance recipient a co-payor. MA is the only first dollar health insurance in Minnesota."

In summary, most physicians were unhappy with Medicaid reimbursement and many were also critical of Medicaid administration. Overuse of services by some recipients is an additional irritant for physicians. In the next section, we review evidence bearing on physician complaints about Medicaid.

ARE PHYSICIAN COMPLAINTS JUSTIFIED?

Reimbursement Rates

As we noted earlier, Medicaid payment policy fundamentally changed in 1981 when the Legislature froze reimbursement rates. Although there have been numerous changes since then, basically there has only been one major fee increase since 1981. In 1985 the Legislature changed the base year for calculating reimbursement rates from 1979 to 1982 resulting in increased fees. The 1987 Legislature cut fees five percent and the 1988 Legislature rescinded the five percent cut effective October 1, 1988.[6]

Physicians say their overhead costs are between 50 and 55 percent of their charges.

This study did not attempt to determine what the appropriate payment levels for physicians should be. We did, however, want to determine what percentage of charges Medicaid pays. Physicians reported their overhead costs (all costs except the physician's salary) ranged from 50 to 55 percent of their charges. There was no way for us to verify what physician overhead costs are, or how and why costs vary. Nonetheless, because physicians discuss reimbursement in terms of average overhead costs as a percent of their charges, we examined Medicaid payments in this way.[7]

We examined Medicaid claims for the last several years to find out what percentage of physicians' charges Medicaid paid. As Table 4.4 shows, physicians' Medicaid payments averaged about 65 percent of charges submitted in 1987. The table also shows great variability in reimbursement by provider. Some providers are paid 100 percent of their charges. In most cases these providers'

6 However, the 1988 Legislature raised fees for obstetric and prenatal services an additional five percent.

7 As we noted in Chapter 3, using average overhead costs is not the best way to examine costs or the right basis for decision making about whether to serve Medicaid patients. Assuming physicians are not at capacity, they should continue to see Medicaid patients if Medicaid payments are greater than their variable costs.

Average Percent of Charges Paid	Physician Billing Sources: 1984 Number	1984 Percent	1985 Number	1985 Percent	1986 Number	1986 Percent	1987 Number	1987 Percent
0-50%	1,134	15.6%	1,219	15.8%	484	6.2%	678	8.8%
50-60	1,898	26.1	2,225	28.9	1,138	14.5	1,651	21.5
60-70	2,360	32.4	2,377	30.9	2,473	31.5	2,717	35.3
70-80	1,217	16.7	1,160	15.1	2,265	28.9	1,640	21.3
80-90	409	5.6	420	5.5	934	11.9	640	8.3
90-100	137	1.9	146	1.9	337	4.3	222	2.9
100	120	1.6	153	2.0	208	2.7	139	1.8
Total	7,275	99.9%*	7,700	100.1%*	7,839	100.0%	7,687	99.9%*
Overall Average	61.9%		62.9%		69.2%		65.3%	
Metro Average	61.2		62.2		67.9		63.7	
Non-Metro Average	63.2		69.2		71.7		67.9	
Out-of-State	59.9		68.2		67.1		64.1	

*Does not total 100 due to rounding.

Table 4.4: Percent of Physicians' Submitted Charges Paid by Medicaid

Medicaid pays physicians an average of 65 percent of their charges, but there is considerable variation among providers.

charges are all below the Medicaid maximum payment; therefore, they are paid their complete charge. Also, in most cases, these providers have a lower than average number of Medicaid procedures billed. In a few cases, the provider has some items that have been paid more on an exceptional basis.[8] In 1987 Medicaid paid about 9 percent of all physicians less than 50 percent of their submitted charges, and another 21 percent were paid less than 60 percent of their charges.

As Table 4.5 shows, the average percent of submitted charges Medicaid pays also varies by medical specialty, because different specialties perform different sets of procedures.

The Department of Human Services has compared Minnesota Medicaid payments with other states' Medicaid payments.[9] As Figure 4.2 shows, overall Minnesota Medicaid pays relatively well, compared with other states. However, there are a number of difficulties comparing state Medicaid rates. First, Minnesota providers do not make decisions about whether to accept Minnesota Medicaid patients based on what Medicaid pays in Arkansas. Participation decisions are based on what options are available in the local health care market. Second, many other states have much more limited access than in Minnesota, so comparing rates to gauge the adequacy of Minnesota's payment levels may lead one to the wrong conclusion. Third, rates are not adjusted for differences in health care, labor, and living costs across the country and thus are not directly comparable.

8 In most cases, these claims are paid on a by-report or case-by-case basis. A number of surgeons and anesthesiologists were in this category.

9 See Steven Foldes. "Medicaid Payment to Physicians, A National Comparison With Attention To Minnesota." *Minnesota Medicine* 71(July 1988) : 425-430. The department compared what would have been paid for 74 common procedures in each of 35 states using each state's payment rates in March 1987.

Specialty	1984	1985	1986	1987
General Practice	66.2%	64.6%	69.6%	66.8%
Emergency Services	65.6	72.3	71.8	63.0
Allergy	65.7	64.9	68.9	68.2
Cardiovascular Disease	57.2	56.6	63.7	61.9
Dermatology	64.9	63.5	70.4	66.8
GI	60.1	60.9	67.1	65.3
Internal Medicine	61.9	60.0	66.5	63.6
Pediatrics	65.3	73.0	68.1	62.4
Physical Medicine (Rehabilitation)	57.5	58.3	63.6	59.1
Preventive Medicine	54.7	55.9	66.7	64.3
Pulmonary Disease	60.9	62.4	68.5	61.2
Child Psychology	57.7	51.4	54.7	53.1
Neurology	53.9	52.9	59.9	58.3
Psychiatry	59.6	59.7	66.9	64.1
Pathology	62.5	54.4	56.4	53.4
Radiology	58.7	66.1	79.4	65.9
Anesthesiology	41.5	44.4	80.7	77.8
Endocrinology	51.8	52.8	54.4	50.3
Gerontology	61.6	65.1	69.8	64.7
Immunology	57.9	53.9	56.3	56.3
Colon-Rectal Surgery	58.2	55.6	63.9	57.9
General Surgery	64.2	61.5	66.9	65.6
Neuro Surgery	54.2	53.9	59.7	59.7
OB-GYN	63.8	62.7	69.3	64.7
Ophthalmology	67.9	67.1	77.0	76.9
Orthopedic Surgery	62.1	61.0	68.1	66.4
Otolaryngology	65.0	65.6	71.9	69.9
Plastic Surgery	58.8	54.8	61.2	60.1
Thoracic Surgery	53.9	53.8	55.8	53.2
Urology	64.9	63.1	67.9	65.2
OB-GYN Osteopath	68.2	65.6	69.1	67.3
Opthalmology Osteopath	60.5	64.5	77.8	78.4
Clinical Pathology	65.0	58.8	62.6	56.1
Vascular Surgeon	62.7	70.9	74.2	69.3
Psych-Neurology	64.1	58.1	62.5	60.8
Radiology/Radiation	66.4	62.1	65.7	66.6
Family Practice	66.0	64.7	69.2	64.9

Table 4.5: Average Percent of Charges Reimbursed by Medicaid, by Medical Specialty, 1984-1987

The Hennepin County Academy of Family Physicians conducted a survey of family practitioners' costs and production in 1988. They found that the office overhead of family physicians, excluding physician compensation, was about 56 percent in Hennepin County.[10] Table 4.6 presents, for a variety of health plans, the dollar returns on a hypothetical $25 office visit, with profit referring to the amount available for physician compensaton and profit sharing. The table shows that Medicaid paid 67 percent of family practitioners' charges -- 12th highest of the 16 plans listed. Medicaid paid more than PHP, Share non-seniors, and HMO Gold.

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10 Hennepin County Academy of Family Practitioners. *Special Report: Cost and Production Survey*, (Minneapolis, 1988).

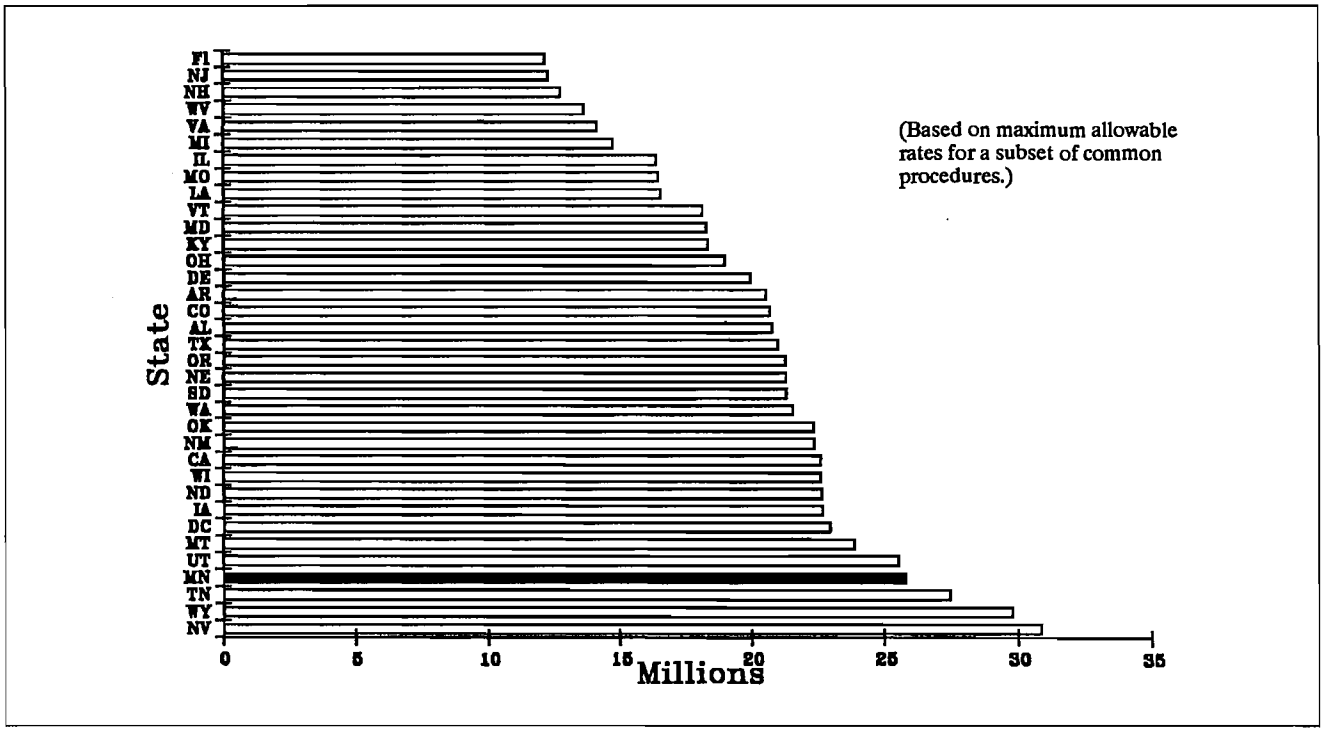

Figure 4.2: Hypothetical Amount of Medicaid Reimbursement in 1987
(Source: Department of Human Services.)

Medicaid paid Hennepin County family practitioners 67 percent of charges.

Health Plan	Survey Clinics	Average Return
AWARE & AWARE Gold	7	85%
Family Health Plan	6	81
HMO Gold	3	62
HMO Minnesota		
Non-seniors	3	94
Seniors	2	71
Medcenters*		
Non-seniors	1	71
Seniors	0	--
Medicaid	8	67
Medicare	8	68
Physician's Health Plan		
Non-seniors	8	65
Seniors	5	62
Preferred One	4	72
SelectCare	3	78
SHARE*		
Non-Seniors	5	57
Seniors	2	77
Workers' Compensation	6	94
All Others	5	82
1987 Weighted Average		73.8%

Source: HCAFP Cost and Production Survey, 7.

*Five clinics combine senior and non-senior data.

Table 4.6: Percent of Charges Paid by Various Health Plans in Hennepin County

- **We found that physicians' complaints about low Medicaid payments for immunizations and other injectable drugs are justified. In many cases Medicaid may be paying less than the physician's cost of the drug.**

Medicaid underpays for immunizations and injectable drugs.

Medicaid pays for drugs dispensed through pharmacies based on the average wholesale cost of the drug. DHS subscribes to a service that provides monthly updates of drug costs. However, DHS does not automatically update prices for drugs dispensed in physicians' offices because they are billed with a different coding system. As a result, if drug costs increase and Medicaid's payment does not, physicians lose money.

The department agrees that it should be paying at least the actual costs for drugs dispensed in physician clinics and offices, and it has manually changed the prices for a few drugs to mollify complaining physicians. However, these drug prices have not been updated systematically since May 1987. Moreover, when drug prices were updated in May 1987, the department used 1985 prices and it mistakenly subtracted $1.50 from all drugs' 1985 rates. The department tells us that it would be a six month job for one person to update reference file drug prices and there are no available personnel to do this.

Medical clinic administrators noted that Medicaid payments for obstetric services were low. On average, Medicaid paid obstetricians 64.7% of their 1987 charges, about the overall average for physicians. However, clinic administrators noted that obstetricians had higher costs than other practitioners, most notably for malpractice insurance.

Washington state recently conducted a Maternity Care Access and Reimbursement Survey of 49 state Medicaid programs. Table 4.7 shows how Minnesota's payment rates ranked for 12 commonly billed obstetric codes. Although, as we noted earlier, interstate rate comparisons may be misleading, it appears that Minnesota's payments for some of the more frequently performed obstetric procedures may be low.

Minnesota's payment levels for some obstetric procedures may be low.

The sub-sample of obstetricians in our survey were more likely to limit the number of Medicaid patients they see (31 percent vs. 21 percent of all physicians). Obstetricians were more dissatisfied than other physicians with the Medicaid program's: administrative requirements (77 percent vs. 56 percent of all physicians), untimely payments (65 percent vs. 52 percent), processing of prior authorizations (47 percent vs. 27 percent), and reimbursement rates (100 percent vs. 88 percent). Eleven percent of obstetricians said they would terminate participation in 1989 compared with 1.5 percent of all physicians.

Administration

In Chapter 3 we examined dentists' complaints about administration. Some of the discussion is also relevant to physicians, but we do not repeat it here. In this section we examine those concerns most specific to physicians.

CPT-4 Codes	Procedure	Number of Times Billed in MN 1987	Medicaid Payment Rates Minnesota*	Low	High	Average
59400	Total Obstetrics - Vaginal Delivery	5,564	$500	$236.00	$1,520.00	$683.71 (39)**
59410	Delivery Only - Vaginal	2,334	319	160.00	895.00	436.80 (50)
59500	Delivery Only - Cesarean - Low Cervical	884	715	290.00	1,150.00	618.71 (50)
59520	Delivery Only - Cesarean - Classic	82	545	290.00	1,200.00	604.30 (50)
59540	Delivery Only - Cesarean - Extraperitoneal	1	374	340.00	1,305.63	629.96 (47)
59501	Total Obstetrics - Cesarean - Low Cervical	987	915	369.00	2,000.00	872.29 (38)
59521	Total Obstetrics - Cesarean - Classic	58	880	369.00	1,500.00	822.02 (37)
59541	Total Obstetrics - Cesarean - Extraperitoneal	0	598	369.00	1,700.00	888.63 (36)
59560	Delivery Only - Cesarean - With Hysterectomy, Subtotal	0	598	350.00	1,485.68	726.45 (46)
59561	Delivery Only - Cesarean - With Hysterectomy, Total	0	598	350.00	1,485.68	781.00 (47)
59580	Total Obstetrics - Cesarean - With Hysterectomy, Subtotal	0	748	400.00	1,760.98	897.46 (36)
59581	Total Obstetrics - Cesarean - With Hysterectomy, Total	0	715	400.00	1,760.98	915.41 (36)

NOTE: Forty-nine of the 50 states and the District of Columbia are represented. The only state that did not respond was Alaska.

Source: State of Washington and Minnesota Department of Human Services.

*Minnesota rates reflect a 10 percent raise that was effective October 1, 1988.

**Number of states reporting.

Table 4.7: Results of Maternity Care Access and Reimbursement Survey, September 1988

Claims Processing Performance

Doctors feel Medicaid takes too long to pay claims.

Doctors feel Medicaid takes too long to pay claims. Table 4.8 shows Medicaid pays a claim with no errors in an average of 21.5 days. However, the average number of days between the time the service is provided and the time when Medicaid pays is almost 75 days.[11] This includes the time necessary to bill Medicaid and any time spent dealing with claims rejected by Medicaid.[12] This latter number is almost 25 days more than it takes for dentists to be paid. This is because Medicaid rejects and suspends more physician than dentist invoices. Table 4.9 shows the distribution of average time until payment by

11 DHS statistics suggest the average time until adjudication considering all physician Medicaid claims is about 100 days for physicians. However, the reports generated by the Management and Reporting System contain many anomalies and they are considered unreliable by many in the department. We chose to generate a consistent number directly from the department's research database.

12 Some providers bill Medicaid every two weeks or less often.

Average Number of Days Between Service and Date Paid

	Number of Days		
Billing Source	1985	1986	1987
Physician	81.3	82.5	74.8
Physician Clinic	108.6	90.0	86.0

Average Number of Days Between DHS Receiving Error-Free Claim and Date Claim is Paid

	Number of Days		
Billing Source	1985	1986	1987
Physician	26.4	25.5	21.5
Physician Clinic	35.4	30.3	26.2

Table 4.8: How Quickly the Department of Human Services Pays Medical Doctors

Time Between Service and Date Paid

	Physician Billing Sources		Physician Clinic Billing Sources	
Average Number of Days	Number	Percent	Number	Percent
0-20	37	0.5%	2	1.0%
20-40	396	5.3	15	7.2
40-60	1,295	17.3	24	11.6
60-80	1,987	26.6	29	14.0
80-100	1,496	20.0	16	7.7
More Than 100	2,269	30.3	121	58.5
Total	7,480	100.0%	207	100.0%

Time Between Receipt of Error-Free Claim and Date Paid

	Physician Billing Sources		Physician Clinic Billing Sources	
Average Number of Days	Number	Percent*	Number	Percent
0-20	3,336	44.6%	82	39.6
20-40	3,587	48.0	64	30.9
40-60	469	6.3	44	21.3
60-80	74	1.0	12	5.8
80-100	7	0.1	0	0
More Than 100	7	0.1	5	2.4
Total	7,480	100.1%	207	100.0%

*Does not total 100 due to rounding.

Table 4.9: Payment of Medical Claims, 1987

provider. The table illustrates that some providers are able to get their invoices through the system more quickly than others.

Problems With Coordination of Benefits

Many providers commented on the difficulties associated with coordination of benefits. When a Medicaid recipient has some other form of insurance, workers' compensation, or other third-party coverage, Medicaid pays the balance of the claim after the insurer. Prior to 1986, Medicaid paid the claim and then tried to recover from the liable third party, a so-called "pay-and-chase" strategy.

Federal law changes in 1986 require that the provider try to collect from the third party before Medicaid pays the claim, a strategy known as "cost avoidance." Many providers complained about this change of federal strategy because it requires that they track down and bill the liable third party. Ideally, the provider should note that the Medicaid ID card indicates other health coverage and they should collect the appropriate information from the recipient about whom to bill. In practice this is sometimes difficult. Sometimes recipients do not know their other coverage, and sometimes provider staff do not realize they should bill another party. As a result, many times providers bill Medicaid. Medicaid rejects these claims, and sends a remittance advice form to the provider indicating what is known about the recipient's other health care coverage. If the provider attempts to bill the liable party or to get insurance policy information three times, then Medicaid will pay the claim and attempt to collect from the liable party.

- **In short, coordination of benefits provisions do result in more problems for the providers. However, because it is a federal requirement, there is little the state can do to ease the problem.**

SUMMARY AND CONCLUSIONS

Physicians are dissatisfied with Medicaid reimbursement, administration, and patients, but to date they are not dropping out of the program. In some areas of the state physicians have limited the number of Medicaid patients they will see. Overall, physicians' reimbursement is about 65 percent of the charges they submit for payment, but there is considerable variation among physicians and practice specialties. Medicaid pays nine percent of physicians less than 50 percent of their submitted charges, and an additional 21 percent less than 60 percent of charges. Medicaid also pays less than physicians' cost for many injectable drugs and immunizations.

Physicians are also dissatisfied with Medicaid administration. We conclude that there is some basis for that dissatisfaction, but that the Department of Human Services has been making progress in paying claims more quickly with fewer problems for providers. However, provider relations with the department are poor.

DISCUSSION AND RECOMMENDATIONS

Chapter 5

We examined access to health care services for Medicaid recipients because of claims that some providers were declining to serve Medicaid patients. The primary purpose of our project was to provide an objective assessment of the situation. We particularly wanted to examine the complaints health care providers have made about the program.

We found that many dentists are declining to participate, causing difficult access for Medicaid and GAMC recipients in some areas of the state. Finding willing medical service providers also was difficult in a few areas of the state.

We found that Medicaid patients were able to receive needed care. However, increasing difficulty in finding willing providers raises questions about future access to health care for public assistance recipients.

The state's goal is to provide reasonable access to health services for public assistance recipients. However, exactly what constitutes "reasonable" access is uncertain because there is no generally accepted standard. We found that some GAMC and Medicaid recipients had difficulty finding willing providers and often had to travel to another county to do so.

The most important reason dentists and some physicians are declining to serve Medicaid patients is the perception that Medicaid reimbursement rates are too low. We found that Medicaid appeared to pay more than the provider's average overhead costs, but there is wide variability in payment levels.

The second important reason providers limit the number of Medicaid patients they see is a perception that getting Medicaid bills paid is too difficult. We found that providers have problems dealing with what they call the Medicaid "bureaucracy."

PROPOSED CHANGES

Medicaid services are paid on the basis of a reference file of over 15,000 procedure codes and rates.[1] There are significant problems with the reference

1 There are actually several different reference files for different provider types. Some of the same procedures are contained in different files, resulting in over 86,000 codes and rates that must be kept consistent.

Reimbursement rates for many procedures have not been updated regularly or consistently.

file which contribute to the frustrations of providers. For example, the reimbursement amounts for many procedures have not been updated regularly, and many have not been updated consistently. This results in discrepancies in payment between different providers depending on how they bill. Also, in the past, there was no control over how changes to reference file rates were made. Many individuals made changes to the reference file without any overall control or coordination. Although the department now has better control over reference file changes, there are many pricing inconsistencies resulting from previous *ad hoc* changes.

Keeping Medicaid rates and codes current as medical and dental practice changes is a complex job that has sometimes received little attention from the department. The department is aware of problems with the reference file, and has had several projects to update parts of it. However, the department reports that its current staffing is inadequate to systematically resolve the reference file problems. As we saw in Chapter 4, the failure to update reference file rates also results in providers being paid less than cost for certain drugs and immunizations administered in their offices. We believe that many Medicaid provider complaints are related to reference file inconsistencies.

What can the state do to raise Medicaid provider participation? Of course, providers propose that reimbursement levels should be raised, although some physicians and dentists also say they will quit serving Medicaid patients because of administrative problems. The Department of Human Services' 1990-1991 budget request proposes to raise provider reimbursement rates in a targeted fashion. DHS proposed increases of 15 percent, 7.5 percent, and 3 percent depending on the type of service. The total cost of these increases is estimated at $6.4 million for fiscal year 1990. The Department of Finance and the Governor have recommended no increase in provider reimbursement rates.

Whether or not these increases are needed or are the right amounts is a matter for legislative debate. However, it is very clear that the current basis for payment, the reference file, has serious flaws. In some respects, payment increases would compound the already serious reference file problems, because they would be adding varying percentage increases to rates that contain many inaccuracies and inconsistencies. This problem will not be solved by the new Medicaid Management Information System (MMIS). In fact, unless the reference file is fixed, the new MMIS will inherit the flaws of the current system.

DHS should have the authority to correct reference file errors.

The department's job is further complicated by the fact that it does not technically have authority to set reference file prices, although it has made changes in the past anyway.[2] We believe it is reasonable that the department have the authority to make technical and administrative changes to Medicaid rates where necessary. The department should have appropriate internal controls over reference file changes, and it should not decide on broad changes in reimbursement levels. The department should disclose its actions to the Department of Finance, the House Appropriations Committee, and the Senate Finance Committee.

We believe the problems with the reference file are serious enough that they demand immediate attention. Therefore, we recommend:

2 It is possible that Minnesota will face federal cost disallowances because of reference file problems.

DHS should review and correct problems with its Medicaid payment rates.

- **The department should systematically review and correct problems with its Medicaid rates. It may be necessary to seek additional staffing to complete this task.**

- **The Legislature should amend Minnesota Statutes 256B to allow the department the authority to make necessary administrative changes to Medicaid prices. The Department should be required to report such changes to the Department of Finance and appropriate legislative committees.**

Systematically reviewing rates and changing them where necessary would help to rationalize provider payments. We believe it will also ease some of the department's provider relations problems.

The department also proposes to "study a restructure of the pricing method on which the reference file is based." While we believe this is a worthwhile effort, it is critical that the current reimbursement system be brought up-to-date and made consistent before trying to make a transition to some new payment scheme.

We believe better provider relations and training would encourage participation.

The department proposes to add one person to keep its recently completed provider manual up-to-date and perform other provider relations tasks. DHS also seeks funding to regularly update and disseminate the provider manual. Based on provider complaints we reviewed, we believe this is a worthwhile effort. However, we believe that several more persons should be devoted to provider relations and training functions. Many problems are created for both providers and the department because of miscommunication and a lack of provider training. All other third-party payors we contacted had personnel devoted to this function. Many providers who responded to our surveys expressed the general attitude, "If you can't pay me well, at least ease my problems in getting paid in a timely way." We believe that a dedicated provider training and support function can help turn around the perception of the Medicaid "bureaucracy." Therefore, we recommend:

- **The Department of Human Services should devote several positions to Medicaid provider support and training.**

The state will have to maintain consistently higher reimbursement levels if administrative problems are not fixed.

We believe that the state will have to maintain a consistently higher level of reimbursement to ensure provider participation if administrative problems are not remedied. We believe that pursuing a policy of consistent, timely, and fair provider payment will discourage many providers from dropping out of the Medicaid program at any given level of reimbursement.

RECIPIENT GROUPS CONTACTS LIST

Appendix A

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Appendix B

**

Minnesota Dentists Survey

Instructions: We are seeking your opinions about Minnesota's major health care program for low-income persons -- the Medical Assistance program. Your opinions are important whether or not you are currently an enrolled provider of the Medical Assistance program. Your reply will be kept strictly confidential.

1. Do you participate in Minnesota's Medical Assistance Program, that is, do you receive payments from Medical Assistance?

N = 724

81.9% ☐ Yes

18.1 ☐ No →

1a. Did you participate in Medical Assistance at any time in the past?

N = 128

83.6% ☐ Yes

16.4 ☐ No → *Please turn to Question 12 on Page 4*

(If yes) When did you stop? N = 104

6.7% ☐ 1. Less than six months ago

12.5 ☐ 2. About six months to a year ago

80.8 ☐ 3. More than a year ago

Briefly, what was the major factor that led you to end your Medical Assistance participation?

Please turn to Question 5 on Page 2. →

2. Do you now see all Medical Assistance patients who contact you or only some?

N = 589

36.8% ☐ All

63.2 ☐ Some →

2a. How do you limit your Medical Assistance practice?

N = 372

65.6% ☐ a. Will see only established patients, not new Medical Assistance patients.

15.9 ☐ b. Limit the total number or proportion of Medicaid patients served in my practice.

3.5 ☐ c. See only referrals

2.7 ☐ d. See only emergencies

1.3 ☐ e. Will see only MA patients from my county.

9.9 ☐ f. Other *(Please Explain)*

3. About what percentage of the office visits you have during a typical week are with Medical Assistance patients? 8.6 (mean) % N = 699

** This number is used solely to register receipt of your survey. The survey's identification will be destroyed. Your reply is strictly confidential and only summary data will be published.

NOTE: Percentages may not total 100 due to rounding.

4. Would you like to change the number of Medical Assistance patients you see?

N = 575

43.5%	☐	No, I don't anticipate the number changing.
5.9	☐	Yes, I would like to serve more.
50.6	☐	Yes, I would like to serve fewer.

4a. What would make you consider cutting back on the number of Medical Assistance patients you see?

5. **In comparison to your experience with other third party payors** do you Strongly Agree, Agree, Disagree, or Strongly Disagree with the following statements about the Minnesota Medical Assistance program:

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	N
a.	Medical Assistance administrative requirements for dentists are generally reasonable.	1.0%	33.1%	27.2%	35.3%	3.5%	692
b.	Payments usually are received within 30 days of submitting an invoice.	2.3	34.1	27.9	27.8	7.9	687
c.	The state communicates program requirements well.	1.5	42.3	32.5	19.0	4.8	686
d.	Medical assistance invoices are difficult to fill out correctly.	21.3	30.2	39.3	4.8	4.4	689
e.	The state's list of services requiring prior authorization is reasonable.	1.3	50.0	27.0	14.8	6.9	684
f.	Prior authorization requests are processed promptly.	.6	35.1	33.9	20.3	10.1	684
g.	Prior authorization criteria are appropriate.	.6	39.6	31.0	18.8	10.1	672
h.	Reimbursement rates are reasonable overall.	.7	2.2	13.4	83.0	.7	693
i.	Reimbursement is too low for certain procedures.	76.2	14.1	1.3	7.6	.7	694
j.	Medical Assistance reimbursement generally covers my costs of providing services.	.9	11.2	29.4	57.2	1.3	690

6. **In comparison with your other patients** do you Strongly Agree, Agree, Disagree, or Strongly Disagree with the following statements about Medical Assistance recipients:

		Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	
a.	Medical Assistance patients keep their appointments as often as other patients.	.6	7.6	30.3	61.1	.4	697
b.	Medical Assistance patients' dental problems are no more difficult to treat than other patients'.	3.0	43.2	33.5	19.7	.6	695

7. Given current reimbursement levels under the Medical Assistance system, what are your practice's plans for the program in 1989?

N = 649

33.9% ☐ Will accept new patients as time permits
46.8 ☐ Will treat current patients but not accept new patients
19.3 ☐ Will terminate participation in the program

8. What changes in Medical Assistance program administration or reimbursement policies would you recommend?

9. Has your office received calls from or served medical assistance patients who could not receive care from other dental providers?

N = 673

86.3% ☐ Yes
13.7 ☐ No

10. For the most part, where is your practice based?

N = 698

63.5% ☐ 1. Private office (solo practice)
33.4 ☐ 2. Private clinic (group practice) → 10a. How many full-time equivalent dentists practice at your location?
.7 ☐ 3. Health Clinic Staff
1.0 ☐ 4. Hospital or Dental School
.3 ☐ 5. Residential Facility/Home
0 ☐ 6. I have retired from practice *(Skip to Question 16)*
1.1 ☐ 7. Other *(Please explain)*

11. Do you perceive yourself as more or less satisfied than your peers with the Medical Assistance program?

N = 673

7.1% ☐ Less satisfied than my peers
85.6 ☐ About the same
7.3 ☐ More satisfied than my peers

12. Do you limit your practice to a specialty?

N = 716

13.7% ☐ Yes → 12a. What specialty do you practice?
86.3 ☐ No

N = 100

43.0% Orthodontist
21.0 Oral Surgeon
13.0 Periodontist
9.0 Endodontist
7.0 Pediatrics
5.0 Prosthodontist
2.0 Other

13. Are you able to accept new patients?

N = 703

3.8% ☐ 1. No, my practice is at capacity.
96.2 ☐ 2. Yes, I am able to accept new patients.

14. What county is your practice located in?

15. Minnesota also runs a smaller but distinct state-funded program General Assistance Medical Care (GAMC) with somewhat different reimbursement policies. Do you have any comments specifically about GAMC?

16. Are there any comments you would like to add?

Thank you for your participation.

Please return the survey in the enclosed envelope to: Office of the Legislative Auditor
122 Veterans Service Bldg.
St. Paul, Minnesota 55155

Appendix C

**

Minnesota Physicians Survey

Instructions: We are seeking your opinions about Minnesota's major health care program for low-income persons -- the Medical Assistance program. Your opinions are important whether or not you are currently an enrolled provider of the Medical Assistance program. Your reply will be kept strictly confidential.

1. Do you participate in Minnesota's Medical Assistance Program, that is, do you receive payments from Medical Assistance?

N = 513

97.1% ☐ Yes
2.9 ☐ No →

1a. Did you participate in Medical Assistance at any time in the past?
N = 14

57.1% ☐ Yes
42.9 ☐ No → *Please turn to Question 12 on Page 4*

(If yes) When did you stop? N = 7

14.3% ☐ 1. Less than six months ago
28.6 ☐ 2. About six months to a year ago
57.1 ☐ 3. More than a year ago

Briefly, what was the major factor that led you to end your Medical Assistance participation?

Please turn to Question 5 on Page 2. →

2. Do you now see all Medical Assistance patients who contact you or only some?

N = 499

78.8% ☐ All
21.2 ☐ Some →

2a. How do you limit your Medical Assistance practice?
N = 102

60.8% ☐ a. Will see only established patients, not new Medical Assistance patients.
8.8 ☐ b. Limit the total number or proportion of Medicaid patients served in my practice.
8.8 ☐ c. See only referrals
0 ☐ d. See only emergencies
2.0 ☐ e. Will see only MA patients from my county.
19.6 ☐ f. Other *(Please Explain)*

3. About what percentage of the office visits you have during a typical week are with Medical Assistance patients? 14.0 (mean) % N = 464

** This number is used solely to register receipt of your survey. The survey's identification will be destroyed. Your reply is strictly confidential and only summary data will be published.

NOTE: Percentages may not total 100 due to rounding.

4. Would you like to change the number of Medical Assistance patients you see?
N = 475

59.2% ☐ No, I don't anticipate the number changing.
5.9 ☐ Yes, I would like to serve more.
34.9 ☐ Yes, I would like to serve fewer.

4a. What would make you consider cutting back on the number of Medical Assistance patients you see?

5. **In comparison to your experience with other third party payors** do you Strongly Agree, Agree, Disagree, or Strongly Disagree with the following statements about the Minnesota Medical Assistance program:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	N
a. Medical Assistance administrative requirements for physicians are generally reasonable.	1.0%	30.2%	32.6%	23.6%	12.6%	484
b. Payments usually are received within 30 days of submitting an invoice.	.6	15.6	25.6	26.6	31.6	488
c. The state communicates program requirements well.	.8	31.3	31.3	19.4	17.1	485
d. Medical assistance invoices are difficult to fill out correctly.	13.7	26.3	22.2	3.7	34.2	483
e. The state's list of services requiring prior authorization is reasonable.	1.2	46.3	21.9	8.5	22.1	484
f. Prior authorization requests are processed promptly.	1.0	34.4	20.1	6.7	37.7	477
g. Prior authorization criteria are appropriate.	.6	42.2	23.1	4.9	29.1	467
h. Reimbursement rates are reasonable overall.	.2	4.1	27.6	60.8	7.3	490
i. Reimbursement is too low for certain procedures.	50.6	25.9	3.3	10.6	1.6	490
j. Medical Assistance reimbursement generally covers my costs of providing services.	1.2	10.4	34.3	45.3	8.8	490

6. **In comparison with your other patients** do you Strongly Agree, Agree, Disagree, or Strongly Disagree with the following statements about Medical Assistance recipients:

	Strongly Agree	Agree	Disagree	Strongly Disagree	Don't Know	N
a. Medical Assistance patients keep their appointments as often as other patients.	1.2%	27.3%	43.9%	25.5%	2.0%	501
b. Medical Assistance patients' medical problems are no more difficult to treat than other patients'.	2.2	44.8	35.4	16.4	1.2	500

7. Given current reimbursement levels under the Medical Assistance system, what are your practice's plans for the program in 1989?
N = 474

78.3% ☐ Will accept new patients as time permits
20.3 ☐ Will treat current patients but not accept new patients
1.5 ☐ Will terminate participation in the program

8. What changes in Medical Assistance program administration or reimbursement policies would you recommend?

9. Has your office received calls from or served medical assistance patients who could not receive care from other medical providers?
N = 431

57.8% ☐ Yes
42.2 ☐ No

10. For the most part, where is your practice based?
N = 505

12.7% ☐ 1. Private office (solo practice)
77.0 ☐ 2. Private clinic (group practice) → 10a. How many full-time equivalent dentists practice at your location ?
1.6 ☐ 3. Health Clinic Staff
1.8 ☐ 4. HMO Staff
5.1 ☐ 5. Hospital
0 ☐ 6. Residential Facility/Home
0 ☐ 7. I have retired from practice *(Skip to Question 16)*
1.8 ☐ 8. Other *(Please explain)*

11. Do you perceive yourself as more or less satisfied than your peers with the Medical Assistance program?

N = 494

3.0% ☐ Less satisfied than my peers
85.6 ☐ About the same
11.3 ☐ More satisfied than my peers

12. Do you limit your practice to a specialty?

N = 507

84.8% ☐ Yes → 12a. What specialty do you practice?
15.2 ☐ No

N = 436
50.0% Family Practice
22.9 Internal Medicine
11.9 OB/GYN
10.6 Pediatrics
4.6 Other

13. Are you able to accept new patients?

N = 495

13.7% ☐ 1. No, my practice is at capacity.
86.3 ☐ 2. Yes, I am able to accept new patients.

14. What county is your practice located in?

15. Minnesota also runs a smaller but distinct state-funded program General Assistance Medical Care (GAMC) with somewhat different reimbursement policies. Do you have any comments specifically about GAMC?

16. Are there any comments you would like to add?

Thank you for your participation.

Please return the survey in the enclosed envelope to : Office of the Legislative Auditor
122 Veterans Service Bldg.
St. Paul, Minnesota 55155

SELECTED PROGRAM EVALUATIONS

Board of Electricity, January 1980	80-01
Twin Cities Metropolitan Transit Commission, February 1980	80-02
Information Services Bureau, February 1980	80-03
Department of Economic Security, February 1980	80-04
Statewide Bicycle Registration Program, November 1980	80-05
State Arts Board: Individual Artists Grants Program, November 1980	80-06
Department of Human Rights, January 1981	81-01
Hospital Regulation, February 1981	81-02
Department of Public Welfare's Regulation of Residential Facilities for the Mentally Ill, February 1981	81-03
State Designer Selection Board, February 1981	81-04
Corporate Income Tax Processing, March 1981	81-05
Computer Support for Tax Processing, April 1981	81-06
State-sponsored Chemical Dependency Programs: Follow-up Study, April 1981	81-07
Construction Cost Overrun at the Minnesota Correctional Facility - Oak Park Heights, April 1981	81-08
Individual Income Tax Processing and Auditing, July 1981	81-09
State Office Space Management and Leasing, November 1981	81-10
Procurement Set-Asides, February 1982	82-01
State Timber Sales, February 1982	82-02
Department of Education Information System,* March 1982	82-03
State Purchasing, April 1982	82-04
Fire Safety in Residential Facilities for Disabled Persons, June 1982	82-05
State Mineral Leasing, June 1982	82-06
Direct Property Tax Relief Programs, February 1983	83-01
Post-Secondary Vocational Education at Minnesota's Area Vocational-Technical Institutes,* February 1983	83-02
Community Residential Programs for Mentally Retarded Persons,* February 1983	83-03
State Land Acquisition and Disposal, March 1983	83-04
The State Land Exchange Program, July 1983	83-05
Department of Human Rights: Follow-up Study, August 1983	83-06
Minnesota Braille and Sight-Saving School and Minnesota School for the Deaf,* January 1984	84-01
The Administration of Minnesota's Medical Assistance Program, March 1984	84-02
Special Education,* February 1984	84-03
Sheltered Employment Programs,* February 1984	84-04
State Human Service Block Grants, June 1984	84-05
Energy Assistance and Weatherization, January 1985	85-01
Highway Maintenance, January 1985	85-02
Metropolitan Council, January 1985	85-03
Economic Development, March 1985	85-04
Post Secondary Vocational Education: Follow-Up Study, March 1985	85-05
County State Aid Highway System, April 1985	85-06
Procurement Set-Asides: Follow-Up Study, April 1985	85-07

Insurance Regulation, January 1986	86-01
Tax Increment Financing, January 1986	86-02
Fish Management, February 1986	86-03
Deinstitutionalization of Mentally Ill People, February 1986	86-04
Deinstitutionalization of Mentally Retarded People, February 1986	86-05
Management of Public Employee Pension Funds, May 1986	86-06
Aid to Families with Dependent Children, January 1987	87-01
Water Quality Monitoring, February 1987	87-02
Financing County Human Services, February 1987	87-03
Employment and Training Programs, March 1987	87-04
County State Aid Highway System: Follow-Up, July 1987	87-05
Minnesota State High School League,* December 1987	87-06
Metropolitan Transit Planning, January 1988	88-01
Farm Interest Buydown Program, January 1988	88-02
Workers' Compensation, February 1988	88-03
Health Plan Regulation, February 1988	88-04
Trends in Education Expenditures,* March 1988	88-05
Remodeling of University of Minnesota President's House and Office, March 1988	88-06
University of Minnesota Physical Plant, August 1988	88-07
Medicaid: Prepayment and Postpayment Review - Follow-Up, August 1988	88-08
High School Education,* December 1988	88-09
High School Education: Report Summary, December 1988	88-10
Statewide Cost of Living Differences, January 1989	89-01
Access to Medicaid Services, February 1989	89-02
Minnesota Housing Finance Agency, Forthcoming	
Participation in Public Assistance Programs, Forthcoming	
Community Residences for the Mentally Ill, Forthcoming	

Evaluation reports can be obtained free of charge from the Program Evaluation Division, 122 Veterans Service Building, Saint Paul, Minnesota 55155, 612/296-4708.

*These reports are also available through the U.S. Department of Education ERIC Clearinghouse.