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HCFA Looks at Medicaid Mills

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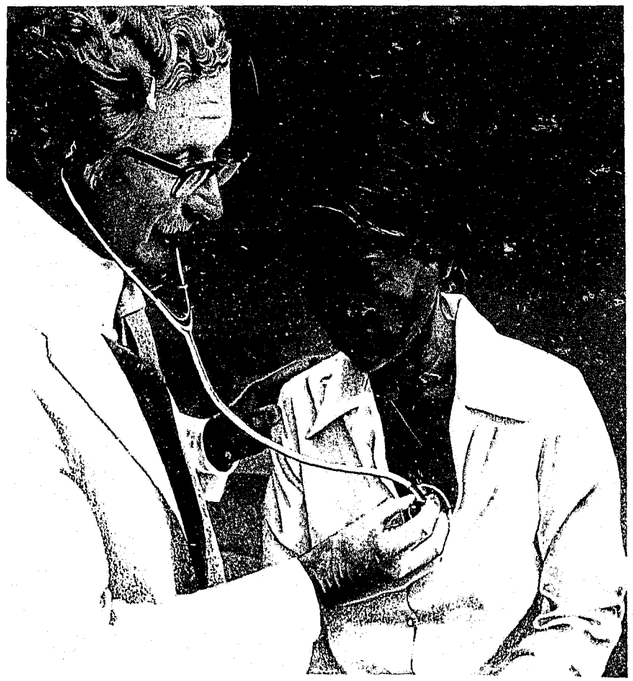
Is It True What They Say about "Medicaid mills?"

by James E. Kendrick



For the physician seeing large numbers of Medicaid patients, the images painted by Norman Rockwell are shattered. No more good-natured grandfathers mending broken dolls or treating freckle-faced boys. No more nostalgia about the homelike comfort of the nearby doctor's office.

Public hearings, investigations, and the media have sketched a new portrait: A money-hungry charlatan becoming extraordinarily wealthy through the publicly-financed Medicaid program. A turncoat doctor who victimizes the poor and medically needy—giving inadequate, inappropriate, and even unnecessary services. An opportunist, running a shabby operation out of a filthy office.

Investigations by Senator Frank Moss have spotlighted fraud and abuse in large Medicaid practices. His team of researchers found instances in which practices were functioning as "Medicaid mills:" ambulatory health care operations set up to maximize profits by serving a large number of Medicard-eligible patients. The physicians involved were poorly trained, had few credentials, and gave patients as little as three minutes of attention during an office visit. Moreover, they ordered unnecessary income-producing services, received kickbacks from laboratories, and submitted fraudulent bills.

Exception or rule?

But such fraud and abuse may be the exception rather than the rule, according to a recent study. Most physicians with large Medicaid practices (defined as those in which 30 percent or more of the patients are Medicaid beneficiaries) fits the image of neither Rockwellian nostalgia nor mercenary villain. Positive findings on such physicians show that they:

- Average about the same income as those whose caseloads include only a small proportion of Medicaid beneficiaries;
- Are more often found in small cities, rural areas, and the South than in large, urban ghettos;
- Do not order significantly more income-generating ancillary services than other physicians, except for injections;
- Do not mark up fees over costs excessively when compared to other physicians;
- Are solo practitioners, rather than members of a large clinic.

On the negative side, office visits to physicians with large Medicaid practices do tend to be shorter, but only by a few minutes. Generally, such physicians have inferior background and training, when compared to practitioners serving small numbers of Medicaid patients. They have fewer credentials, such as board certification, and more have been graduated from foreign medical schools.

Some Medicaid physicians enjoy conspicuously high incomes. One out of five has an income of $80,000 a year or more. For this exceptional group, the general practitioners are at the top, averaging $101,453, and the pediatricians the least well off, making do on $92,592.

This new picture emerges from a study, *Large Medicaid Practices: Are They Medicaid Mills?** by Janet B. Mitchell, Ph.D., of Boston University, and Jerry Cromwell, Ph.D., of Health Economics Research, Inc.

They analyzed information collected during a 1977 survey by the National Opinion Research Center of a nationally representative sample of 3,482 physicians in 15 specialties. All surveyed were in private practice, although group practices with ten or more physicians were excluded. The Mitchell-Cromwell study also compared the survey results with 1976 cost and income data. (Both study and survey were funded by the Health Care Financing Administration.)

"We can be fairly confident about our conclusions," Dr. Mitchell said in an interview. "They are based on data from a large, carefully selected sample of physicians."

Medicaid and the reluctant physician

If Medicaid seeks to move its beneficiaries into the mainstream of America's health care delivery system, the statistics argue that such a goal is as yet unrealized. Whether because of Medicaid's typically low fee schedule, opposition to government intervention in the financing of health care, or other reasons, many physicians are clearly relectant to care for program beneficiaries. Nearly one-fourth of the nation's 300,000 physicians do not participate, while another half see only one-quarter of Medicaid's patients.

Care for the remaining three-quarters of the Medicaid population is rendered by one-fourth of the physicians. Indeed, the concentration is so great that about 5 percent of physicians serve nearly a third of this population.

The one out of seven physicians with large Medicaid practices offers a focal point for evaluating the costs and services financed by Medicaid. On average, 42 percent of their patients receive Medicaid. In turn, most Medicaid patients have access to a limited number of physicians—and frequently these are among the few with large Medicaid practices.

One of five Medicaid physicians has an income of $80,000 a year or more.

Thus patients and physicians tend to be in the same boat. A critical analysis of these physicians reflects much about the costs and quality of health care available for millions of Medicaid patients.

Large practices in Rockwell country

Media attention has concentrated on so-called Medicaid mills in the large, central-city ghetto, suggesting that this is the customary habitat of large Medicaid practices. Such is not the case.

Three out of every five are in Norman Rockwell country—small cities and rural areas. Only two out of every five are in large metropolitan areas. This is the same pattern of distribution characteristic of practices with small Medicaid caseloads.

But what of those few physicians who earn very high incomes from large numbers of Medicaid patients? Surely they are located in big cities.

Physicians who earn $80,000 or more a year are indeed atypical, but the difference is surprising. Four out of

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every five practice in small cities and rural areas, with only one of five in big cities (see Figure 1).

The majority of LMPs are in the South and West, not the older industrial communities of the North. The exception is the physician with extra-large Medicaid caseloads, where at least half of the patients are program beneficiaries. Over 50 percent of these physicians are located in *small* cities of the Northeast.

Making a living through Medicaid

Most LMP physicians do not make extraordinary incomes. Their earnings are similar to practices with small Medicaid caseloads.

Comparing general practitioners having large Medicaid caseloads with counterparts having few Medicaid patients shows that the former earn about $53,100 a year—about $3,700 less than the latter. General surgeons with large Medicaid practices seem to fare slightly better, earning about $72,200 a year—or $3,400 more than their counterparts. Among pediatricians, those with many Medicaid patients constitute the "low-income" group, averaging about $47,200—several thousand less than the comparative specialists. Additional comparisons for internists and obstetricians-gynecologists are shown in Figure 2.

Averages can be misleading, of course. Two-thirds of physicians with large Medicaid practices earn between $40,000 and $60,000 a year, but an additional one out of every five earns less than $40,000.

General practitioners with small Medicaid caseloads have a better chance of earning over $60,000 a year than do those with large caseloads. Of the former, 36 percent fall into this upper range, compared to only 14 percent for large Medicaid practices.

The average physician with a large Medicaid practice earns a net hourly wage of $23.63, Mitchell and Cromwell estimate. Physicians with extra-large Medicaid caseloads (where at least half of the patients are beneficiaries) average even less—$18.22 an hour. These hourly earnings vary little from the $24.40 for physicians with small Medicaid practices and $23.69 for physicians with no Medicaid patients.

Since Medicaid fees per visit are typically lower, the physician with a large Medicaid practice must maintain a larger caseload and schedule more patient visits each week to keep up financially with his or her peers.

This physician averages 188 total visits a week, somewhat more than those with small Medicaid practices (169) and practitioners seeing no Medicaid patients (157). Despite the larger caseloads, however, they do not work significantly longer than the other practitioners, in part because visits to them average a minute or two less in duration.

High-income practitioners

Despite dollar limitations on Medicaid fees, one of every five physicians with a large Medicaid practice earns at least $80,000 a year. This group averages $96,447 yearly or $37.49 hourly.

Most—two out of every five—high-income physicians seeing many Medicaid patients are general surgeons. Internists make up nearly one-third of the group, but general practitioners constitute only one out of seven members of these top Medicaid moneymakers. Obstetricians-gynecologists and pediatricians make up 9 and 5 percent of this group, respectively.

On average, physicians with large Medicaid practices spend less time with patients during office visits (17.8 minutes) than do physicians with small or no Medicaid practices (19.6 minutes and 22 minutes respectively), although the difference is small.

Three-fifths of these physicians are located in the South. Nearly a quarter are in the West, and just over one-tenth are in the North Central region. Very few are in the Northeast.

Southern physicians who see Medicaid patients can earn higher incomes than their colleagues in other regions partly because states in the South pay Medicaid fees that are closer to or the same as fees for non-Medicaid patients. Only Mississippi has a fixed-fee schedule for reimbursing physicians for Medicaid cases. The other Southern states reimburse on the basis of "usual, customary, and reasonable" procedures. In other regions

Figure 1.

Distribution of Practices by Community Size

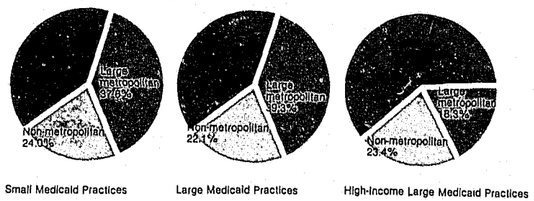
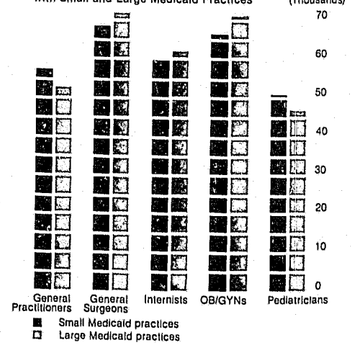


Figure 2.

Average Incomes of Physicians with Small and Large Medicaid Practices



of the country, the fixed-fee schedule is the norm—establishing Medicaid fees well below those paid by other health care plans.

The Medicaid practitioner with a high-income receives an average of $21.88 in gross revenues for each office visit. This is better than six dollars above the gross revenues for all physicians with large Medicaid practices and more than four dollars higher than the revenues of practitioners with small Medicaid caseloads (the latter presumably can set any fee that fits local market conditions).

The widest absolute gap in fees charged appears to be for internists with high incomes and large Medicaid practices, who gain seven dollars more in gross revenues for a visit than the average physician with a small Medicaid caseload ($25.47 versus $18.46).

In addition to grossing more, the high income physicians seeing many Medicaid patients also keep more money for themselves. On the average, they pocket 75 cents out of every dollar grossed, well above the 60 cents for large Medicaid practices as a whole and 65 cents for practices with small Medicaid caseloads.

High patient load

Another way a physician achieves an unusually high income is by seeing a large number of patients each week. It is not unusual to find physicians in this group scheduling 200 or more visits a week.

Why does a physician see this many patients? The researchers did not examine motives, but some possible reasons might include the unavailability of other physicians willing to care for Medicaid patients, an outright shortage of physicians in certain communities, or a desire to maximize income.

It is difficult to generalize about high-income physicians with large Medicaid practices. Three-fifths of them enjoy higher gross revenues by accident of being located in the South, where more liberal Medicaid reimbursements prevail. Also the mixture of cases they see may differ significantly from that of other groups of physicians. To illustrate, surgeons—who make up two-fifths of the group—perform operations, which increase revenues. Because they are more specialized than physicians with large Medicaid practices in general, they may perform services that command higher fees.

These high-income physicians do spend less time with each Medicaid patient—but high-income practitioners with small Medicaid caseloads also devote less time to each patient. "If short visit lengths are a sign of mills," according to Mitchell and Cromwell, "then there must be Blue Shield and Medicare 'mills' being run by other high-income physicians."

What a physician actually earns depends upon various factors. Revenues are generated through charges for visits, special procedures, and ancillary services. To illustrate, in-office surgery, laboratory tests, injections, and X-rays can all generate income. For specialists, there can be fees for special procedures—such as electrocardiograms, proctoscope examinations, spinal punctures, hernia repairs, and delivery of babies.

Then there are costs—for office space, personnel, equipment, laboratory tests, insurance, bookkeeping, and the like. Theoretically, the LMP physician scheduling 188 visits a week would be expected to incur weekly expenses of about $1,163, according to projections derived from data in the Mitchell and Cromwell study. The amount left after expenses is net income.

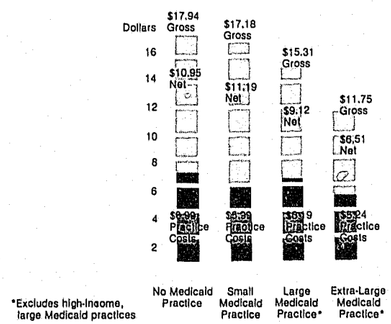
Medicaid profiteering?

Is the physician with a large Medicaid practice is profiteering from the program through high fees, high profit margins, and extra charges for unnecessary ancillary services? The answer is of great interest to Medicaid administrators at both the federal and state levels and to taxpayers.

On the whole, the physicians studied appear to be receiving rather modest payments for Medicaid patients, and their profit margins are equally restrained. Their average revenue per patient visit is $15.31 gross, compared to $17.18 for physicians with small Medicaid practices. Even more striking, the physicians with extra-large Medicaid practices gross $11.75 a visit.

Figure 3.

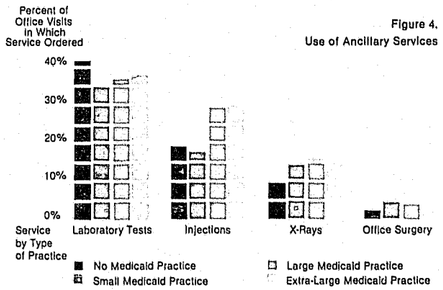
Physician Revenues and Costs per Patient Visit



*Excludes high-income, large Medicaid practices

Figure 4.

Use of Ancillary Services



Profit margins are relatively low for large Medicaid practices. Out of the $15.31 received in gross revenues, an average of $6.19 in practice costs is paid out—leaving $9.12 in net revenue or income. This is more than two dollars under the net revenue of practitioners with small Medicaid caseloads.

The extra-large Medicaid practice nets only $6.51, and the physician who sees no Medicaid beneficiaries nets $10.95. Physician revenues and costs per patient visit are summarized in Figure 3.

In terms of ancillary services, physicians seeing many Medicaid patients do not order extraordinary numbers of laboratory tests, x-rays, or office surgery. They order laboratory tests for about 37 percent of office visits, but physicians with no Medicaid patients order such tests in nearly 42 percent of office visits.

However, physicians with large Medicaid practices do order injections much more frequently. This is done for about three out of every ten visits—compared to fewer than two in ten physicians with small or no Medicaid caseloads. A profile of the use of ancillary services is presented in Figure 4.

Solo practice typical

Who is this person caring for large numbers of Medicaid patients? How does he or she fit into the general picture of health care in America?

We do not have sufficient information to paint the entire picture, but there are enough clues to offer at least a rough sketch. Clearly, the typical physician with a large Medicaid practice is a solo practitioner. Four out of five practice alone. By comparison, about six of every ten physicians with small Medicaid practices practice alone, as do seven of ten with large, high-income Medicaid caseloads.

Not counting sub-specialties, three out of ten are internists. Another three are general practitioners, and two are general surgeons. The remaining two are about equally divided between the OB/GYN and pediatric specialties.

This is not the case, though, for extra-large Medicaid practices. Of these, nearly 60 percent are general practices, and internists are only about half as frequently found as among physicians with large Medicaid practices (see table).

Distribution of Medicaid Practices Among Specialties

Specialty	No Medicaid Practice	Small Medicaid Practice	Large Medicaid Practice	Extra-Large Practice
General practitioner	46.0%	39.9%	29.3%	59.2%
General surgeon	6.9	21.2	22.3	10.1
Internist	17.5	20.9	30.5	15.4
OB/GYN	19.8	9.9	9.4	2.7
Pediatrician	9.8	8.2	8.4	12.5
	100.0%	100.0%	100.0%	100.0%

Credentials gap

A profile of physicians with large Medicaid practices is incomplete without addressing their credentials and training. While some would question whether credentials are a valid measure of competence, it is clear that physicians caring for large caseloads of Medicaid patients fall short in terms of qualification.

About one out of every five was trained at a medical school outside the U.S., compared to one out of eight for practices with small Medicaid caseloads. Since there are no uniform international standards for medical schools comparable to U.S. standards there is concern that such schools may offer generally inferior training.

These physicians are less likely to be board-certified—three in ten, compared to four in ten for practitioners with small Medicaid practices. Those in extra-large Medicaid practices lag even farther behind, with only 15 percent board-certified.

Nearly half of the physicians in extra-large Medicaid practices are 60 years of age or older. This is a neutral characteristic, but some policymakers express the concern that a disproportionate share of older physicians may not be keeping up to date medically.

"Some of the older physicians went to school back in the 1920s," Dr. Mitchell said, "and their schools may not even exist today. Many of the defunct schools simply couldn't meet quality standards."

The Mitchell and Cromwell study postulated that there are two separate markets for physicians' services. In one market, the physician is the price-setter, establishing fees in relationship to community demand. In the second market, prices are predetermined by a Medicaid fee structure, and the physician active in this market can decide, within limits, how many patients to serve.

The younger, better educated physicians will capture most of the first market, where fees are higher, the researchers feel. Their competitive edge will tend to drive less qualified physicians into the second market, where fees are less attractive.

One of the goals of the Medicaid program has been to move the medically disadvantaged into the mainstream of the American health care delivery system. If the program is indeed a "last resort" market for physicians, then many Medicaid recipients may be stranded in the backwaters of medicine.

Many Medicaid beneficiaries are receiving regular, office-based care for the first time in their lives. This alone is significant and may overshadow issues about the qualifications of their attending physicians. Yet a two-market theory leaves a nagging question: Are we fostering a health care sub-system that is separate and certainly not equal?

Hero, fall guy, or villain?

To accept the media portrayal of a physician who cares for large numbers of Medicaid patients as a villain (except in cases of outright fraud) seems inaccurate and unfair.

Certainly many—probably most—are providing competent medical care. Some physicians carry large Medicaid caseloads out of a moral commitment to serve all the people of their community. Others find themselves with predominantly Medicaid patients by default. They set up practice 20 or 30 years ago in a neighborhood that has since changed, now having large concentrations of low-income households. Or they practice in a community where many physicians refuse to participate in the Medicaid program, leaving such patients to their colleagues.

Whatever the reason, spreading the Medicaid caseloads more evenly throughout the medical community would mean that program beneficiaries would more likely become part of the health care mainstream, thus raising the level of care.

Castigation of physicians with large Medicaid practices can be a two-edged sword. While it may discourage fraud and abuse, it also casts an unsavory image on all physicians who care for Medicaid patients. This can only hinder efforts to encourage more physicians to serve program beneficiaries.

Formidable problems

Attempts to improve physician services financed through Medicaid inevitably become intertwined with strategies for strengthening the American system of health care deliver in general. Basic concerns persist: uneven distribution of physicians in relationship to the population, need for continuing health manpower education and training programs for practitioners, segmentation of the medical community on the basis of the patient's ability to pay different levels of fees, questions about the qualifications of foreign medical school graduates, and rising costs of medical care in general. The Department of Health and Human Services is taking initiatives to address these issues, but the problems are formidable.

Some physicians carry large Medicaid caseloads out of a moral commitment to serve all the people of their community; others do so by default.

Solutions will not be found solely at the national level. State decisions do much to shape the characteristics of the Medicaid market. The type of reimbursement a state adopts (fixed fee or URC) has implications for the health care marketplace, program costs, and the availability of health care to Medicaid eligibles.

For states using a fixed-fee schedule, the dollar value assigned to different services can effect physician willingness to take on large Medicaid caseloads. Surgeons, for example, are well represented among high-income LMP physicians; this may be partly a function of state fee schedules for surgery. Is care for a Medicaid patient worth a smaller fee than care for a Blue Shield or Medicare patient? If so, Medicaid may remain largely outside the health care mainstream, and program beneficiaries continue to be served primarily by a small proportion of physicians.

But if service to Medicaid patients and to other patients is declared to be of equal financial value, policy-makers have three options. They can decide to serve fewer Medicaid beneficiaries by tightening eligibility requirements and raising payments to physicians for those who qualify. They can earmark additional tax funds for higher payments. Or they can work to reform the American health-care delivery system through measures that contain health costs and make such care more affordable to both public and private pocketbooks.

Quality health care involves more than economics. Physician acceptance of the Medicaid program is vital, if program beneficiaries are to be served by a larger share of the country's medical practices. This may involve examining payment procedures, promptness, and diplomacy—as well as the dollar involved. And for those physicians who are doing a meritorious job in serving large Medicaid practices, there needs to be recognition, rather than bad press.

The Medicaid picture is part of the complex landscape of national health economics. To further illustrate it, Drs. Mitchell and Cromwell have sketched a portrait of the physician who cares for the majority of Medicaid patients. It is not as unflattering a likeness as the media might have us believe. ■

A research article on this subject, "Medicaid Mills: Fact or Fiction," will appear in the summer issue of the **Health Care Financing Review.** *Readers may obtain a copy of the publication from HCFA, ORDS Publications, Room 1-E-9, Oak Meadows Building, 6340 Security Blvd., Baltimore, Md. 21235 (telephone: 301-597-2345).*

As Medicaid programs are administered by the states, methods for reimbursing physicians vary accordingly. Within a given state, the method of reimbursement applies to all Medicaid patients and physicians who treat them.

Twelve states and the District of Columbia use the "customary, prevailing and reasonable charge" (CPR) methodology, which is the same as that used by Medicare medical insurance (Part B) and Blue Shield. Under this method, the reasonable charge or amount a physician is reimbursed for a service is the lesser of: the actual fee, the customary fee (the physician's average fee in the previous year), or the prevailing fee (at the 75th percentile for all physicians in an area). CPR takes into account the distribution of physician charges in a community and incorporates both historical and geographic variations in fee.

The remaining 39 states and territories participating in Medicaid use fee schedules or variations of the CPR. Medicaid fee schedules are lists of established rates for various procedures, applied state-wide, that may not exceed the existing Medicare reasonable charge for any procedure.

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