From: Tate, Larry
To: HFS.BPPC
Cc: Pignon, Brad
Subject: [External] proposed changes to Medicaid reimbursement
Date: Thursday, December 28, 2023 3:13:50 PM

In reference to the percent of Medicare approved amount, what **year** of Medicare allowed amounts is HFS using for this calculation (copied section below):

Practitioner rates are being adjusted from generally reimbursing at 60% of Medicare to 72% of Medicare for most services, including office visits, with a reimbursement ceiling set at 80% of Medicare

Larry Tate
Billing Compliance Manager/Compliance Officer
Patient Accounting, Adloff Facility (3rd floor)
Direct phone (217) 391-0761
Extension 77107
ltate@springfieldclinic.com

From: Brian Morse
To: HFS.BPPC
Subject: [External] Proposed rate increases for doctors
Date: Wednesday, December 6, 2023 2:28:56 PM

Hi,

As a pediatrician who has taken public aid for 21 years, this could be good news.

How can I see the details of the proposed fee schedule?

Thank you very much.

Dr. Morse.

From:	Kevin Daley
To:	HFS.BPPC
Subject:	[External] HFS Public Notice Comment Submission
Date:	Wednesday, January 3, 2024 3:25:44 PM
Attachments:	FINAL IL Medicaid Fee Schedule Proposed Changes Joint Comment Letter.pdf

Hello –

Attached are comments from the emergency physician community in response to the public notice titled, *Practitioner and Durable Medical Equipment Rates*. A hard copy of the comments have also been mailed to the address outlined in the public notice.

Best,

Kevin Daley
VP, State Government Affairs
Hart Health Strategies Inc.
C:779-970-8568
www.hhs.com

January 2, 2024

Bureau of Program and Policy Coordination
Division of Medical Programs
Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763-0001

Submitted electronically via www.hfs.illinois.gov

RE: Proposed Changes in Methods and Standards for Establishing Medical Assistance Payment Rates

Department of Healthcare and Family Services:

On behalf of the undersigned organizations, we write to express our strong desire to see emergency physician (EP) services included in the proposed methods and standards $97.7M and $5M bonus rate increases for the Illinois Medicaid Practitioner Fee Schedule.

Based on the methodology provided in the proposed changes, the current Medicaid reimbursement rate for emergency procedure codes in Illinois falls well below the 72% of Medicare rate that would be the new minimum threshold set for most procedural codes in the fee schedule.

Illinois EP's Medicaid reimbursement rates are among the lowest in the nation and fall in the lowest quartile of all state Medicaid Fee-For-Service (FFS) rates. The severity of this reality is only exacerbated when compared to some of our neighboring states, as the national average for 99285 is $138.28.

Procedure Code	Illinois	Indiana	Missouri
99285	$69.25	$166.70	$146.64
99284	$44.00	$114.79	$100.99
99283	$32.20	$67.92	$59.80
99282	$24.20	$39.61	$35.15
99281	$14.85	$10.97	$18.83

This problem is compounded by the fact that EPs and hospital emergency departments (EDs) are mandated by federal law to stabilize and treat anyone coming to an ED, regardless of their insurance status or ability to pay. Since EPs provide care to all patients who walk through their doors, they are the only universal health care providers in the system. It is a mission we are proud of, but it has complex implications.

Emergency services have continued to provide a safety net for Illinois residents who are without a primary care provider. ED visits between 1997 and 2007 nearly doubled the projected rate, which was attributed to an increase in visits by Medicaid adult and pediatric populations.[1]

Adding to the evolving role of EPs, there has also been a dramatic rise in the proportion of patients referred to the ED by primary care providers, creating significant difficulties in completing a complex work-up in the outpatient setting. This trend has led to a dramatic increase in hospital admissions from the ED. In the interval from 2003 to 2009, the proportion of emergent hospital admissions from the ED

[1] Tang N, Stein J, Hsia RY, Maselli JH, Gonzales R. Trends and characteristics of US emergency department visits, 1997-2007. JAMA. 2010;304:664–670.

increased from 60% to 69%, while the proportion of direct admissions from a primary care clinic decreased from 32% to 23%.[2]

The significant changes in the role of EPs have created challenges that we work to overcome every day to maintain the safety net for patients. We are the frontline for patient care and strongly believe that our increased responsibilities should be reflected in the methodology for both the $97.7M and $5M bonuses being used to increase reimbursement rates in the Medicaid Practitioner Fee Schedule.

As such, we urge the Department of Healthcare and Family Services (HFS) to consider these comments as the proposed changes are finalized.

Sincerely,

American College of Emergency Physicians
Emergency Department Practice Management Association
Illinois College of Emergency Physicians

[2] Gonzalez Morganti K, Bauhoff S, Blanchard JC, Abir M, Iyer N, Smith AC, et al. The evolving role of emergency departments in the United States. USA: The RAND Corporation; 2013.

Illinois Chapter
INCORPORATED IN ILLINOIS
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®

January 2, 2024

Bureau of Program and Policy Coordination
Division of Medical Programs
Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763-0001

Re: Public Notice on December 3, 2023: PROPOSED CHANGES IN METHODS AND STANDARDS FOR ESTABLISHING MEDICAL ASSISTANCE PAYMENT RATES

The Illinois Chapter of the American Academy of Pediatrics (ICAAP) seeks to improve the health and well-being of children and families in Illinois through education, advocacy, and support of pediatric healthcare providers across the state. On behalf of ICAAP and its 2100 members consisting of pediatricians, pediatric sub-specialists, nurse practitioners, and physicians in training, we are reaching out today to express our concern regarding the public notice posted on December 3, 2023, announcing Illinois' proposed changes to Medicaid physician payment rates.

Medicaid, administered by the Illinois Department of Healthcare and Family Services (HFS), has a significant impact on the overall health of children in our state. Children are disproportionally affected by low Medicaid reimbursement as they comprise 41% of all Illinois Medicaid enrollees[1]. Most severely affected is the health of Black and Brown children as nearly 62% of all Medicaid enrollees are non-white.[2] Because nearly 38% of Illinois youth are insured under Medicaid[3], every pediatrician and pediatric healthcare professional in the state has provided care for children enrolled in the program – either in their training or as one of the many currently enrolled healthcare providers across Illinois.

[1] https://www.kff.org/medicaid/state-indicator/total-medicaid-and-chip-child-enrollment
[2] https://www.kff.org/medicaid/state-indicator/medicaid-distribution-nonelderly-by-raceethnicity/
[3] https://files.kff.org/attachment/fact-sheet-medicaid-state-IL

Medicaid reimbursement rates directly affect physician participation in the Medicaid program and are a key factor in ensuring access to care for Medicaid enrollees. Low Medicaid payments force many providers in Illinois to make the difficult decision to limit or stop the treatment of Medicaid patients, as current reimbursements do not cover the costs of providing care. Research has demonstrated that physicians are far less likely to accept new Medicaid-enrolled patients than they are patients with other insurance types.[4] All Illinois children—including the more than 1,574,000 enrolled in Medicaid/CHIP[5]—deserve access to a high-quality medical home. Current low Medicaid reimbursement rates limit access to local consistent pediatric care, especially for Black and Brown children. Youth without a stable medical home are less likely to see a physician than those who do,[6] and several studies have demonstrated that children who have a consistent primary care provider have lower total healthcare expenses.[7] When children are shut out of mainstream healthcare in a physician's office, parents are forced to seek expensive, episodic treatment in Urgent Care Clinics and Emergency Rooms, often when their children are sicker, or they do not access care at all. The establishment of appropriate Medicaid rates will increase access, create more medical homes, and prevent families from accessing care in high-cost settings.

Medicaid in Illinois pays only 59% of what Medicare pays for all services and only 44% of what Medicare pays for primary care.[8] Medicaid payment rates for pediatric services have not been updated in Illinois since 2002 under the Memisoviski Consent Decree.

In 2013-2014, the federal government addressed the historic problem of low Medicaid physician payment by raising Medicaid payment rates for Evaluation and Management codes (preventive care) and immunization administration services to Medicare-equivalent levels. This was a historic investment in the care provided through the Medicaid program. Research has shown the positive effect of the 2013-2014 federal Medicaid payment increase. A 2018 study in *Pediatrics* shows that office-based primary care pediatricians broadened their Medicaid participation during the 2013-2014 federal payment increase in large part by boosting their Medicaid panels.[9] Another 10-state study in the *New England Journal of Medicine* showed the availability of physicians treating Medicaid patients jumped by 8 percentage points during the

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[4] https://www.ajmc.com/view/physicians-far-less-likely-to-take-new-medicaid-patients-cdc-finds

[5] https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

[6] https://ccf.georgetown.edu/2021/10/15/kids-with-gaps-in-coverage-have-less-access-to-care/

[7] https://www.milbank.org/wp-content/uploads/2016/02/PCPCC_2016_Report.pdf

[8] https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00611

[9] https://publications.aap.org/pediatrics/article/141/1/e20172570/37705/Increased-Medicaid-Payment-and-Participation-by?autologincheck=redirected

federal Medicaid payment increase. States with larger increases in payment saw availability increase by over 10 percentage points.[10]

Payment levels have a direct impact on access to care. A 2019 study by the National Bureau of Economic Research found that "Among children covered by Medicaid, a $10 increase in Medicaid payments leads to a 25 percent decrease in parents reporting trouble finding a doctor for their children." The authors found that taking the further step of *closing the gap between Medicaid payment and that of private payers* would close over 2/3 of the disparities in access for adults and eliminate such disparities for children.[11]

Physicians across Illinois reported the 2013-2014 federal payment increase made a real difference for children and practices—from large medical centers to small private practices. However, since that time, payment in Illinois has lagged and now sits at 56% less than Medicare levels for primary care services (source: Health Affairs citation). A recent study has shown that over 96% of Illinois physicians are willing to accept patients with private insurance, while only 73.6% of Illinois physicians accept patients covered by Medicaid[12]. Lower Medicaid payment creates a 2-tiered system in which those with private insurance have access to medical care and those enrolled in Medicaid increasingly do not. This is especially true for Black and Brown children who are more likely to be part of the Medicaid program.

Greater payment leads to greater utilization and improved health. A $10 increase in payment "leads to a 1.4 percent increase in the probability that beneficiaries visited a doctor in the past two weeks and a 1.1 percent increase in the probability that beneficiaries report being in very good or excellent health. Using self-reported data on school absences from the NHIS and administrative data on school attendance from the restricted-access National Assessment of Educational Progress (NAEP) files, we further find that a $10 increase in Medicaid payments leads to a 14 percent decrease in chronic absenteeism due to illness or injury and a 2.6 percent decrease in chronic absenteeism overall."[13] This confirms what we know—Medicaid payment levels directly impact the ability of physicians to accept Medicaid patients, the ability of patients to access care, and therefore the health and well-being of children and families.

While we are grateful that HFS is working to increase Medicaid payment across the state, we have identified some specific concerns regarding the proposed changes to codes and rates provided to ICAAP on December 20, 2023.

Method of Determination of Benchmark Rate

HFS is seeking to set a Medicaid benchmark as outlined in the public notice between 72% and 80% of Medicare rates. As such, they created a spreadsheet shared with ICAAP on December

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[10] https://www.nejm.org/doi/full/10.1056/NEJMsa1413299?query=featured_home
[11] https://www.nber.org/system/files/working_papers/w26095/w26095.pdf

[12] https://www.shadac.org/news/14-17-physician-Mcaid-SHC
[13] *Ibid*

20, 2023, that listed current Medicaid payment rates, Medicare rates for those codes in region 99, utilization data for physician types, and calculated the changes needed to move all rates to either 72% or 80% of Medicare fees. This resulted in increases in some codes but significant decreases in others. We are concerned about the methodology of this calculation due to the use of the lowest-cost region of the state and the use of facility (hospital) codes rather than non-facility (office) codes.

Medicare rates have regional differences that account for various factors and costs associated with care in those areas. Illinois has four specific areas – Chicago (16), Suburban Chicago (15), East St. Louis (12), and "Rest of Illinois" (99). Medicare fees in these areas can vary greatly due to differences in work relative value units (PW) related to time and intensity of services, practice expense (PE) related to costs of supporting practices such as rent, and malpractice values (MP) related to the costs of malpractice insurance in each region. Costs associated with providing care in Chicago are approximately 20% higher than in region 99 used to establish the benchmark for rates in Illinois. Variation in these rates by region is expressed in the Geographic Practice Cost Indices (GPCIs) issued by CMS:

CY 2023 GEOGRAPHIC PRACTICE COST INDICES (GPCIs) BY STATE AND MEDICARE LOCALITY						
Locality Number	Locality Name	2023 PW GPCI	2023 PE GPCI	2023 MP GPCI	Total	% of "99"
16	CHICAGO	1.009	1.033	1.945	3.987	20%
12	EAST ST. LOUIS	1	0.93	1.723	3.653	13%
15	SUBURBAN CHICAGO	1.007	1.055	1.53	3.592	11%
99	REST OF ILLINOIS	1	0.912	1.282	3.194	0%

Chicago (locality 16) consists of all of Cook County. Suburban Chicago (locality 15) consists of DuPage, Lake, Kane, and Will Counties. East St. Louis (locality 12) consists of Bond, Calhoun, Jersey, Macoupin, Madison, Monroe, Montgomery, Randolph, St. Clair, and Washington counties.

Medicaid enrollment also varies by region with the largest enrollment in the higher-cost area of Chicago. In FY23, Illinois reported a total enrollment of 3.9 million people of which 1.5 million are children. Regional breakdowns of each population based on Medicare region are listed below:

CY 2023 Rates of Illinois Medicaid Enrollment by Locality

Locality	Number of Children Enrolled	% of Total Children Enrolled	Number of Individuals Enrolled	% of Total Enrolled
Chicago (16)	687,090	45%	1,868,393	47%
Suburban (15)	283,754	18%	658,637	17%
East St. Louis (12)	84,493	5%	223,590	6%
Rest of Illinois (99)	486,778	32%	1,231,347	31%
TOTAL	1,542,115		3,981,967	

The proposed changes to the fee schedule are based on Medicare rates in Region 99 and do not consider the higher costs of care in other parts of the state. In addition, an estimated 70% of the Medicaid population lives in an area with higher healthcare costs than the area HFS is proposing to use as a benchmark for Medicaid rate determination. Rate increases associated with specific codes will continue to fall short of the costs associated with caring for the majority of Medicaid clients. The proposed decreases will have a larger effect on those living and practicing in Cook and the collar counties.

In addition, HFS utilized facility fees to determine their benchmark rates. Medicare provides rates based on the location type where services are provided. The two designations are "facility", covering services provided in a hospital, and "non-facility" for services provided in an office setting. CMS has determined higher rates for services delivered in the office due to the greater cost associated with supplying clinical staff, supplies, equipment, etc. Children are much more likely to access services in physician offices and facility fees do not cover the cost of these services. The chart below highlights the difference in using Facility (hospital) vs. non-facility (office) codes for the most common sick visits (99211-99215):

Procedure Code	FY 2023 Fee Schedule Rate	CY 2023 Medicare Rate FACILITY	Current % of Medicare	CY 2023 Medicare Rate NON-FACILITY	Current % of Medicare
99211	12.30	8.70	141%	21.99	56%
99212	24.25	35.29	69%	54.76	44%
99213	31.01	65.40	47%	87.96	35%
99214	47.62	96.49	49%	124.61	38%
99215	67.22	141.59	47%	174.96	38%

Although we are supportive of the increase proposed for 99212 to 99215, which will result in an estimated additional $19 million for pediatric healthcare, it will only cover 80% of projected costs for facilities (hospitals) not for care provided in offices. Proposed rate increases to these codes are only an average of 49% of Medicare costs for non-facilities. The chart below highlights the proposed rate changes for these codes and is expressed as an overall percentage of 2023 Medicare rates for care provided in non-facility settings. For example, code 99211 is scheduled

for reduction from $12.30 to $6.96 – 80% of the rate for care provided in a hospital (facility)- but $6.96 is only 32% of the costs of care for providing care in a clinic office (non-facility).

Procedure Code	CURRENT 2023 Fee Schedule Rate	2023 Medicare FACILITY RATE	PROPOSED 2024 RATE	2023 Medicare Rate - NON FACILITY	2024 rate as a % of 2023 Medicare non-facility rates
99211	$ 12.30	$ 8.70	$ 6.96	$ 21.99	32%
99212	$ 24.25	$ 35.29	$ 25.41	$ 54.76	46%
99213	$ 31.01	$ 65.40	$ 47.09	$ 87.96	54%
99214	$ 47.62	$ 96.49	$ 69.47	$ 124.61	56%
99215	$ 67.22	$ 141.59	$ 101.94	$ 174.96	58%

In addition, these four codes make up the bulk of the projected increase for pediatric care, while codes related to pediatric well child visits will decrease or remain stagnant. Many of the codes targeted for reductions in pediatrics are due to the baseline pricing of facility vs. non-facility services. For example, 30901 used for controlling a nosebleed is targeted for a reduction of $28.59. However, HFS is using the facility fee of $57.89 to determine that rate instead of the non-facility fee of $152.46. The same calculation using the non-facility fee would be an increase of $34.87. Services, such as this, that could be provided in physicians' offices will instead be referred to hospitals, creating not only increases in overall costs of care for the system but also sub-standard care for Medicaid-insured families.

ICAAP strongly recommends that HFS amend its benchmark rates in the following ways:

- Adjust benchmark rates to account for the population distribution of enrollees and differences in costs associated with care in various regions of the state.
- Adjust benchmark rates to non-facility fees for services provided in physician offices and not base increases or reductions on the fees for hospital-based care.

Without these changes, the proposed benchmark rates will not cover the costs of providing care for 1.5 million children in Illinois. Those in areas of high Medicaid utilization and/or higher costs of care will continue to receive substandard reimbursement that will limit access to healthcare.

Omission of Pediatric Primary Care Codes

Proposed changes omit pediatric primary preventative care. Pediatric well-child-care codes are not published in the Medicare fee schedule but are determined by CMS based on the Medicare formula using regional differences in practice expenses and professional liability insurance as well as RVUs.

In Illinois, Medicaid rates for preventative care have not increased since the Memisoviski Consent Decree in 2002. The consent decree addressed specific codes associated with pediatric and maternal care. These codes were omitted from all rate increases in 2020 and are not included in the proposed increases for 2024. The chart below lists the most common pediatric preventive care codes with the payments for 2023 based on current HFS fees plus the Maternal Child Health (MCH) add-on as consent decrees, the calculated rates for region 99 (rest of Illinois) as well as Chicago/Cook region. Although some codes are above the region 99 benchmark established by HFS, codes related to established patients (99391-99395) and providing vaccinations are below the 80% benchmark.

Procedure Code	Description	Current fee + MCH add-on	2024 Region 99 Calculated rate	Current % of Medicaid + MCH addon	2023 Chicago/Cook Region codes
Various	VFC Immunization**	16.71	$ 23.87	70%	n/a
99381	E/M new patient infant	91.90	$ 105.55	87%	$ 114.94
99382	E/M new patient age 1-4	98.65	$ 110.18	90%	$ 119.76
99383	E/M new patient age 5-11	96.60	$ 114.49	84%	$ 124.23
99384	E/M new patient age 12-17	104.96	$ 129.23	81%	$ 140.00
99385	E/M new patient age 18-39	104.96	$ 125.60	84%	$ 136.22
99391	E/M return patient infant	69.52	$ 94.71	73%	$ 102.87
99392	E/M return patient age 1-4	77.87	$ 101.53	77%	$ 110.39
99393	E/M return patient age 5-11	76.84	$ 101.22	76%	$ 110.04
99394	E/M return patient age 12-17	84.62	$ 110.47	77%	$ 119.68
99395	E/M return patient age 18-39	85.65	$ 113.22	76%	$ 122.75

** VFC reimbursement is determined by CMS through a rule, not an RVU formula. This is the Illinois regional maximum charge: www.federalregister.gov/documents/2012/11/06/2012-26507/rin-0938-aq63

We strongly recommend that Illinois follow the lead of 16 other states and raise pediatric primary care rates to 100% of Medicare rates. With increasing costs, and increasing administrative barriers in managed care, pediatric primary care providers across the state will continue to operate at a loss. Without increases in reimbursement for pediatric primary care services, children will continue to lose access to medical homes and physicians will not be able to provide important services – such as development and mental health screenings - that have proven benefits and long-term cost savings.

In summary, we call on HFS to:

- Determine the valuations for all pediatric codes and include these codes in all rate increases.
- Raise preventive pediatric primary care codes (Evaluation and management) to 100% of calculated Medicare rates.
- Specifically analyze codes 99391-99395 and those associated with participation in the Vaccinee for Children (VFC) program

Reduction of Codes in Pediatric Primary Care

ICAAP is strongly opposed to the proposed reduction of Medicaid payment for pediatric codes. There is ample research showing a direct connection between payment for services and access to care as highlighted above. We are gravely concerned that these code reductions are proposed to take effect on January 1, 2024, while the fee schedules are not projected to be posted until April 1, 2024. In the current proposal, healthcare providers will deliver care, submit for reimbursement, be paid on the 2023 fee schedule, and then – if services provided are connected to a fee reduction – will have the difference in those rates recouped months later when the 2024 fee schedule is posted. Healthcare providers and institutions, unaware of proposed code reductions in the coming year, will be unable to adjust practices to account for these losses.

In addition, multiple codes that will decrease under the proposed changes will likely affect pediatricians' ability to deliver care in pediatric offices. Many tests – such as lead and hemoglobin – are targeted for reductions and are critical tests of infants and toddlers that are routinely provided in offices. Other codes, such as those pertaining to asthma management and testing for strep and Influenza in the office are also targeted for reductions. Because HFS used only facility pricing on these codes, pediatric offices are going to be forced to either provide these services at a loss or refer families to hospitals for care.

We call on HFS to adjust the proposal in the following ways:

- Rate reductions should only go into effect 60 days after publication of the new rate schedule and not retroactively to January 1.
- Analyze the reduction in codes to determine the impact on access to care for pediatric patients and the ability to provide care in pediatric offices with a specific focus on codes used for well-child visits.
- Adjust codes to account for services provided in pediatric offices rather than hospital-based settings.

Incentive Pool

HFS highlights in its notice a "$5M incentive bonus pool for practitioners that provide certain services within local areas of the state with high concentrations of Medicaid eligible residents." HFS has provided no information regarding the allocation of this bonus pool. ICAAP urges the

department to be more transparent in the allocation of the pool and to ensure that pediatric healthcare providers are included in this funding.

Now is the time for Illinois to raise Medicaid payments to appropriate levels. The state must develop a benchmark that is fair and appropriate for each service in the region of the state in which it is provided. State funds used to increase rates will be matched by federal Medicaid dollars, thus serving as a force multiplier in strengthening our healthcare infrastructure in Illinois. Under current rules, for every $1 the state spends to increase Medicaid payment rates, the state will bring in an additional $1.04 in federal matching dollars.[14] Raising Medicaid payments not only benefits the children and families of Illinois but also brings additional federal dollars to our state. This is an investment in the children of Illinois and in our state's future that we cannot afford to miss.

We look forward to working with HFS to develop proposals that increase access to care for the 1.5 million children in their program. Additional questions can be directed to our Chief Executive Officer, Jennie Pinkwater at jpinkwater@illinoisaap.com

Sincerely,

Margaret Scotellaro, MD, FAAP
President, Executive Committee
Illinois Chapter, American Academy of Pediatrics

Cc: Lizzy Whitehorn, Director, Illinois Department of Healthcare and Family Services
Grace Hou, Deputy Governor, Health and Human Services
Representative Robyn Gabel, Majority Leader, House of Representatives
Senator Ann Gillespie, Chair, Health and Human Services Appropriation Committee

[14] Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier | KFF

[redacted]

[redacted]

[redacted]

From: Reimers, Scott <scottreimers@isms.org>
Sent: Wednesday, December 27, 2023 8:39 AM
To: Winick, Ben <Ben.Winick@Illinois.gov>; Ryan, Angela <Angela.W.Ryan@Illinois.gov>; Hostert, Patrick S <Patrick.S.Hostert@Illinois.gov>; Mendez, Dani <Dani.Mendez@Illinois.gov>
Cc: Carr, Jodi C. <Jodi.Carr@Illinois.gov>; Porter, David <davidporter@isms.org>
Subject: [External] Medicaid Comment Letter

Good morning HFS, just wanted to send this letter to all of you that contains ISMS' comments regarding the proposed "changes in methods and standards for establishing medical assistance payment rates," issues December 5, 2023 with an effective date of January 1, 2024. We are going to further submit these comments to the Medicaid Working Group as well.

We are grateful for all of your responsiveness and willingness to discuss this topic with us, but we are hoping for further discussions before this is finalized.

If you have any questions, please contact David Porter or myself.

Scott A. Reimers
Vice President
State Legislative Affairs
Illinois State Medical Society
Cell Phone: 217-274-8188
scottreimers@isms.org

From: Veton Hasku
To: Griffin, Jessica
Cc: HFS.BPPC
Subject: Re: [External] Fwd: 12/04/2023 - Public Notice - Practitioner and Durable Medical Equipment Rates
Date: Friday, December 8, 2023 12:27:19 PM

Jessica,
I have one more question. Is this going to go through JCAR? The constituent wants to know if there will be a public comment period for the new rates before they're approved.

Please let me know.

On Fri, Dec 8, 2023 at 9:04 AM Veton Hasku <veton@senatorram.com> wrote:

> Thank you fo the update, Jessica.
>
> Please let me know when the new fee schedule is released.
> Have a nice weekend.
>
> On Fri, Dec 8, 2023 at 9:02 AM Griffin, Jessica <Jessica.Griffin@illinois.gov> wrote:
>
> > I do not know if an updated Fee schedule has been released yet, but I will reach out and see if we can locate those fact if they are available.
> >
> > ---
> >
> > **From:** Veton Hasku <veton@senatorram.com>
> > **Sent:** Tuesday, December 5, 2023 2:25 PM
> > **To:** Griffin, Jessica <Jessica.Griffin@Illinois.gov>
> > **Cc:** HFS.BPPC <HFS.BPPC@Illinois.gov>
> > **Subject:** [External] Fwd: 12/04/2023 - Public Notice - Practitioner and Durable Medical Equipment Rates
> >
> > Jessica,
> >
> > Are you able to provide me with the exact details on these rate increases? A constituent
> >
> > ---------- Forwarded message ---------
> > From: **Brian Morse** <nppsc@me.com>
> > Date: Tue, Dec 5, 2023 at 1:40 PM
> > Subject: Fwd: 12/04/2023 - Public Notice - Practitioner and Durable Medical Equipment Rates
> > To: Veton Hasku <veton@senatorram.com>
> >
> > Veton,

This may be what I have been trying to get accomplished for umpteen years.

Can you please get me the detailed numbers in this proposed increase?

Thanks.

Dr. Morse

Begin forwarded message:

> **From:** "HFS.Webmaster" <HFS.Webmaster@illinois.gov>
> **Date:** December 4, 2023 at 12:05:15 PM CST
> **To:** nppsc@me.com
> **Subject: 12/04/2023 - Public Notice - Practitioner and Durable Medical Equipment Rates**
>
> The Illinois Department of Healthcare and Family Services has posted a new Public Notice regarding **Practitioner and Durable Medical Equipment Rates.** You may view the new Notice at the following link:
>
> https://hfs.illinois.gov/info/legal/publicnotices.html
>
> Thank You,
>
> HFS Webmaster

We improve lives.

--

Best,

Veton Hasku

Chief of Staff

Senator Ram Villivalam-8th Senate District

Phone: (872) 208-5188

Text: (224) 592-5819

veton@senatorram.com

**Sign up for Senator Villivalam's newsletter for the latest updates and resources regarding COVID-19: www.senatorram.com (sign up on the right side of the page)

If you have any policy proposals you'd like our office to work on, please fill out of Policy Proposal form at http://senatorram.com/contact-us/legislative-policy-proposals

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>

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Best,

Veton Hasku
Chief of Staff
Senator Ram Villivalam-8th Senate District
Phone: (872) 208-5188
Text: (224) 592-5819
veton@senatorram.com

**Sign up for Senator Villivalam's newsletter for the latest updates and resources regarding COVID-19: www.senatorram.com (sign up on the right side of the page)
If you have any policy proposals you'd like our office to work on, please fill out of Policy Proposal form at http://senatorram.com/contact-us/legislative-policy-proposals

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www.twitter.com/senvillivalam

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Best,

Veton Hasku
Chief of Staff
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Illinois State Medical Society

December 26, 2023

Ms. Theresa Eagleson, Director
Illinois Department of Healthcare and Family Services
2200 Churchill Road
Springfield, IL 62702

Dear Director Eagleson:

On behalf of the physicians of the Illinois State Medical Society (ISMS), I am writing to share our comments and concerns regarding the Department of Healthcare and Family Services' (DHFS) "proposed changes in methods and standards for establishing medical assistance payment rates," issued December 5, 2023, with an effective date of January 1, 2024.

We appreciate the Department's efforts to update the Medicaid physician fee schedule, something that's long overdue. As you know, ISMS supported the enacted FY24 state budget that contained a $25 million increase for physician reimbursements in Medicaid beginning on January 1, 2024. We have previously advocated that these rate changes should be used to increase rates for certain physician codes that have been historically underpaid. Further, in a letter dated November 22, 2023, we advocated for an across-the-board physician rate increase, to avoid increasing the reimbursements of one physician specialty at the expense of another.

The notice provided by the Department, however, does not address any of those concerns. Rather, the proposal appears to be a reshaping of the fee schedule, expressed in the form of 10,000+ CPT codes based solely on cost, and without consideration to the service being provided. The Department has provided no specific information about which types of procedures are getting higher reimbursements, and which types of procedures will be reduced. This seems rather arbitrary and in no way addresses long-standing concerns that medical specialists are disincentivized to accept Medicaid patients due to extremely low reimbursements.

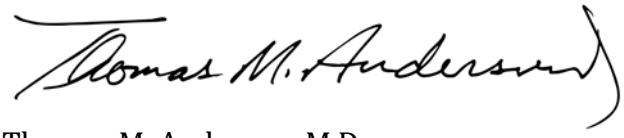
Twenty North Michigan Avenue, Suite 700 Chicago, IL 60602 Web site: www.isms.org
Telephone: 312-782-1654 Toll Free: 800-782-4767 Fax: 312-782-2023

Given the very short comment period, exacerbated by this occurring during the holiday season, it's extremely unlikely the affected healthcare professionals, including multiple medical specialists, will have an adequate opportunity to review the proposed changes to the 10,000+ CPT codes to determine how these changes impact their reimbursements for treating Medicaid patients. Most important to Medicaid beneficiaries is having a reliable primary care physician on a regular basis, but also access to specialty medical care when needed. We remain concerned that this proposal, as presented, does not clearly maintain Illinois Medicaid fees for specialists that will ensure continued patient access to comprehensive care.

In the near term, we urge the Department to minimize any reimbursement reductions that may imperil patient access to necessary specialty medicine care, and we remain committed to working with you and the Department to advocate for the appropriation of sufficient funds by the General Assembly to create and maintain a stable Medicaid reimbursement model for physicians.

We thank you for the opportunity to share our concerns. If you have any questions, please contact David Porter, Senior Vice President of Health Policy, at davidporter@isms.org.

Sincerely,



Thomas M. Anderson, M.D.
Chair, Board of Trustees
Illinois State Medical Society

cc: Rodney S. Alford, M.D., M.B.A.
Piyush I. Vyas, M.D.
Alexander R. Lerner
Medicaid Working Group

North Park Pediatrics, SC
5962 N Lincoln Ave Ste 6
Chicago, IL 60659

P 773-728-7337
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January 3, 2024

(via e-mail to HFS.BPPC@illinois.gov)

Bureau of Program and Policy Coordination
Division of Medical Programs
Department of Healthcare and Family Services
State of Illinois
201 South Grand Ave East
Springfield, IL 62763-0001

Re: Comments on the December 4, 2023 public notice on proposed increases in Medicaid fees

To whom it may concern,

My name is Brian Morse. I am a pediatrician in private solo practice in the city of Chicago. I opened this practice with a partner on August 26, 2002, two years after graduating from the University of Illinois at Chicago, where I had completed medical and graduate degrees, as well as residency. I am writing today to comment on the December 4, 2023 public notice from the Illinois Department of Healthcare and Family Services (IDHFS) titled "Proposed changes in methods and standards for establishing medical assistance payment rates."

First, I appreciate that the state is proposing a rate increase. This is long overdue, as the last one that affected pediatricians[1] occurred in January of 2006 as a consequence of a 2005 consent decree between the state of Illinois and the mother of a child with Medicaid, who had sued IDHFS in 1992 for inadequate care (Memisovski v Maram; ruling in favor of plaintiff, August 23, 2004; 92 C 1982). Second, as this is the only rate increase for children's doctors in nearly two decades, it ought to be done right. This is the reason for my comments.

There are two issues to address: fairness to doctors (and other providers of medical care) and fairness to the children we serve. They both matter, but the latter matters more. Medical professionals who care for children don't choose their profession to make money, they choose it to make a difference.

In terms of fairness to doctors (for clarity, I will write "doctor"or "physician" or "pediatrician," but I mean my statements to encompass all people who provide healthcare to children), the issue is

straightforward: it is patently unjust to pay doctors the same fee for almost two decades! Inflation has increased 55% since 2006[2]; Medicare rates have gone up even more.[3] Thus, while providing the same good care, I make 36% less today than I did in 2006. I know that this argument for fairness in Medicaid payments to physicians, though true, falls on deaf ears (when I complained to my state senator a few years back, she replied that she had tried many times to get rates increased, but that the signed physician contracts kept "flying by."). Essentially, doctors who see Medicaid will have advantage taken of them, because they permit it by their commitment to doing the right thing and taking Medicaid. Though this may be our personal ethos, the state's ongoing disregard for fairness to doctors is shameful. Yes, my colleagues and I have seen and will continue to see Medicaid patients until our offices are nearly broke, but that time is nigh.

In terms of fairness to the children, our patients, Illinois Medicaid has fallen short for decades. When Judge Lefkow found in her August 23, 2004 opinion (92 C 1982) that the state had failed to uphold parts of the federal Medicaid Act, a major fault was the lack of adequate access to medical care. To quote one of the Judge's decisions on the case (92 C 1982; November 29, 2007): "On August 23, 2004, this court entered a memorandum opinion and order finding that the defendants, including the Illinois Department of Healthcare and Family Services ("HFS") (collectively, "defendants" or "the State"), were in violation of their obligations under the federal Medicaid Act. This finding was based in part on the State's ongoing failure to ensure that plaintiffs (a class of children in Cook County eligible for Medicaid coverage) were provided pediatric care and services to the extent that such care and services were available to the general population." The federal act on Medicaid adequacy states (42 U. S. C. § 1396(a)(30)(A)) that a state medical plan for assistance must "(3)(A) - provide such methods...and to **assure that payments** are consistent with efficiency, economy, and quality of care and **are sufficient to enlist enough providers** (emphasis added) so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area..."

When the Judge issued her findings and when the state consented to raise some physician fees (see attached document[4]), the approximate reimbursement to physicians for the most-commonly-billed code, 99213, was only ~55% of Medicare. Low fees, such as these, were considered by Judge Lefkow to be a major obstacle to fulfilling the statutory requirement for "equal access to care," writing that (in 92 C 1982, August 23, 2004) "The starting point for the issue of equal access must be rates Illinois Medicaid pays to medical providers for providing services to Medicaid patients. Rates and equal access simply cannot be divorced." The rates today, 18 years after they were last raised, are as low now as they were then (see attached table[5]; 99213 is now 53% of Medicare [downstate Illinois, non-facility Medicare rates used], rates are worse if Chicago rates are used instead). It is illogical to assume that the problem of inadequate care (a violation of the "equal access" provision) for Medicaid children no longer exists today when the major driver, poor reimbursement for medical care, is as much an issue now as it was in 2006.

Furthermore, research spanning three to four decades finds Medicaid reimbursements have a substantial impact upon access to medical care. This is true whether one examines the type of care (primary vs specialty), as well as the site of care (private offices vs hospital- or clinic-based). In Cohen and Cunningham's 1995 study,[6] "Medicaid Physician Fee Levels and Children's Access to Care," it is stated (referencing eight articles published between 1978 and 1990): "Research on Medicaid physician payment policies has shown that payment levels are a primary determinant of office-based doctors' participation in the Medicaid program: The lower the Medicaid payments are relative to private or Medicare fees, the less office-based doctors participate in the program." In 2011, Bisgaier and Rhodes, writing in The New England Journal of Medicine,[7] reach the same conclusion (referencing four articles between 1999 and 2007): "It is well established that reimbursement levels influence providers' decisions about whether to accept public insurance."

Research consistently shows that access to both primary care doctors and specialists are decreased when Medicaid reimbursements are low. "Fees are significantly associated with the probability of having an office-based doctor as a usual source of care..." (Cohen and Cunningham, 1995[6]) "The findings presented below...are consistent with a model in which the overall quantity of services and access to services is primarily determined by the generosity of provider payments." (White, 2012[8]). Interestingly (and of significant import for states trying to both improve healthcare for Medicaid children and control costs), Cohen and Cunningham also find[6] that "Average total expenditures for ambulatory physician visits generally decreased as the generosity of Medicaid reimbursement increased...One explanation for this may be the place where Medicaid children usually receive their medical care. Services provided in hospital emergency rooms and outpatient clinics are typically much more costly than similar services provided in doctors' offices...Furthermore, use of the hospital as a usual source of care is likely to engender costs beyond those attributable to higher emergency room fees, because emergency room patients are more likely to be admitted to the hospital than are patients who are seen in a physician's office."

Studies consistently find that Medicaid patients have decreased access to doctors (primary and specialty) and longer wait times for appointments. The aforementioned NEJM article (Bisgaier and Rhodes, 2011[7]) finds that when attempting to obtain appointments in Cook County, Illinois in eight different types of pediatric specialist offices, Medicaid recipients (vs those with private insurance) were six times less likely to be given appointments and had wait times for those appointments that were twice as long. Interestingly, this study was supported by the state of Illinois as a result of the Memisovski v Maram court-ordered consent decree. It was likely also the last such study (based on my review of the titles of all articles listed in PubMed that cited it.). Other research reach the similar conclusions: (Sharma et al, 2017[9]) "We found that states with high Medicaid fees had higher probabilities of appointment offers and shorter wait times for Medicaid patients..."; (Medford-Davis et al, 2017[10]) "Appointment success rate was 83.1% for privately insured, 81.4% for uninsured, and 14.0% for Medicaid callers."; and (Hsiang et al, 2019[11]) "Overall, 34 audit studies were identified, which demonstrated that Medicaid insurance is associated with a 1.6-fold lower likelihood in successfully scheduling a primary care appointment and a 3.3-fold lower likelihood in successfully scheduling a specialty appointment when compared with private insurance." Clearly, the problem of "equal access to care" for Medicaid patients still exists.

As Judge Lefkow wrote in her August 3, 2004 opinion, the goal and the obligation of the state in providing medical care for children with Medicaid is <u>not</u> a two-tiered system: "Moreover, the court also takes issue with the inclusion of these so-called "safety net" providers in the equal access analysis. The inquiry is, after all, of *equal* (emphasis in original) access and not simply of access. The plaintiffs are entitled to the same level of medical care as is provided to children covered under private insurance. That must include mainstream medical care."

As the above demonstrates clearly, Medicaid patients in Illinois deserve, must have (by the terms of the Medicaid Act), and do not receive adequate care ("equal access"). How can we make sure that the current proposal by the state to raise physician rates for the first time in 18 years is the best attempt to achieve this (or, at least, come close)? I suggest that the state raises the rates for the major procedure codes affecting primary and specialty care (for pediatrics, these would be 99213-99215 and 99391-99394; 99215 was previously excluded from the consent-decree rate increase, but this must be corrected if we are to attempt to achieve any cost savings by avoiding some unnecessary emergency room visits) to either the same levels as they were after the consent decree was in place, after adjusting for the 55% increase in inflation since 2006, or to 80% of the 2023 Medicare rate for physicians (non-facility; although Chicago rates are greater than the rest of Illinois, I would not argue with the state's preference to use downstate

Medicare rates). In addition, I urge the state to commit to some regular increase in the rates (as one change in nearly two decades is simply not acceptable), such as by tying the rates to either inflation or to a constant percentage of Medicare rates (my suggestion of 80% is only marginally greater than the state's proposed range of 72-80%). I have created a detailed table of the most-relevant rates and attached it here.

From my 20+ years of experience in private practice pediatrics (and always accepting Medicaid, generally at 20-30% of my patient population), I have a plethora of additional ideas on how we could advance the two objectives of improving the health of the Medicaid (and other) children for whom we care and saving money for the state (to be shared at another time). These objectives are not necessarily mutually exclusive.

Thank you very much. I hope that we can work together on our shared goals to improve the health of the Medicaid-covered children of Illinois.

Sincerely,

Brian S. Morse, MD, PhD
North Park Pediatrics, SC
Hearts and Minds, 20/20
(e-mail: nppsc@me.com)

[1] excluding a recent increase in one fee only, vaccine administration, which had been unchanged at $6.40 since 2006
[2] using US Bureau of Labor Statistics Consumer Price Index Inflation Calculator (accessed at https://www.bls.gov/data/inflation_calculator.htm)
[3] as example, comparing the three main sick visit codes (99213-99125), the increases from 2006 to 2023 for non-facility rates in the "rest of Illinois" region (0095299 locality) are: 78% [$49.55 to $87.96], 60% [$77.99 to $124.61], and 64% [$114.32 to $174.96]). These can be accessed at https://www.cms.gov/medicare/physician-fee-schedule/search.
[4] "Remedies announced in Memisovski Medicaid Suit;" copy enclosed here
[5] "ILDPA Fee Schedule Comparison, 1/3/24" (this is my own table with data gathered from various sources; see notes at bottom of table for more information)
[6] Cohen, JW, and Cunningham, PJ. Medicaid Physician Fee Levels and Children's Access to Care. Health Affairs 1995;14(1):255-262
[7] Bisgaier J, and Rhodes, KV. Auditing Access to Specialty Care for Children with Public Insurance. N Engl J Med 2011;364:2324-33
[8] White, C. A Comparison of Two Approaches to Increasing Access to Care: Expanding Coverage versus Increasing Physician Fees. Health Services Research 2012;47(3):963-982
[9] Sharma, R, Tinkler, S, Mitra, A, Pal, S, Susu-Mago, R, and Stano, M. State Medicaid fees and access to primary care physicians. Health Economics 2018;27:629-636
[10] Medford-Davis, LN, Lin, F, Greenstein, A, and Rhodes, KV. "I Broke My Ankle": Access to Orthopedic Follow-up Care by Insurance Status. Acad Emergency Medicine 2017;24(1):98-105
[11] Hsiang, WR, Lukasiewicz, A, Gentry, M, Kim, C-Y, Leslie, MP, Pelker, R, Forman, HP, and Wiznia, DH. Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared With Private Insurance Patients: A Meta-Analysis. Inquiry 2019;56:1-9

REMEDIES ANNOUNCED IN MEMISOVSKI MEDICAID SUIT

Primary Care Providers, Dentists to Receive Rate Increases

Both parties engaged in extensive settlement negotiations in order to avoid the burden, costs, and risks of further litigation. After extensive delays, the resulting Consent Decree was issued on June 27, 2005. The following provides a summary of the changes put forward in the Consent Decree. (Dates of proposed implementation are indicated in parentheses.)

For full information, use the following link:

http://www.illinoisaap.org/medicaidjune2005.htm

CHANGES TO MEDICAID FOR PRIMARY CARE PROVIDERS

Rate Increases
Illinois Medicaid will increase rates for Maternal and Child Health (MCH)* providers for 12 primary care codes that represent the vast majority of all pediatric visits. Rates will be increased to at least** the following amounts (January 1, 2006):

Code	Service	2005 Rate	New Rate	Dollar (Percent) Increase
	Office or Outpatient Services, Established Patient			
99213	Expanded problem-focused history and exam (low complexity)	$28.35	$46.56	$18.21 (64%)
99214	Detailed history and exam (moderate complexity)	$44.55	$72.97	$28.42 (64%)
	Preventive Medicine Services, New Patient			
99381	Infant	$42.45	$91.90	$49.45 (116%)
99382	Age 1-4	$42.45	$98.65	$56.20 (132%)
99383	Age 5-11	$42.45	$96.60	$54.15 (128%)
99384	Age 12-17	$42.45	$104.96	$65.21 (147%)
99385	Age 18-39	$42.45	$104.96	$65.21 (147%)
	Preventive Medicine Services, Established Patient			
99391	Infant	$42.45	$69.52	$27.07 (64%)
99392	Age 1-4	$42.45	$77.87	$35.42 (83%)
99393	Age 5-11	$42.45	$76.84	$34.39 (81%)
99394	Age 12-17	$42.45	$84.62	$42.17 (99%)
99395	Age 18-39	$42.45	$85.65	$43.20 (102%)

** MCH providers are primary care physicians who have completed a simple application stating they have hospital privileges, provide EPSDT services, maintain 24-hour telephone coverage, and other criteria. The MCH Primary Care Provider Agreement provides additional information.*
*** Information on exact rate increases will be distributed to enrolled providers by IDHFS.*

Furthermore, the cost basis for Federally-Qualified Health Center (FQHC) reimbursement will allow FQHCs to be reimbursed using cost information from the cost report years 2002 and 2003, representing an increase in payments to FQHCs (January 1, 2006).

Bonus Payments
In order to further encourage provider participation while also increasing the number of children who receive all EPSDT services, Medicaid will pay a $30 bonus to any eligible physician or FQHC for each patient who receives all EPSDT health screenings, with proper billing documentation required (April 1, 2007, based on billing data through December 31, 2006). These bonus payments will be made on an annual basis, and properly-billed services within 31 days after a patient's birthday will be applicable. This includes the following:

Age	Number of Well-child Screens
10 days to 1 year	6
1-2 years	3
2-3 years	1
3-4 years	1
4-5 years	1

The rate increases and bonus payments have the potential to more than double what pediatricians and family physicians are currently paid by Medicaid for well-child care. ICAAP is confident that these rates will enable providers to cover their expenses and open their practices to additional Medicaid patients. Increases in dental rates (below) will similarly help address the shortage of dental care and assist primary care physicians in referring patients for dental care.

Payment Cycles
Medicaid will continue to provide expedited processing of claims for MCH Providers, and the contracted referral service explained below will actively promote the MCH program and corresponding benefits.

Provider Recruitment, Notices, and Billing Information
IDHFS is directed to increase the use of the Internet and e-mail for provider communications (January 1, 2006). IDHFS will also contract with at least one third party to develop and maintain an information, recruitment and referral service. This service will serve many purposes, including recruiting physicians to participate and educating them through various strategies about program changes, billing (including how to bill for multiple specialty services on one day), expedited payments, and securing referrals. This service will also provide assistance to families in locating providers and accessing EPSDT services (July 1, 2007).

Healthcare and Family Services

Rod R. Blagojevich, Governor
Barry S. Maram, Director

201 South Grand Avenue East
Springfield, Illinois 62763-0002

Telephone: 1-877-782-5565
TTY: (800) 526-5812

December 29, 2005

INFORMATIONAL NOTICE

TO: Physicians and Advanced Practice Nurses

RE: Increases to the Maternal and Child Health (MCH) Add-ons

Effective with dates of service on or after January 1, 2006, the department will increase the reimbursement rate for the MCH add-ons. The following table identifies the procedure code, description, base reimbursement rate and the new MCH add-on amount. Only enrolled MCH providers will be paid the MCH add-on in addition to the base rate.

Procedure Code	Description	Base Rate	MCH Add-on
99213	E/M Office/OH Visit Est Pt	$28.35	$18.21
99214	E/M Office/OH Visit Est Pt	$42.50	$30.47
99381	Initial Eval Healthy Infant	$32.15	$59.75
99382	Initial Eval Healthy Child	$32.15	$66.50
99383	Initial Eval Healthy Child	$32.15	$64.45
99384	Initial Eval Healthy Adoles	$32.15	$72.81
99385	Initial Eval Healthy /18-20 yr	$32.15	$72.81
99391	Periodic Re-eval Estab Infant	$32.15	$37.37
99392	Periodic Re-eval Healthy Child	$32.15	$45.72
99393	Periodic Re-eval Healthy Child	$32.15	$44.69
99394	Periodic Re-eval Healthy Adoles	$32.15	$52.47
99395	Periodic Re-eval/Mgmt. 18-20 yr	$32.15	$53.50

Increased reimbursement rates for selected maternal and child health services are available to physicians and APNs who meet the criteria of, and sign the department's MCH Primary Care Provider Agreement. The MCH Primary Care Provider Agreement can be found on the department's website at: http://www.hfs.illinois.gov/enrollment/

Providers wishing to receive e-mail notification, when new provider information is posted by the department, may register at the following HFS Web site:
http://www.hfs.illinois.gov/provrel

Electronic claim submission via the Internet is available by registering on the department's Medical Electronic Data Interchange, Internet Electronic Claims (MEDI/IEC) System: <http://www.myhfs.illinois.gov/>.

If you have questions regarding this notice, please contact the Bureau of Comprehensive Health Services at 1-877-782-5565.

Anne Marie Murphy

Anne Marie Murphy, Ph.D.
Administrator
Division of Medical Programs

ILDPA FEE SCHEDULE COMPARISON (1/3/24b), Brian Morse, MD, PhD

CPT code	Base 2006-2023	MCH Add-on*	Total w/ MCH	2023 Medicare^		2023 Medicaid/ Medicare Ratio - Base		2023 Medicaid/ Medicare Ratio - with MCH		Expected 2023# (2006 + inflation)		100% M-care**, per AAP		72% of 2023 Medicare		State Proposal^^		Act % of M-care for Chgo		Act % of M-care for IL-Rest		% of 2006 fee adj for inflation##	
				Chgo	IL-Rest	Chgo	IL-Rest	Chgo	IL-Rest	Base	+ MCH	Chgo	IL-Rest	Chgo	IL-Rest	Base	+ MCH	Base	+ MCH	Base	+ MCH	Base	+ MCH
99211	12.30	0.58	12.88	24.32	21.99	0.51	0.56	0.53	0.59	19.07	19.99			17.51	15.83	6.96	7.54	0.29	0.31	0.32	0.34	36	38
99212	24.25	1.40	25.65	60.09	54.76	0.40	0.44	0.43	0.47	37.58	39.81			43.26	39.43	25.41	26.81	0.43	0.45	0.46	0.49	68	67
99213	28.35	18.21	46.56	95.85	87.96	0.30	0.32	0.49	0.53	43.94	72.97			69.01	63.33	47.09	65.30	0.49	0.68	0.54	0.74	107	89
99214	42.50	30.47	72.97	135.44	124.61	0.31	0.34	0.54	0.59	66.88	113.26			97.51	89.72	69.47	99.94	0.51	0.74	0.56	0.80	105	88
99215	48.00	1.95	49.95	189.78	174.96	0.25	0.27	0.26	0.29	74.40	77.53			136.64	125.97	101.94	103.89	0.54	0.55	0.58	0.59		
rates above here are for sick visits, those in blue are the most commonly-used ones (as you can see, the 99215 was never increased); those below are check-ups, which generally take about 2 x as long as a 99214; blue are for most common, as these are for established (not new) patients. Check-ups in primary care are almost always these.																							
99381	32.15	59.75	91.90							49.83	142.64	114.94	105.55					0.28	0.80	0.30	0.87		
99382	32.15	66.50	98.65							49.83	153.12	119.96	110.18					0.27	0.82	0.29	0.90		
99383	32.15	64.45	96.60							49.83	149.94	124.23	114.49					0.26	0.78	0.28	0.84		
99384	32.15	72.81	105							49.83	162.91	140.00	129.23					0.23	0.75	0.25	0.81		
99391	32.15	37.37	69.52							49.83	107.90	102.87	94.71					0.31	0.68	0.34	0.73		
99392	32.15	45.72	77.87							49.83	120.86	110.39	101.53					0.29	0.71	0.32	0.77		
99393	32.15	44.69	76.84							49.83	119.27	110.04	101.22					0.29	0.70	0.32	0.76		
99394	32.15	52.47	84.62							49.83	131.34	119.68	110.47					0.27	0.71	0.29	0.77		

Notes: All Medicare rates are non-facility (office-based); * result of 2004 consent decree after lawsuit settlement (Memisovski v Maram); unshaded eff 7/1/06, shaded 1/1/06; MCH is the maternal and child health add-on; ^ 2006 Il-Rest Medicare rates for 99213-5 are $49.55, $77.99, & $114.32; # 2006 rates adjusted for inflation (Per US Gov CPI, 55% inflation from 1/2006 to 11/2023); ** see Pinkwater e-mail on 12/20/23 1126 (corrected in 1/1/24 e-mail); ^^ state "proposal," as best as understood from notice of 12/4/2023 (and from personal discussions with J. Pinkwater, IL chapter of American Academy of Pediatrics; ## taking into account inflation from 1/2006 to 9/2023

Colours: blue - most commonly-used codes; grey - MCH add-ons eff 1/2006 (last fee increase!!!); pink - total rates incl MCH 2006-current; green - 2006 rates adjusted for inflation (my fair proposal; also must include future cost-of-living or medicare-tied annual increases); orange - state's suggested raise, correctly calculated based on non-facility Medicare rates for 2023; yellow - my understanding of the state proposal, to take effect 1/1/2024; red - % shortfall for state's proposal vs mine (yellow vs green). Note that 99215 was never increased and must be increased to the 72% rate, at least, now.2012 il Medicare rates, 99211-15, $18.65, $40.74, $68.07, $100.78, $135.73; The KFF considered Primary care M/M to be 0.54 for IL. If I take the incr in Medicare rates into effect, our current M/M ratio for primary care (using 99212-99214 rates) would be 0.42!!!

ILDPA FEE SCHEDULE COMPARISON (1/3/24b), Brian Morse, MD, PhD

CPT code	Base 2006-2023	MCH Add-on*	Total w/ MCH	2023 Medicare^		2023 Medicaid/ Medicare Ratio - Base		2023 Medicaid/ Medicare Ratio - with MCH		Expected 2023# (2006 + inflation)		100% M-care**, per AAP		72% of 2023 Medicare		State Proposal^^		Act % of M-care for Chgo		Act % of M-care for IL-Rest		% of 2006 fee adj for inflation##	
				Chgo	IL-Rest	Chgo	IL-Rest	Chgo	IL-Rest	Base	+ MCH	Chgo	IL-Rest	Chgo	IL-Rest	Base	+ MCH	Base	+ MCH	Base	+ MCH	Base	+ MCH
99211	12.30	0.58	12.88	24.32	21.99	0.51	0.56	0.53	0.59	19.07	19.99			17.51	15.83	6.96	7.54	0.29	0.31	0.32	0.34	36	38
99212	24.25	1.40	25.65	60.09	54.76	0.40	0.44	0.43	0.47	37.58	39.81			43.26	39.43	25.41	26.81	0.43	0.45	0.46	0.49	68	67
99213	28.35	18.21	46.56	95.85	87.96	0.30	0.32	0.49	0.53	43.94	72.97			69.01	63.33	47.09	65.30	0.49	0.68	0.54	0.74	107	89
99214	42.50	30.47	72.97	135.44	124.61	0.31	0.34	0.54	0.59	65.88	113.26			97.51	89.72	69.47	99.94	0.51	0.74	0.56	0.80	105	88
99215	48.00	1.95	49.95	189.78	174.96	0.25	0.27	0.26	0.29	74.40	77.53			136.64	125.97	101.94	103.89	0.54	0.55	0.58	0.59		
rates above here are for sick visits, those in blue are the most commonly-used ones (as you can see, the 99215 was never increased); those below are check-ups, which generally take about 2 x as long as a 99214; blue are for most common, as these are for established (not new) patients. Check-ups in primary care are almost always these.																							
99381	32.15	59.75	91.90							49.83	142.64	114.94	105.55					0.28	0.80	0.30	0.87		
99382	32.15	66.50	98.65							49.83	153.12	119.96	110.18					0.27	0.82	0.29	0.90		
99383	32.15	64.45	96.60							49.83	149.94	124.23	114.49					0.26	0.78	0.28	0.84		
99384	32.15	72.81	105							49.83	162.91	140.00	129.23					0.23	0.75	0.25	0.81		
99391	32.15	37.37	69.52							49.83	107.90	102.87	94.71					0.31	0.68	0.34	0.73		
99392	32.15	45.72	77.87							49.83	120.86	110.39	101.53					0.29	0.71	0.32	0.77		
99393	32.15	44.69	76.84							49.83	119.27	110.04	101.22					0.29	0.70	0.32	0.76		
99394	32.15	52.47	84.62							49.83	131.34	119.68	110.47					0.27	0.71	0.29	0.77		

Notes: All Medicare rates are non-facility (office-based); * result of 2004 consent decree after lawsuit settlement (Memisovski v Maram); unshaded eff 7/1/02, shaded 1/1/06; MCH is the maternal and child health add-on; ^ 2006 Il-Rest Medicare rates for 99213-5 are $49.55, $77.99, & $114.32; # 2006 rates adjusted for inflation (Per US Gov CPI, 55% inflation from 1/2006 to 11/2023); ** see Pinkwater e-mail on 12/20/23 1126 (corrected in 1/1/24 e-mail); ^^ state "proposal," as best as understood from notice of 12/4/2023 (and from personal discussions with J. Pinkwater, IL chapter of American Academy of Pediatrics; ## taking into account inflation from 1/2006 to 9/2023
Colours: blue - most commonly-used codes; grey - MCH add-ons eff 1/2006 (last fee increase!!!); pink - total rates incl MCH 2006-current; green - 2006 rates adjusted for inflation (my fair proposal; also must include future cost-of-living or medicare-tied annual increases); orange - state's suggested raise, correctly calculated based on non-facility Medicare rates for 2023; yellow - my understanding of the state proposal, to take effect 1/1/2024; red - % shortfall for state's proposal vs mine (yellow vs green). Note that 99215 was never increased and must be increased to the 72% rate, at least, now.2012 il Medicare rates, 99211-15, $18.65, $40.74, $68.07, $100.78, $135.73; The KFF considered Primary care M/M to be 0.54 for IL. If I take the incr in Medicare rates into effect, our current M/M ratio for primary care (using 99212-99214 rates) would be 0.42!!!