Medicaid Reimbursement Policy

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Medicaid Commission Meeting

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Preview of Presentation

- Private providers
- Safety-net providers
- Public providers
- Managed care organizations

Private Providers

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In general, federal Medicaid law does not set precise requirements

- "[A]ssure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers 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."

  42 USC Section 1396a(30)(A)

State flexibility in setting private physician fees leads to great variation around the country.

Table 1 - Fees for High-Volume Evaluation and Management Procedures

CPT Code	CPT Procedure Description	DC	DE	PA[a]	VA	W VA	MD	Medicare[b]
99201	Office/outpatient visit; new Minimal	$25	$35	$25	$25	$26	$29	$38
99202	Office/outpatient visit; new Moderate	$33	$63	$25	$44	$47	$51	$68
99203	Office/outpatient visit; new Extended	$49	$93	$25	$65	$70	$77	$101
99204	Office/outpatient visit; new Comprehensive	$69	$132	$25	$92	$100	$109	$143
99205	Office/outpatient visit; new Complicated	$88	$167	$30	$117	$127	$139	$181
99211	Office/outpatient visit; established Minimal	$15	$21	$25	$15	$15	$17	$23
99212	Office/outpatient visit; established Moderate	$19	$37	$25	$26	$27	$30	$41
99213	Office/outpatient visit; established Extended	$27	$51	$25	$36	$37	$42	$55
99214	Office/outpatient visit; establ. Comprehensive	$42	$79	$30	$56	$59	$66	$86
99215	Office/outpatient visit; established Complicated	$62	$115	$45	$81	$87	$97	$125
99241	Office consultation Minimal	$32	$48	$30	$34	$36	$39	$53
99242	Office consultation Moderate	$46	$88	$30	$62	$67	$73	$96
99243	Office consultation Extended	$61	$118	$30	$83	$90	$97	$128
99244	Office consultation Comprehensive	$87	$166	$49	$116	$126	$137	$180
99245	Office consultation Complex	$113	$215	$49	$151	$164	$178	$232

[a] - Pennsylvania's fees correspond to 2004. All other states' and Washington, DC's fees correspond to 2005.
[b] - Medicare Fee schedule for 2005.

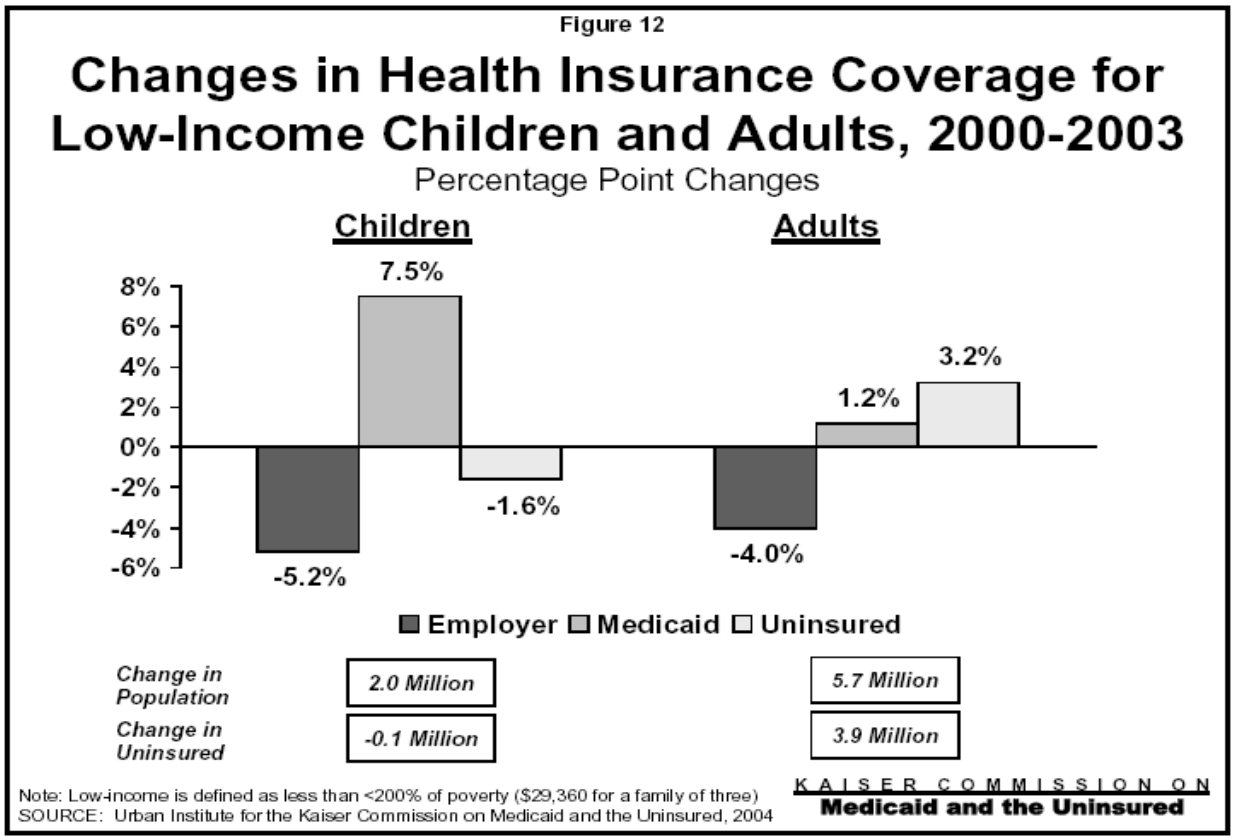
Private Medicaid fees have significantly increased, especially in primary care . . .

Cumulative Percentage Change in Medicaid Fees, By Type of Service, 1998-2003

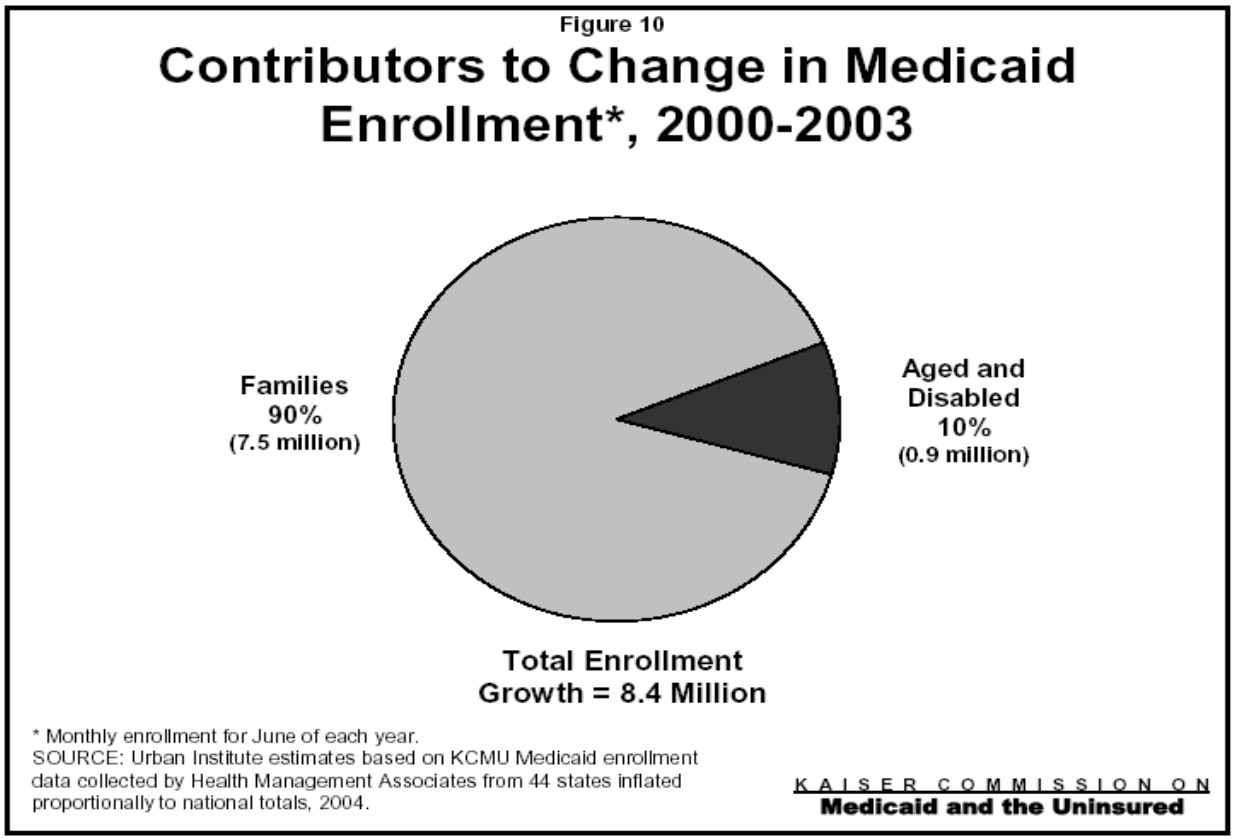
Type of Service	US	DC	VA	MD
All Services	27.4	-2.4	8.3	46.2
Primary Care	41.2	-0.1	17.2	54.5
Obstetric Care	10.2	0.0	-1.0	0.0
Other Services	11.1	-11.2	-2.3	51.1

Source: Urban Institute/Center for Studying Health System Change 2003 Medicaid Physician Fee Survey as presented in Zuckerman, S., McFeeters, J., Cunningham, P., & Nichols, L. (2004, June 23). Changes in Medicaid physician fees, 1998-2003: Implications for physician participation. *Health Affairs – Web Exclusive*.

. . . but Medicaid has replaced private insurance for many people during the same period . . .



. . . resulting in net Medicaid enrollment growth from 2000-2003 by 8.4 million people . . .



. . . so many physicians have backed away from Medicaid in spite of the fee increases . . .

Percent of Physician Participation by Insurance Type

	1996-97	2000-01	2004-05
Medicaid			
No Medicaid Revenue	12.9	14.6*	14.6*
Accepting No New Patients	19.4	20.9*	21.0
Accepting All New Patients	51.1	51.9	52.1
Privately Insured			
Accepting No New Patients	3.6	4.9*	4.3
Accepting All New Patients	70.8	68.2*	71.8**
Medicare			
Accepting No New Patients	3.1	3.8*	3.4
Accepting All New Patients	74.6	71.1*	72.9

* Change from 1996-97 is statistically significant at p<.05

** Change from 2000-01 is statistically significant at p<.05

Source: Cunningham, P., & May, J. (2006, August). Medicaid patients increasingly concentrated among physicians. *Center for Studying Health System Change, Tracking Report No. 16*.

. . . leading to a greater concentration of Medicaid patients in Medicaid-focused physician practices.

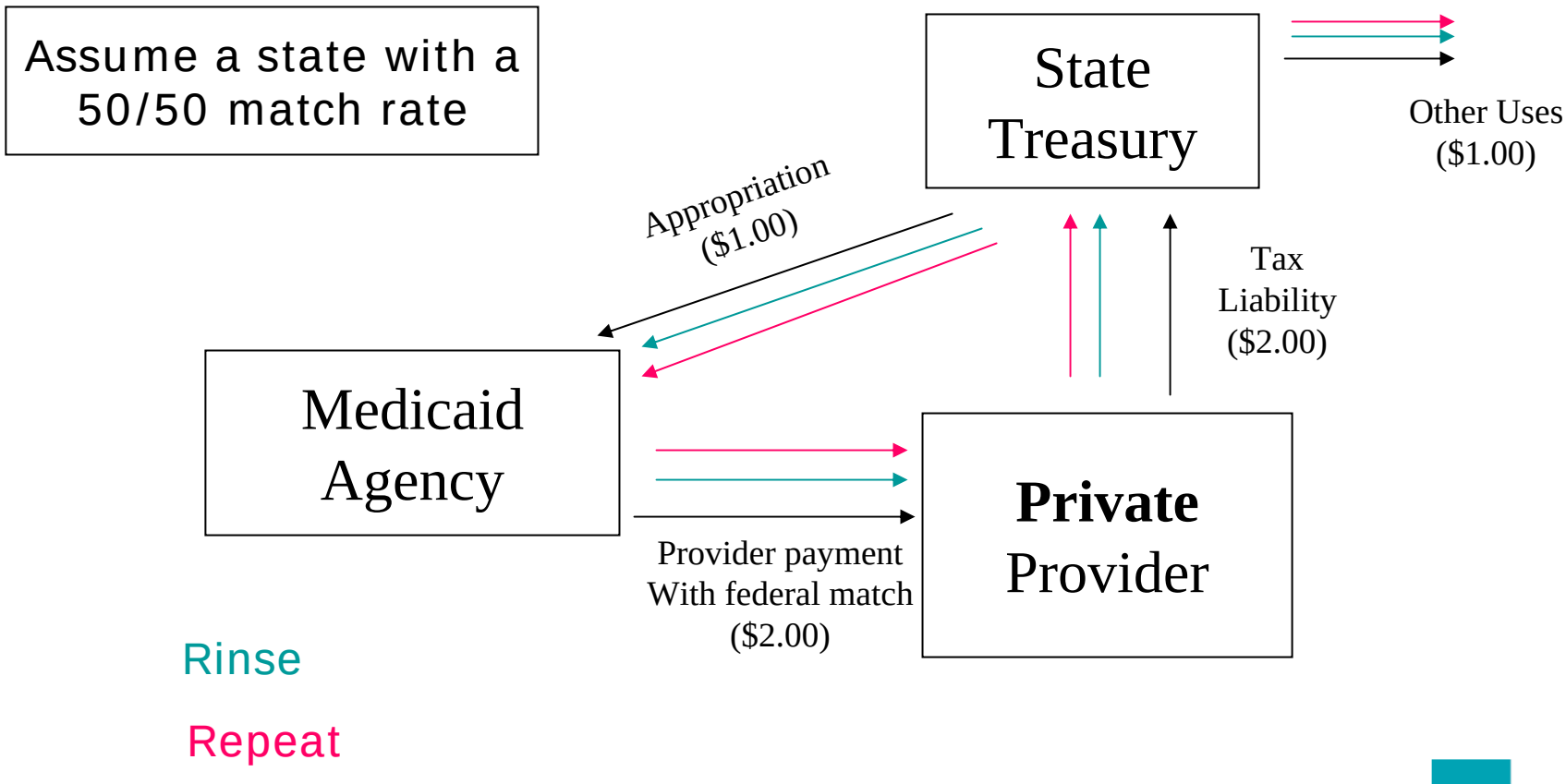
Distribution of Medicaid Physician Practice Revenue

Percent of Revenue from Medicaid	1996-97	2000-01	2004-05
0-9%	10.6	9.0	7.8
10-19%	27.2	24.3	20.6
20-29%	19.1	20.7	20.6
30% or higher	43.1	46.1	51.0

Note: Physicians who derived no revenue from Medicaid are excluded.

Source: Cunningham, P., & May, J. (2006, August). Medicaid patients increasingly concentrated among physicians. *Center for Studying Health System Change, Tracking Report No. 16*.

Meanwhile, CMS scrutinizes private provider taxes to prevent leveraging. These taxes work like this:



Three federal rules apply regarding provider taxes.

- Must be “broad-based” within class (I.e., tax applies to all payers)
- There cannot be a corresponding credit
- Cannot have a “hold harmless” provision (e.g., law creating tax cannot guarantee higher fees)

Safety Net Providers

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Medicaid financing often pursues purposes in tension with paying the "lowest price" for services for Medicaid beneficiaries . . .

- First, Medicaid subsidizes safety-net hospitals that often serve a high number of uninsured:
  - Disproportionate share hospital (DSH) funds
    - A true block grant program
    - Usually allocated, within a state, to public and teaching hospitals
    - Sometimes leads to turf fights, within a state, as private non-profit hospitals that serve the indigent seek DSH funds

. . . in order to advance other health policy goals . . .

- Second, Medicaid must pay federally-qualified health centers (FQHCs) at a cost-based prospective payment system (PPS) rate. This is higher than private physicians. For example, in Maryland in 2006:
  - Encounter rates vary by FQHC; range is $95.16 - $200.62
  - Compare to selected private physician rates:
    - 99212 (established patient, moderate): $ 31.90
    - 99213 (established patient, extended): $ 43.41

. . . or attempt to fulfill the federal government's treaty obligations to Native Americans . . .

- Third, HHS establishes mandatory Medicaid payment rates for services provided by Indian Health Services and Tribal 638 Providers
- Inpatient services rate
  - $1,660 per day ($2,131 in Alaska)
- Outpatient services rate
  - $242 per encounter ($406 in Alaska)
- Federal matching rate is 100%
  - Attached to the provider's, not the patient's, status
  - Enables Congress to not fully fund IHS; Medicaid is a form of third-party liability collections issue

. . . or pursue other purposes beyond paying for services for Medicaid beneficiaries.

- Fourth, training new physicians and supporting medical education offered through academic medical centers:
  - Graduate medical education (GME)
  - Indirect medical education (IME)

Public Providers

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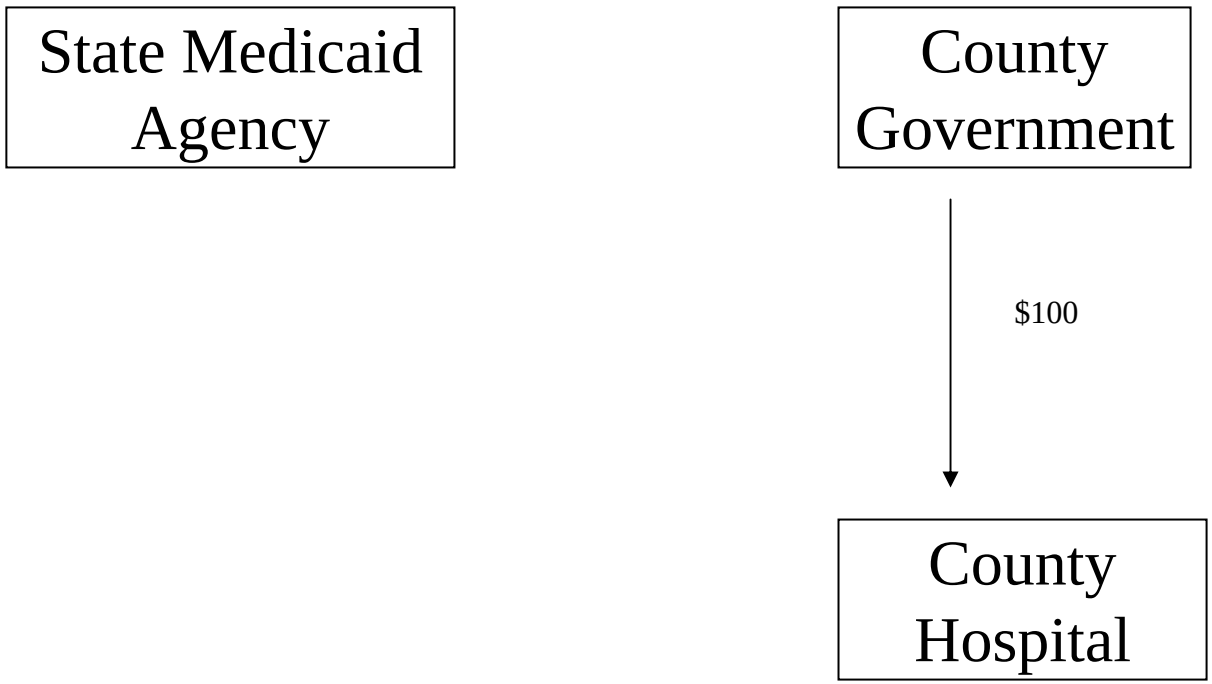
In general, payments to public providers are a source of payment scrutiny by the federal government.

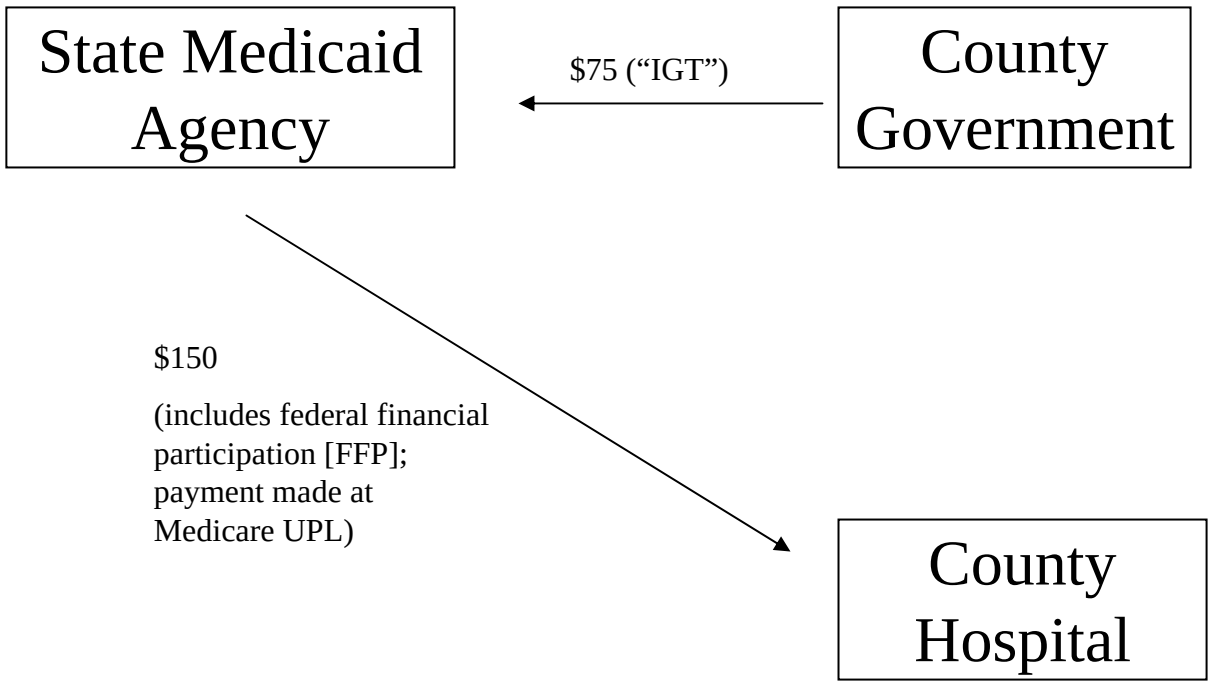
- CMS is concerned that states will overpay public providers (state and local government owned and operated providers) as a maximization device
- Buckle up: Inter-governmental transfers (IGT) and the Upper Payment Limit (UPL)
  - In this arrangement, *public* providers move state or local funds to the Medicaid agency to be matched with federal funds to increase their own rates
  - This arrangement could arise in a number of areas (special education, upper payment limit [UPL], targeted case management, etc.)

The Medicaid IGT and UPL issue explained in five slides. First, assume this is what it looks like pre-Medicaid involvement . . .



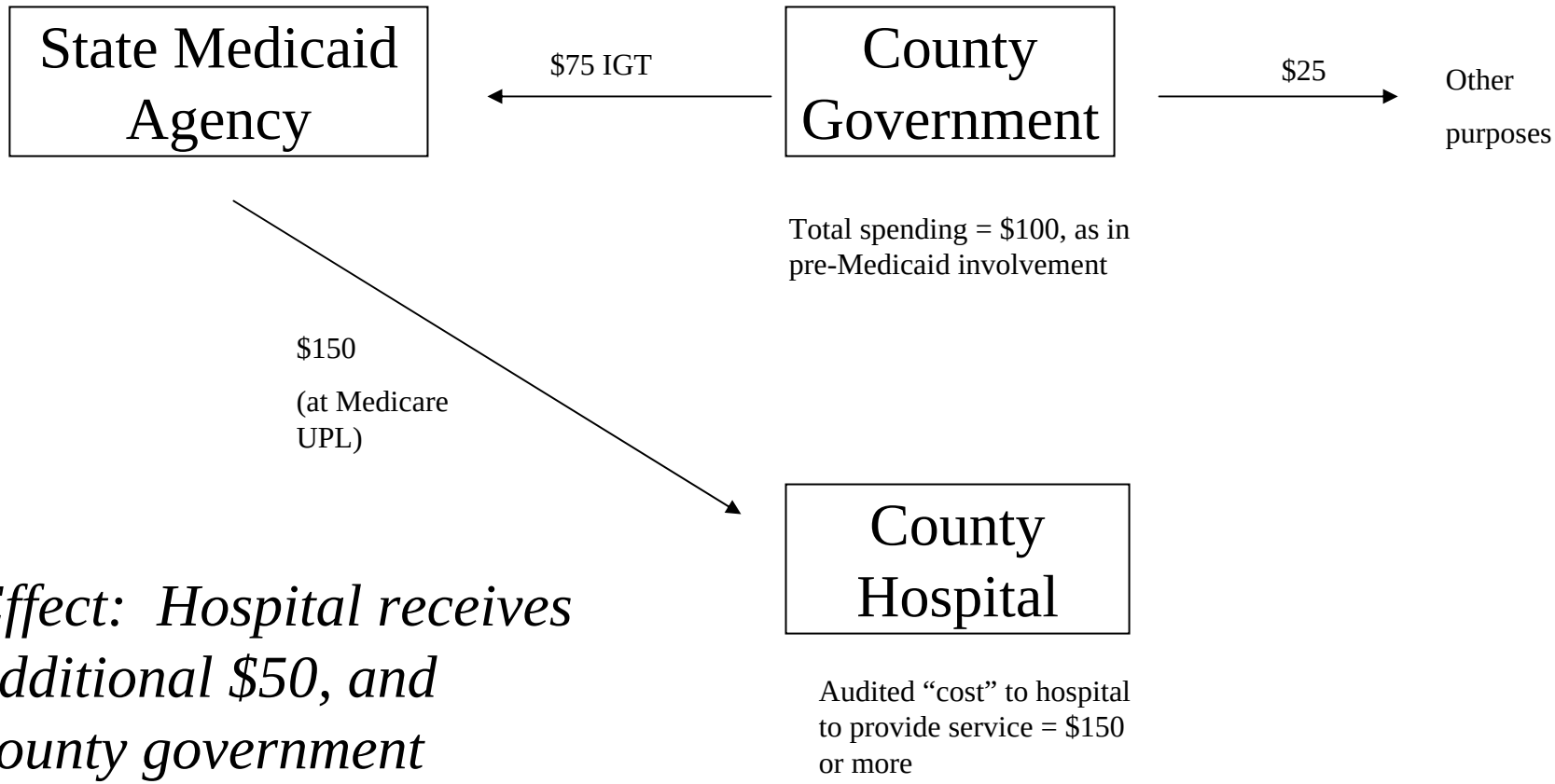
The general concept here also applies to other IGTs, like special education or targeted case management

. . . then assume that the county government instead sends local tax dollars to Medicaid . . .



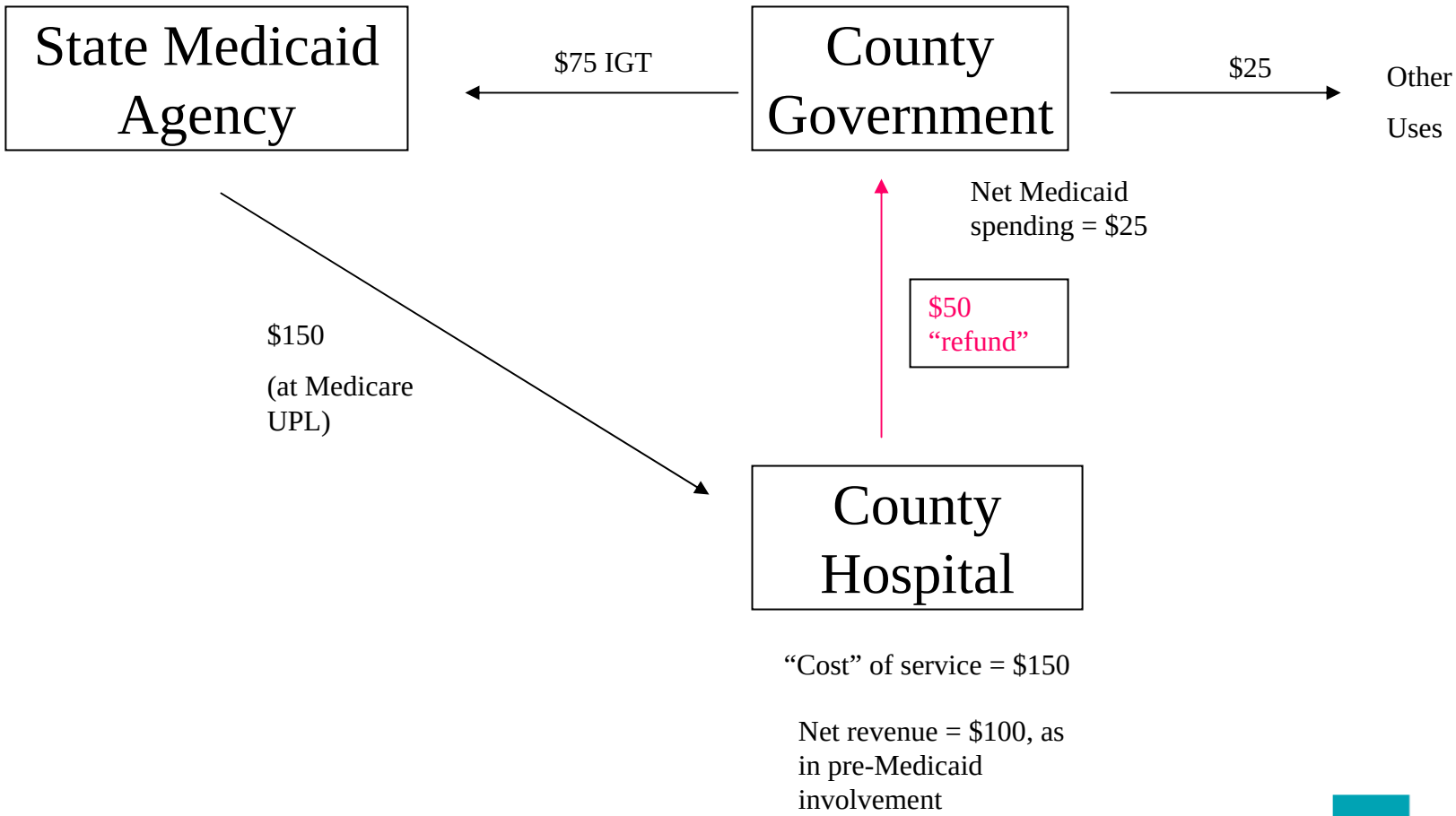
"IGT" = Intergovernmental transfer
"UPL" = Upper payment limit, i.e., what Medicare would have paid for the same service

Under the Bush Administration budget proposal, this IGT/UPL arrangement would be okay . . .

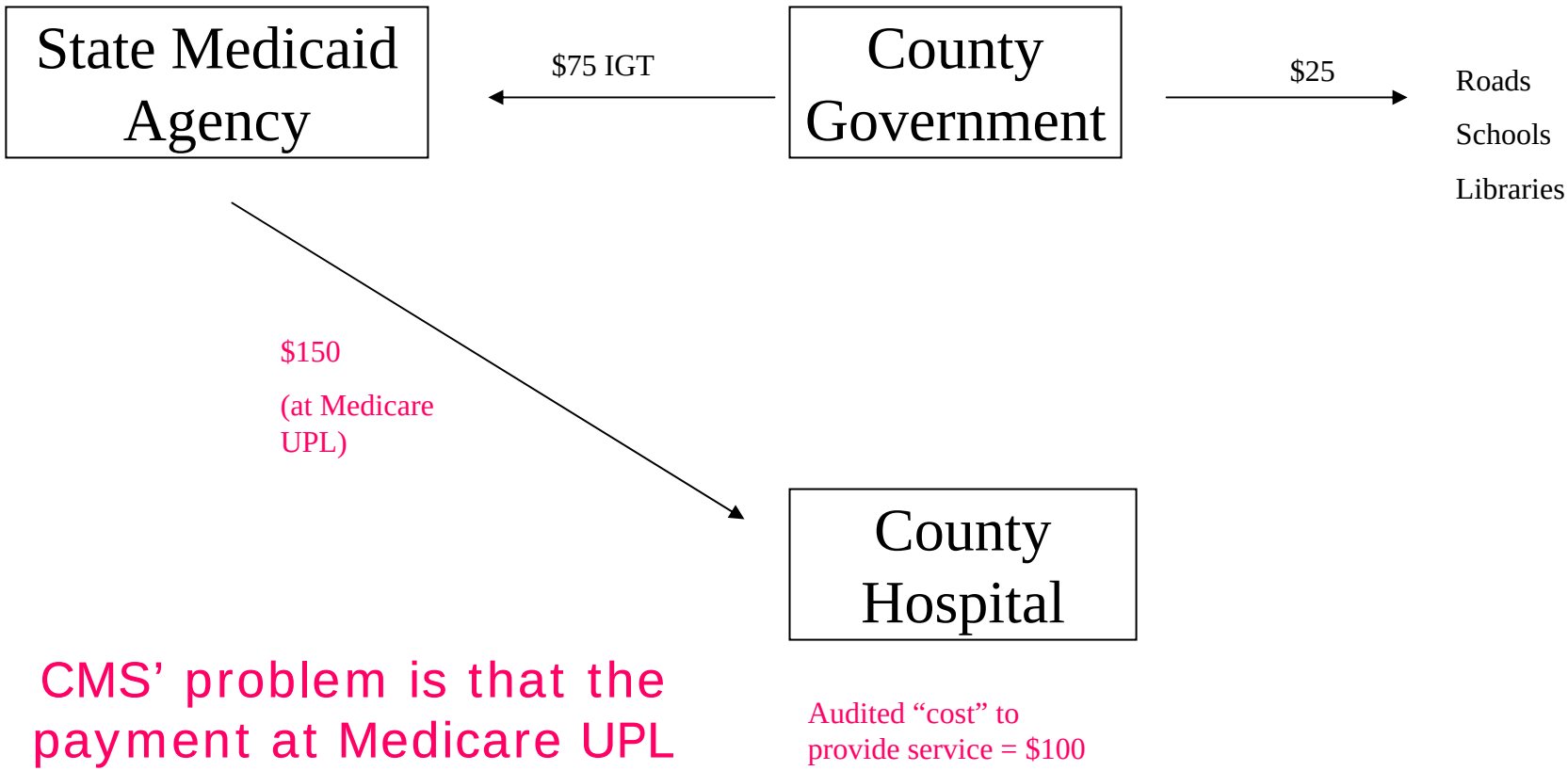


Effect: Hospital receives additional $50, and county government spends $25 on non-health care purposes

. . . and this would not be okay: it would violate the "IGT" provision due to recycling, which alters 50/50 to 75/25 . . .



. . . and this would not be okay: it would violate the "UPL" provision, because the hospital would be paid above its costs.



Managed Care

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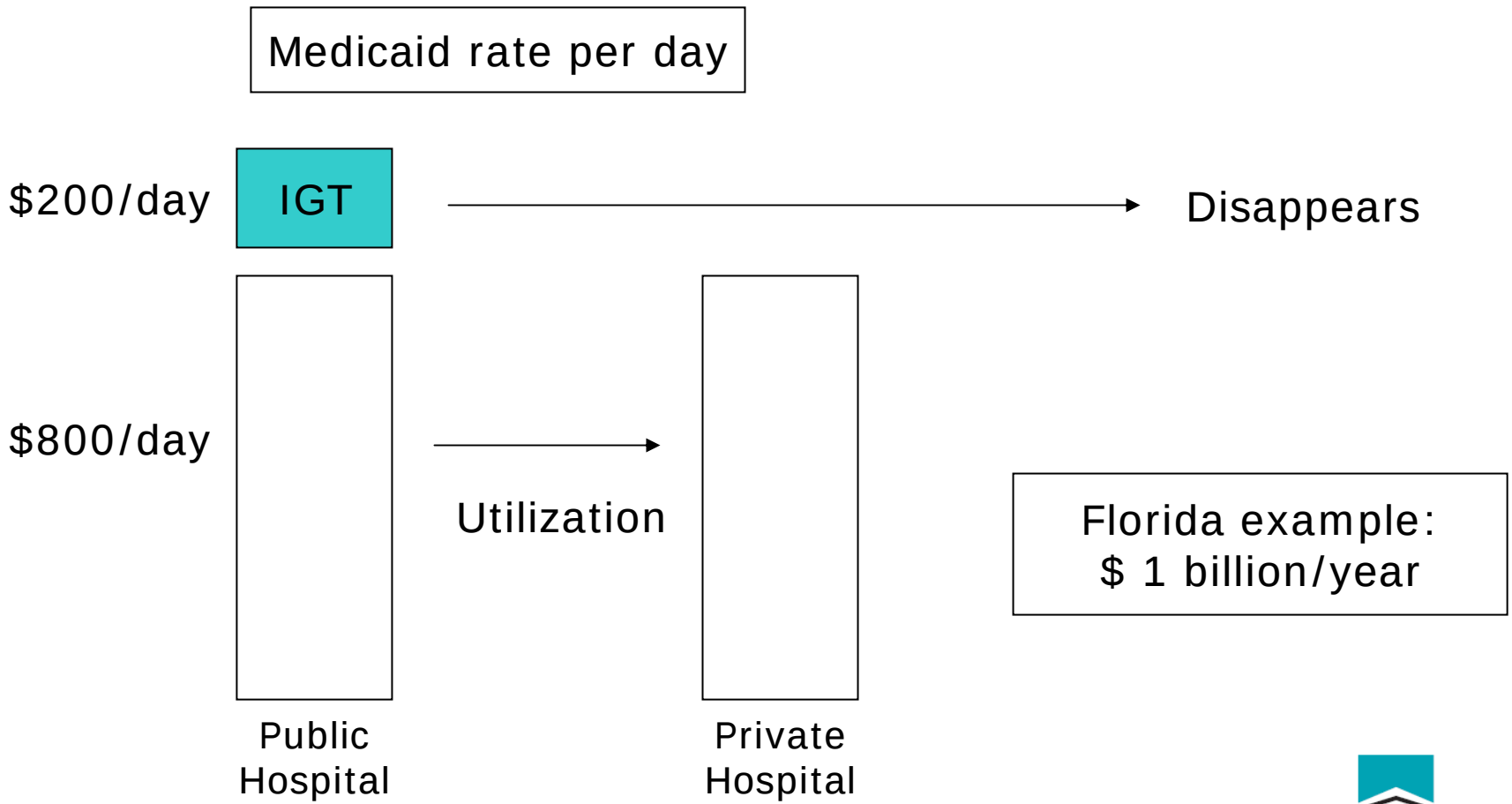
Managed care capitation rates must be actuarially sound

- "All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound."
  42 CFR Section 438
- Capitation rates therefore must be developed based on an actuarial estimate of the units of service per person, at a given unit cost, for a given population
- MCOs and states often disagree about these components, and the underlying actuarial methodology
  - Estimated units of service
  - Unit cost

States utilization of IGT/UPL arrangements has created a barrier to expanded managed care



Questions

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