Medicare Parity – FY 2005 and FY 2006

Preamble

Eileen Ellis of Health Management Associates prepared this document during FY 2005 for *The Partnership for Michigan's Health*, comprised of the Michigan Health and Hospital Association, the Michigan State Medical Society, and the Michigan Osteopathic Association. The analyses are based on facts as they existed in December 2004. Subsequent to that time there have been several changes that further erode the adequacy of Michigan Medicaid payment rates. On May 1, 2005, Medicaid providers experienced a nearly across-the-board rate cut of 4%.[1] This cut was not restored in the FY 2006 budget.[2]

A second change that is not reflected in this document is implementation of new Medicaid copayments for adult beneficiaries that will be effective on May 1, 2006. Currently there are no copayments for adults for physician and hospital services. As of May 1, 2006 the copayment for a physician office visit will be $2, the copayment for an outpatient hospital visit will be $1, and the copayment for a hospital emergency room visit for a non-emergency condition will be $3. In addition, Medicaid beneficiaries will be expected to pay $50 for the first day of an inpatient hospital stay. The State will deduct the expected copayment from its payment to the provider. The Medicaid HMOs have the option of implementing the new copayments as well. As a result, these new copayments are likely to become de facto reductions in Medicaid reimbursement and will result in a widening of the gap between the effective payment rates for Medicaid and those for Medicare.

While some Medicare rates such as payments for physician services did not increase in 2006, the decrease in Medicaid rates and increase in Medicaid copayments result in a greater gap between Michigan Medicaid rates and Medicare rates in 2006 than existed in 2005 and a greater gap than was predicted for FY 2006 in the analysis that follows. Also, the expected increase in Michigan Medicaid HMO rates for FY 2006 did not occur. Rates that were deemed to meet only 96.42% of full actuarial soundness in FY 2005 were subsequently deemed fully actuarially sound for FY 2006. This change in perspective was enabled by use of a different model by the State's actuarial consultant.

Executive Summary

The continued cost increases in the health care sector are not fully recognized by Michigan's Medicaid program for physicians, hospitals and other health care providers. As a result, there is continued deterioration in the fiscal position of Michigan's health care providers.

Medicare is still the key benchmark for measuring the adequacy of Michigan Medicaid payment rates, even though the Medicare program does not cover the full costs of health care services. Notwithstanding the Medicaid reimbursement improvements funded through hospital taxes (the Quality Assurance Assessment Program or QAAP) and the movement toward actuarially sound HMO rates, HMA estimates that Michigan Medicaid payments to hospitals, physicians and HMOs in FY 2005 will average only 82% of what Medicare would pay for the same services, a difference of $665 million. If one subtracts the amount that HMOs and hospitals are paying to the state as QAAP assessments to support the Medicaid program, the result is that current net Medicaid compensation is 74% of Medicare rates and the gap is $972 million. However, the gap in state general fund support is $593 million since the hospitals and

[1] HMOs and pharmacists were not subject to this reduction promulgated through MSA All Provider Bulletin MSA 05-22.

[2] The cuts would have been partially restored if the state had received approval of a proposed change to reduce hospital funding for certain "optional" Medicaid clients.

HMOs have been providing support to the Medicaid program through Quality Assurance Assessment Fees.

The budget for FY 2005 takes Michigan to the legal limit[3] of the ability of the hospitals and HMOs to help fund their Medicaid payment increases.[4] Unless the state is able to contribute state funds for rate increases for Medicaid providers, the gap between Medicaid rates and Medicare rates will grow in FY 2006. For example, since 2001, Medicare has recognized higher patient care costs by increasing hospital rates 16.2% while Michigan Medicaid rates have increased 0%. This gap is so great that it cannot be bridged overnight, especially given Michigan's current fiscal status. **It is therefore again proposed that the State adopt a ten-year schedule to achieve parity between Medicaid and Medicare payment rates.** Each year any Medicare rate increases would be recognized and the historical gap would also be reduced by 10%.

It is further proposed that the FY 2006 budget reflect this commitment in three ways: first, by explicitly embracing this goal; second, by requiring MDCH to annually prepare a report quantifying the gap between Medicaid and Medicare rates and describing the progress being made towards parity, and third, by providing the resources necessary to make an initial adjustment of rates under the ten-year schedule.

Introduction

Since the inception of the Medicaid program in 1966, Michigan providers have embraced and supported it: in 2003, all Michigan hospitals and most Michigan physicians participated in Medicaid. However, the high level of support of physicians and hospitals has begun to erode as a result of inadequate payment rates, which are at historically low levels by comparison with standard benchmarks.

In addition, inadequate Medicaid payment rates have begun to jeopardize the very fabric of Michigan's health care delivery system, particularly in those communities where substantial numbers of residents rely upon Medicaid. In the most extreme cases, inadequate Medicaid funding is contributing to the financial failure of key health care institutions and agencies.

The relatively low rates that the Michigan Medicaid program pays to health care providers and to HMOs have contributed considerably to the current crisis in Michigan's health care system. In 2004 two of the HMOs that had had a significant role in the Medicaid program for many years experienced bankruptcy. Two other HMOs were also under some form of supervision by Michigan's Insurance Commissioner. Implementation of actuarially sound Medicaid HMO rates has alleviated this situation and Michigan's Medicaid HMOs are solvent.

While the fiscal health of the Michigan HMOs that serve Medicaid clients has improved in recent months, some of the hospitals that serve a significant number of Medicaid enrollees are on the verge of bankruptcy. To the extent that Medicaid pays less than the cost of the health care services it purchases, other payers – individuals and businesses - end up with higher health care costs, in payments to health care providers or in insurance rates. And Michigan's physicians are finding it increasingly difficult to accept Medicaid patients in their practices.

Moreover, it is widely understood that inadequate Medicaid payment rates force providers to shift costs to other payers, principally commercial payers, driving up expenses for Michigan employers and employees and exacerbating the problem of rapidly rising health insurance costs. To ensure the long-term stability of

[3] A proposal to further increase the hospital provider tax in FY 2006 and a corresponding in Medicaid hospital rates is still awaiting federal approval.

[4] A tax on physicians could still be used to support Medicaid rate increases. However development of such a program is very complex and there would be a significant number of physicians losing money through such a program.

the Medicaid program, Medicaid payment rates must be tied to a widely accepted benchmark, such as the Medicare program.

Analysis of the Issue

In recent years Michigan Medicaid reimbursement has been driven more by budget than by any objective measure of the cost of health care services, or by what was occurring in the health care market place. Medicare rates are also sometimes budget-driven, but there are formal processes through which Medicare payment rates are evaluated. Medicare inpatient rates are generally regarded as minimally adequate to cover the costs experienced by health care providers. Medicare hospital outpatient rates do not cover the cost of patient services provided. In the aggregate hospitals lose money on Medicare services. [5]

Relationship of Medicaid rates to Medicare rates in FY 2005

In fiscal year 2005 the relationship of Medicaid rates to Medicare rates varies significantly among health care providers.

Physicians

According to a June 23, 2004 web article in the journal *Health Affairs, o*verall Michigan Medicaid rates for physicians averaged 62% of Medicare rates in 2003.[6] This article shows that Michigan Medicaid has lower reimbursement for physician services than all but a handful of states. Since the period covered by that article, Medicare physician fees increased by 2.7% in FY 2004 and FY 2005 while Michigan Medicaid rates were unchanged. As a result, for FY 2005 Michigan Medicaid physician rates will be only 60% of Medicare rates. If this trend continues, for FY 2006 Michigan Medicaid rates for physicians will approach 59% of Medicare rates. These rates do not provide any compensation to physicians for the time they spend treating Medicaid patients since the rates generally do not even cover physician practice costs.

Hospitals

The proposed total Michigan Medicaid fee-for-service payments to hospitals for FY 2005 appear to equal Medicare rates. However this is misleading. Michigan's hospitals are scheduled to pay nearly $194 million in Quality Assurance Assessments to help fund these hospital payments. The net reimbursement to Michigan hospitals for fee-for-service is 93% of Medicare rates when assessment payments made by the hospitals are netted out of the total payments.

For hospitals Medicaid reimbursement from HMOs is even more problematic than fee-for-service reimbursement. The basic Medicaid rate schedule that is used to set the Medicaid HMO rates and is used by many Medicaid HMOs to pay hospitals does not include the enhanced payments that are funded by the hospital assessments. When Medicaid HMOs pay hospitals at these Medicaid base rates, the hospitals receive reimbursement that totals about 73% of Medicare from the HMOs.

HMOs

For FY 2005 Michigan Medicaid HMO rates were increased by 7.5%, which represented 96.42% of "actuarially sound" HMO rates. For FY 2006 the state committed to the federal government that the

[5] For example, MedPAC reports that in 2003 aggregate hospital margins on Medicare were -1.9%.

[6] Stephen Zuckerman, et. al., *Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation*, Health Affairs – Web Exclusive, June 23, 2004.

HMO rates will be fully actuarially sound. Actuarially sound rates should be sufficient for Medicaid HMOs to pay hospitals and doctors the same rates as the Medicaid fee-for-service program if the HMOs achieve expected savings from utilization management.

The FY 2005 Medicaid HMO rates equate to 74% of the cost of providing the same services if they were reimbursed using MEDICARE fee-for-service rates. However in FY 2005 the HMOs, like the hospitals, are also contributing to Medicaid financing through a Quality Assurance Assessment Program. Total assessment payments for the HMOs are estimated at more than $112 million. When the cost of the assessment is recognized, the net reimbursement to Michigan HMOs is only 70% of Medicare parity.

Proposed Solution

There was a time when the Michigan legislature explicitly directed that Medicaid rates for physician services be set at Medicare levels, so using Medicare rates as a benchmark is not a new concept. While it is not possible to achieve parity with Medicare rates overnight, the Partnership proposes a ten-year strategy to achieve this goal. This proposal assumes that at the end of ten years Medicaid rates for physicians, HMOs and hospitals will reach full Medicare rates.

FY 2006

While the State budget picture for FY 2006 is again bleak, it is imperative that the current erosion of Medicaid provider reimbursement rates is halted. It is proposed that the FY 2006 budget reflect a commitment to a Medicare benchmark and adequate Medicaid provider rates in three ways: first, by explicitly embracing this goal; second, by requiring MDCH to annually prepare a report quantifying the gap between Medicaid and Medicare payment levels and describing the progress being made towards parity, and third, by matching the Medicare rate increases and if possible providing the resources necessary to make an initial adjustment of rates under a ten-year schedule to achieve Medicare parity.

Even if the gap between Medicaid and Medicare reimbursement cannot be reduced, Medicaid providers must receive increased funding parallel to the expected Medicare increases of 3.5% for inpatient hospitals, 4.4% for outpatient hospitals and 1.5% for physicians. In addition, Medicaid HMO rates must be actuarially sound at levels that support adequate provider reimbursement.

Appendix – Recent History of Medicaid Rates for Hospitals and HMOs

Hospitals

Prior to FY 2003, aggregate Michigan Medicaid payments, exclusive of Medicaid DSH payments, were 76% of Medicare rates, exclusive of Medicare DSH payments, for inpatient hospital services and 65% of Medicare rates for outpatient hospital services.[7] Medicaid rates for physicians were about 60% of Medicare rates for the same services. This difference in reimbursement levels equates to $199 million for hospitals (inpatient and outpatient) and $138 million for physicians.

The FY 2003 Situation for Hospitals: Fee-for-Service Medicaid

In FY 2003 Michigan implemented the Quality Assurance Assessment Program (QAAP) under which certain health care providers are now paying an assessment that helps fund the Medicaid program. The QAAP facilitated significant increases in Medicaid payments to hospitals, an average of 28% for inpatient hospital care and 44% for outpatient services, at a cost of $177 million per year. As a result Medicaid payments to hospitals were 96.6% of Medicare payments. However Michigan's hospitals paid about $103 million in assessments to fund these rate increases. Therefore in FY 2003 Medicaid FFS reimbursement was effectively 84% of Medicare for hospitals.

The increased hospital payments that are funded by the QAAP are "special payments" that only apply to Medicaid FFS care. Michigan's hospitals receive about half of their Medicaid reimbursement from the HMOs rather than from the state. The cost of these increased rates was not included in Medicaid HMO funding or requirements.

The FY 2004 and FY 2005 Situation for Hospitals: Fee-for-Service Medicaid

In FY 2004 the gap between Medicaid and Medicare hospital rates increased. Current estimates indicate that there is a gap of over $185 million between Michigan Medicaid hospital rates and the Medicare upper payment limit.

In FY 2005 this gap increases as Medicare rates increase by an average of 3.3% for inpatient services and 4.4% for outpatient services. However, the final budget for FY 2005 includes a decision to increase the QAAP assessment and related payments to the Medicare Upper Payment Limit. However when the cost to the hospitals of paying the QAAP assessment is netted out, the effective Medicaid reimbursement rate for hospitals for FY 2005, without Medicaid DSH payments will average only 96% of Medicare rates without Medicare DSH payments.

The FY 2006 Situation for Hospitals

The governor's budget for FY 2006 may further erode effective reimbursement to Michigan's hospitals. Medicare rates are projected to increase by 3% to 4%. If the state's response is to again increase the QAAP assessments to fund this rate increase, Medicaid payments to hospitals will appear to increase at the same rate as Medicare rates. However since hospital taxes are the source of the non-federal revenue, hospitals still lose $15 million to $20 million in net revenue from this proposal.

[7] These comparisons exclude DSH payments from the Medicaid payments, while Medicare DSH is included in the Medicare values.

HMOs

Medicaid HMOs received a rate increase in excess of 11% in the middle of FY 2003. This rate increase was funded with a QAAP assessment of 6% on HMO revenues. As a result, the net increase in revenues was about 5%. In August 2003 rates were increased in selective geographic areas to meet the federal requirements that Medicaid HMO rates be actuarially sound.

The October 2004 Medicaid HMO rates included a significant rate increase to meet actuarial soundness criteria. In the aggregate this was an increase of 7.5%. This increase results in rates that are 96.42% of actuarially sound rates. The agreement that the Michigan Medicaid program reached with CMS calls for much greater rate increases in FY 2006 to bring rates to full actuarial soundness. In the aggregate the rates will increase by more than 12% for FY 2006. Our assessment is that Michigan's HMO rates are now sufficient to purchase services at Michigan fee-for-service rates. However, as noted above, those fee-for-service rates are less than 60% of Medicare rates for physicians. And the hospital rates that the HMO rates are based on do not include the QAAP supported rate increases. By 2006, these inpatient rates will represent about 74% of full Medicare rates and the outpatient hospital rates will represent about 56% of full Medicare rates.

When compared to Medicare rates, Michigan Medicaid HMO rates for FY 2005 equal 74% of the cost of providing the same services on a fee-for-service basis, if they were reimbursed using MEDICARE fee-for-service rates.[8] And when the cost of the QAAP is recognized, the rates are only 70% of Medicare parity.

[8] While Medicaid fee-for-service rates for hospital services (without QAAP related payments) cover only about 73% of expected Medicare hospital rates for 2005 and Medicaid rates for physician services cover only about 60% of Medicare rates, other services fare better. We assume that pharmacy costs would not be different with Medicare rates. In addition, Medicaid rates for many ancillary services are much closer to Medicare rates than physician and hospital rates.