Medicaid Monitoring

Provider Rates: Overview and Recent History in Montana

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for the Children, Families, Health, and Human Services Interim Committee
January 2012

Background

Federal law governs many aspects of how states operate their Medicaid programs.However, states have historically had some flexibility in trying to manage their Medicaid costs by setting their own guidelines in three areas: who will be eligible for the program; the optional medical services the Medicaid program will cover; and the amount of money that health care providers will be paid for their services.

The Patient Protection and Affordable Care Act of 2010 limited the ability of states to change their eligibility guidelines until 2014, when the Medicaid program will be expanded to cover anyone under the age of 64 who has an income of 133% or less of the federal poverty level. Currently, the program is generally limited to pregnant women, children, and people who are aged, blind, or disabled, if they meet certain income standards.

Many states recently have reduced or frozen provider rates in an attempt to manage their budgets as Medicaid rolls have increased during the economic downturn. At least one-third of the state budget offices proposed a reduction or freeze in provider rates for fiscal year 2012, according to the National Association of State Budget Officers. In fiscal year 2010, 39 states put rate cuts or freezes into effect, compared with 33 states in fiscal 2009.[1]

Provider Rates in Montana

State law generally gives the Department of Public Health and Human Services (DPHHS) authority to set rates through administrative rule, based on the amount of money the Legislature appropriates for a 2-year budget period. However, rates for physicians are calculated according to a formula set in law. The formula was enacted by the 2007 Legislature, through passage of Senate Bill 354 (Chapter 414, Laws of 2007).

Following is a chronology of some of the key changes in provider rates in the past decade, as documented in the *Montana Medicaid Program: Report to the 2011 Legislature*:

- **2002**: Rates were reduced 2.6%, with the reduction set to expire on June 30, 2002.
- **2003**: Rates were reduced 7%, with the reduction set to expire on June 30, 2003.
- **2006**: Rates increased by 3% for nursing facilities and community service providers.

[1] "Medicaid Cost Containment: Recent Proposals and Trends," *The National Association of State Budget Officers*, April 13, 2011, P. 2.

- **2007**: Rates increased anywhere from 1.39% to 4.26%, depending on the provider type. The Legislature set the rates at a higher level than proposed by the executive branch.

- **2009**: Rates increased 2% in fiscal year 2010, with another 2% increase scheduled for fiscal year 2011. Funding for the increase came from one-time-only funds, meaning rates would revert to the 2009 biennium without legislative action in 2011.

- **2010**: The increase scheduled to take effect on July 1, 2010, was eliminated when Gov. Schweitzer made budget reductions under section 17-7-140, MCA, the law that requires the governor to identify budget cuts when the ending general fund balance is expected to fall below a certain level.

- **2011**: Rates were reduced by 2% as the 2009 increase was allowed to expire.

Provider Rate Fees/Taxes

Federal law allows states to authorize certain fees on Medicaid providers. Federal dollars then match state funds raised through the fees.

In Montana, the Legislature has approved a so-called "bed tax" for nursing homes and for hospitals. Generally, the money raised by this tax and the additional federal funds it draws down are used to pay for higher reimbursement rates for nursing homes and hospitals. The hospital fee of $50 per inpatient bed day raised $21.8 million in receipts in fiscal year 2011. The nursing home fee of $8.30 per bed day brought in $14.5 million.

Such provider fees have been the target of recent federal-deficit reduction talks. Discussions last year included the idea of reducing or limiting the amount of fees that states would be allowed to impose. However, Congress did not take action on this issue.

Pending U.S. Supreme Court Case

The U.S. Supreme Court is currently considering three related cases challenging the California Legislature's decision last year to reduce provider rates by 10%. Providers challenged the cut on the grounds that it violates the requirement that Medicaid rates be sufficient to attract enough providers into the Medicaid program. This requirement is designed to ensure that Medicaid enrollees have the same access to medical services that other residents have.

The state argued that Medicaid beneficiaries and providers do not have the right to sue to enforce the federal Medicaid Act. Lower courts have split on this issue, and the U.S. Supreme Court heard arguments on the matter in October 2011.

The issue before the Supreme Court involves only the authority of the providers to file suit to stop the rate reduction. If the high court rules that providers have the ability to take a state to court over Medicaid reimbursement rates, then federal courts will review the issue of whether California's proposed rate reductions violate the equal access provisions of the Medicaid Act.