

I-149
MEDICAID - PROVIDER REIMBURSEMENT
Overview and Proposal

Medicaid is designed to provide access to health care and human services to Montana citizens most in need and most vulnerable. The state decides:

- financial eligibility, i.e., who is poor enough to receive services under the Medicaid program? and
- services, i.e., which medical, health-related and human services will the state provide for those who are too poor to pay for their own care?

The state asks “providers” – health care and human services professionals, facilities and community programs – to provide services to Medicaid beneficiaries – those the state has decided are poor enough and sick enough to warrant state help.

The state sets payment rates for the various providers who serve the patients/consumers the state has assumed responsibility for. Traditionally – and particularly over the last several years – the state sets rates that are lower than all reasonable benchmarks:

- Actual cost of providing the service
- Amount charged to non-Medicaid patients/consumers
- Amount paid by the Medicare program

Reimbursement to providers of Medicaid services has a significant impact on a number of important aspects of Montana’s health and human services system. Reimbursement levels can impact:

- the overall quality of care delivered
- the access Medicaid recipients have to health care and human service providers and services
- the number and type of services provided
- the ability of service providers to attract and retain qualified staff and to provide appropriate wages and benefits
- the amount paid for services by other purchasers of health care and human services because of cost shifting
- the overall financial stability of the state’s health and human service system

In setting provider reimbursement rates, another important factor that must be taken into account is the importance of Medicaid reimbursement against the total revenue received by a given provider. Providers who serve a high percentage of Medicaid patients/consumers are dependent on Medicaid for a substantial part of their total revenues. The adequacy of reimbursement rates for those providers has a substantial

impact on these providers' financial stability, service quality and staffing issues. Dependence on Medicaid is not the only factor, however, that must be considered. When providers do not have to depend on Medicaid, low reimbursement and administrative and other burdens may lead to decisions not to serve Medicaid patients/consumers. This leads to a system where Medicaid patients/consumers do not have access to the services they need. For these providers adequate reimbursement rates, targeted funding increases, and other initiatives are appropriate.

For all providers who serve the State by caring for those individuals for whom the state has responsibility, it is important that reimbursement rates meet some appropriate benchmark for adequacy. Failure to set reasonable payment levels results in cost shifting to those who pay for their own care and well as quality, access, and staffing problems. This adversely affects Medicaid patients/consumers, other health care consumers, health care and human service providers and health care workers (who are already in short supply).

PROVIDER SUMMARY STATEMENTS

This section of the Report includes Provider Summaries.

Children's Mental Health Providers

- Children's mental health experienced over 22 cuts and changes in rates, services and programs in 2002-2003. The Legislative Fiscal Office reported in the 2003 Legislature that the cuts were disproportionate to children.
- The Department of Public Health and Human Services indicates that children's mental health provider rates are the most disparate in the system.
- Out of home levels of care including Therapeutic Foster Care and Therapeutic Group Care have received a 1% rate increase over the last 10 years.
- These same provider groups serve a high percentage of Medicaid consumers and are dependent on Medicaid and General Fund for over 90% of their total revenues.
- Residential Treatment Centers are faced with serving more and more children from out of state with higher rates, to subsidize the care of Montana youth.
- The inadequacy of reimbursement rates for those providers has a substantial impact on their financial stability, service quality and staffing issues.
- Current revenues cover on average 60-70% of the cost of doing business. There have been significant increases in utilities and insurance with rates staying stagnant.
- To address increased costs, provider agencies have done such things as freezing wages and reducing benefits to workers; laid off employees; deferred quality monitoring and more.
- The Department of Public Health and Human Services has committed to completing "cost of care" studies for children's mental health providers as part of the commitment to move toward a common set of reimbursement principles as recommended by the Medicaid Redesign project.

Community Based Developmental Disabilities Providers

- Non Profit Agencies providing statutorily-mandated services to people with developmental disabilities need adequate funding to keep up with the cost of doing business. In the last three years these agencies have received no increases in funding from the Legislature while the cost of providing services has increased steadily.
- In a recent survey of provider agencies, costs for health/dental insurance in the last 3 years have increased an average of 41%, and, in many cases, the benefit packages had to be reduced; Worker's Compensation Insurance costs have increased an average of 67%; utilities are up 25%; fuel costs are up 30%; liability and auto insurance increased 54% and food costs have increased (due to food subsidy decreases) an average of 31%. Additionally, new funding is needed to maintain and replace buildings and equipment and to comply with a myriad of state and federal regulations that place new requirements on service providers, but provide no additional funding, e.g. HIPPA, the Safety Culture Act, Infectious Disease Inoculation, Incident Management Policies and more. All of these costs factors have increased while funding has remained level.
- To address increased costs, provider agencies have done such things as freezing wages and reducing benefits to workers; delayed making needed repairs to buildings and equipment; laid off employees; and more.
- A major concern for provider agencies is not being able to pay adequate wages to staff who work directly with persons with disabilities. These individuals determine the quality of service that an individual with disabilities receives and are required to have good judgment and specialized skills. Often the work that these individuals do is very physically demanding and requires long evening and weekend hours. The average entry-level wage for direct-service workers is \$6.73 per hour compared to the entry-level wage for similar workers at Montana's State institutions of \$8.81 per hour (This comparison was made in FY 2002. Since that time, the state's direct-service workers have received wage and benefit increases appropriated by the Legislature while private workers in many cases have received none).
- The negative affect of low wages and poor benefits for direct-service workers is high turn-over in these positions and extreme difficulty in recruiting new workers. This turnover causes significant disruption in the lives of persons with disabilities and is very costly to provider agencies running as high as \$5000 each time a worker is replaced. Staff turnover costs have increased anywhere from 31% to 435% for some agencies during the last 3 years!

Dentists

- In state fiscal year 2004 \$5,787,565 was spent on Medicaid dental services. The Montana Medicaid dental programs served about 21,000 persons in the eligible population. More than 14,000 were children.
- 75% of Montana's actively practicing dentists serve Medicaid patients in varying numbers.
- The average cost of office overhead in a dental office is 65-70% of charges. Medicaid presently pays approximately 65% of average billed charges. This means

that dentists generally are paid at or below their own office expenses when they serve Medicaid patients. The issue of low reimbursement is compounded by the high no show rate of 25-30% for Medicaid dental patients who do not keep their dental appointments. This creates additional financial stress on a dental practice.

- Low Medicaid reimbursement rates result in cost shifting in dental offices.
- In 2001 the Montana Legislature appropriated a rate increase for Medicaid dental services; however, providers and the Medicaid population did not realize this increase in any significant manner because of the increased number of persons who became eligible for dental programs shortly after the increase was put into effect. In fact, from February through July 2003 dental service for adults was reduced to emergency dental services only.
- The proposed funding is intended for rate increases to improve access to dental services for Medicaid patients.

Hospitals

- Hospitals were subjected to a 12 percent budget reduction in 2002-3. Among medical providers, the hospital budget reduction alone was not restored by the 2003 Legislature administratively by the Department.
- The tobacco funding provided by I-149 will:
 - Fund hospital treatment provided to low birth-weight infants in Billings and Butte, Montana. Currently, Deaconess Billings Clinic and St. James Community Hospital do not receive enhanced Medicaid funding for these services.
 - Fund inpatient rehabilitation services at the 2001 levels. Inpatient rehabilitation includes long term inpatient hospital services for post-surgical care, treatment of victims of stroke and head injuries, among other diagnoses.
 - Funding pulmonary rehabilitation services. Current Medicaid policy does not provide any payment for services provided after heart surgery.
 - Base payment rate adjustments are increased to partially restore funding cuts made in previous years. Medicaid rates, even after adjustment, will remain below the cost of providing hospital care.

Long Term Care – Community Based

(Medicaid waiver, personal assistance, home health, hospice)

- Programs serve about 5,000 aged or disabled people annually
- Waiver services include in-home services, adult residential services, TBI services, home modifications and safety, support services and case management
- Personal assistance services are medically oriented in-home services related to a recipient's physical health and personal hygiene
- Medicaid home health services include home health agency services and private duty nursing
- Medicaid hospice provides health and support services to the terminally ill and their families
- Experiencing staff shortages -- difficult to find sufficient number of personal care attendants and other direct care staff

- No rate increase for past three years
- Waiver and personal assistance providers exclusively dependent on Medicaid
- Proposed funding to be used for rate increases and community service initiatives such as serving people on the waiting list, increasing waiver slots, rate equalization, or targeted funding for community services such as respite services, transportation, etc.

Long Term Care – Skilled Nursing Facility/Nursing Home

- 1.2 million Medicaid funded days of nursing home care delivered to about 5,000 people, most of whom are elderly
- Medicaid is the largest single source of revenue for nursing homes – pays for about 60% of all services – Medicaid rates greatly impact the quality of care our residents receive as well as staffing levels, staff pay, training, etc.
- Fewer people are going into nursing homes but those that do are older and sicker than ever before – and therefore more costly to care for
- Nursing homes are experiencing staff shortages – it is difficult to find sufficient numbers of nurses and certified nurse aides to provide care
- Low Medicaid rates translate into substantial cost shifting to the 32% of our patients who pay for their own care
- Nursing homes (and indirectly) their patients who pay for their own care pay a nursing home bed tax of \$5.30 per patient day to help support adequate Medicaid reimbursement rates.
- The state general fund currently contributes \$17.40 per day toward the cost of a day of nursing home care. That amounts to about 13% of the rate. For most other Medicaid services the state is contributing the full 27% match rate. Prior to the bed tax, the state contributed 22% to the nursing home Medicaid rate.
- The state general fund commitment to nursing home care is declining – from 22% for FY 91 prior to the bed tax, to 16% in FY03, to 14% in FY 04, to 13% in FY 05.
- Cost of care vs. Medicaid rate (based on DPHHS analysis and CMS SNF market basket inflation):

Without provider rate increase:

State FY	Medicaid Rate	Actual Cost	Medicare UPL
05	\$121.52*	\$131.64	\$159.00
06	\$121.52	\$136.78	\$167.00
07	\$121.52	\$141.56	\$175.00

With provider rate increase in proposal:

06	\$130.63	\$136.75	\$159.00
07	\$130.63	\$141.56	\$175.00

*For FY 05 nursing homes expect to receive an additional \$6.50 from the IGT program. The program sunsets June 30, 2005. The expectation is that there may be no IGT program at all in the future or a substantially reduced IGT program.

Physicians

- Proposed rates will approach, but not meet, Medicare payment rates.
- Proposed rates will provide an increase in allowances for well child screening services.
- A 1999 MMA survey of primary care physicians in Montana showed that 18% restrict or limit Medicaid patients.
- A 2002 MMS survey of primary care physicians in Montana showed that 27.22% restrict or limit Medicaid patients.

PROPOSAL

The Provider Reimbursement Subcommittee proposal takes into account:

- That Medicaid providers serve those in the most financial need.
- That Medicaid providers serve those with significant health care needs.
- That Medicaid reimbursement should seek to positively affect quality of care, access, staff retention, and cost shifting.
- That Medicaid reimbursement should pay providers according to some reasonable benchmark related to costs, charges or Medicare reimbursement.

In developing its recommendations, the Provider Reimbursement Subcommittee also considered the recommendations of the Montana Public Health Care Redesign Project related to "Medicaid Values, Principles, and Goals," "Funding Priorities", and "Reimbursement Principles".

The Subcommittee also considered the issue of adding new Medicaid services and concluded that it is not wise to add services when the state is having difficulty paying for the services that currently exist. The ability to sustain new services is of great concern. The subcommittee is recommending modest expansion of current services in two areas: neonatal ICU and community services under the Medicaid waiver.

Specific recommendations from the Medicaid Redesign Project report relevant to funding priorities and reimbursement principles are also included as an attachment to this report.

I-149 Tobacco Tax Revenue
 Medicaid Provider Reimbursement Proposal
 To The
HEALTH & HUMAN SERVICES APPROPRIATIONS SUBCOMMITTEE
 1/11/05
 (In thousands)

	<i>FY 06 and 07 (Each year)</i>
Hospital Services	
Expand program for low birth weight – neonatal ICU	\$ 150
Increase Physical Rehabilitation	\$ 120
Pay for Pulmonary Rehab	\$ 121
Pay CAH at 101% of Cost	\$ 40
Fund base rate increase for PPS/APC	\$1,893
Total hospital services	\$2,324
Physician Services	
Targeted rate increase to physician categories currently paid below the Medicare UPL up to the UPL to encourage better access for Medicaid beneficiaries	\$1,620
Long term care - Skilled nursing facility/nursing home	
Rate increase to bring the Medicaid rate closer to the actual cost of providing care and direct care wage initiative to sustain quality, avoid increasing the cost shift, and address direct care staff shortages	\$2,880
Long Term Care - Community Based (Personal care, home health, hospice, Medicaid waiver)	
Rate increases and community service expansion (waiting list, waiver slots, targeted funding) and direct care wage initiative	\$1,080
Dentists	
Targeted rate increases to improve access to Medicaid beneficiaries	\$ 477
Community Children's Mental Health	
Community based rates for Children's MH have increased on average 1% , in the past 10 years. These rates are considered to be the most disparate within DPHHS. Over 90% of these providers are funded with only Medicaid and State GF dollars	\$1,080
DD Medicaid-only Waiver	
Community based DD providers rates cannot compete with the increasing cost of doing business including adequate rates for direct care staff, currently at 64% of wages paid to state direct care workers doing similar work	\$ 360
Mental Health Services	
Non-SED children and non-SDMI adults	\$ 877
Total Annual costs	\$10,708

Notes:

- Funding for the two-year period assumes all increases in year 1, zero percent in year 2.
- Actual rate increase percentages to be calculated by DPHHS using available funds.
- Recommendations take into account reimbursement principles adopted by the MT Public Health Care Redesign Project
- Tobacco funds cannot be used for non-Medicaid provider rates
- This proposal does not intend to address issues such as funding basic programs with IGT, the Prevention and Stabilization Account, I-146 funding and declining tobacco settlement dollars.

