

Reforming health care payments



Doctors seek payments that cover treatment costs

Minnesota's fee-for-service payment rates and methodologies are jeopardizing the ability of physicians to provide care to enrollees in Minnesota's health care safety net programs. The state provides coverage for those in need, recognizing that without these programs many would go without health care. But the state's payments simply don't cover the cost of caring for enrollees in Medical Assistance, which is Minnesota's Medicaid program, MinnesotaCare, and General Assistance Medical Care.

Minnesota physicians caring for health care safety net enrollees have received only one across-the-board increase in the last 16 years—a 3 percent raise in 2000. During this time, practice costs have been escalating. The CPI-U, a common measure of inflation, has increased by 28 percent between 1998-2008. Minnesota's static payments have resulted in the state's public program payment rates falling behind the Medicaid programs of other states. Nationally, physician fees for primary care increased an average of 41 percent from 1998 to 2003, according to the Kaiser Family Foundation. Minnesota physicians are paid considerably less for office visits and other evaluation and management of services than physicians in Iowa, North Dakota, South Dakota, and Wisconsin.

This chronic state of underfunding forces clinics to shift the cost of caring for low-income patients to privately insured patients. It also makes it difficult for physicians caring for low-income Minnesotans to sustain their practices. The MMA contends that the state is obligated to provide fair payment, since it requires physicians to accept enrollees of safety net programs or else lose the ability to care for state employees or enrollees in other programs such as workers' compensation. This requirement is known as Rule 101.

PHYSICIAN SOLUTIONS:

- Institute an automatic annual increase for fee-for-service reimbursement rates
- Require medical managed care plans to pass along payment increases from the state to providers
- Immediately implement a RVU-based payment system.

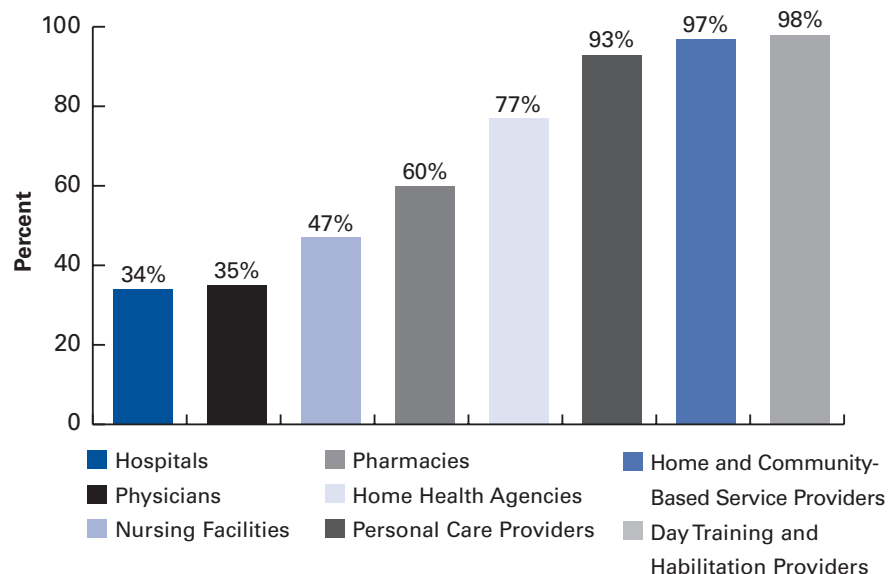
FAST FACTS:

26 other states, including Wisconsin and Iowa, had higher Medicaid physician payment rates than Minnesota in 2003.

Source: Urban Institute study.

There has been only one across-the-board public program payment increase for medical services in 16 years.

Ratio of Fee-for-Service Payments to Charges, 2005



Source: DHS data as reported in Office of the Legislative Auditor, State of Minnesota. Evaluation Report: Financial Management of Health Care Programs, 2008.

Unlike doctors, insurers got pay hikes

While physicians often lose money when caring for low-income Minnesotans, health plans have profited from these programs.

Minnesota started experimenting with using managed care for public programs in the 1980s. Participating health plans receive capitation payments from the state to cover enrollees. Approximately 64 percent of public program enrollees are covered by managed care plans, including all MinnesotaCare enrollees.

Between 1998 and 2008, Minnesota health plans that provide enrollees coverage through the state's managed care program have seen annual increases of about 10 percent. Yet, physicians report those increases have not been passed along to them. Federal law requires the state to set sound capitation rates including adjustments for price increases. Because the state does not collect data on health plan payments to providers, it is unclear whether the annual changes in capitation rates are being appropriately passed through to providers.

PHYSICIAN SOLUTION:

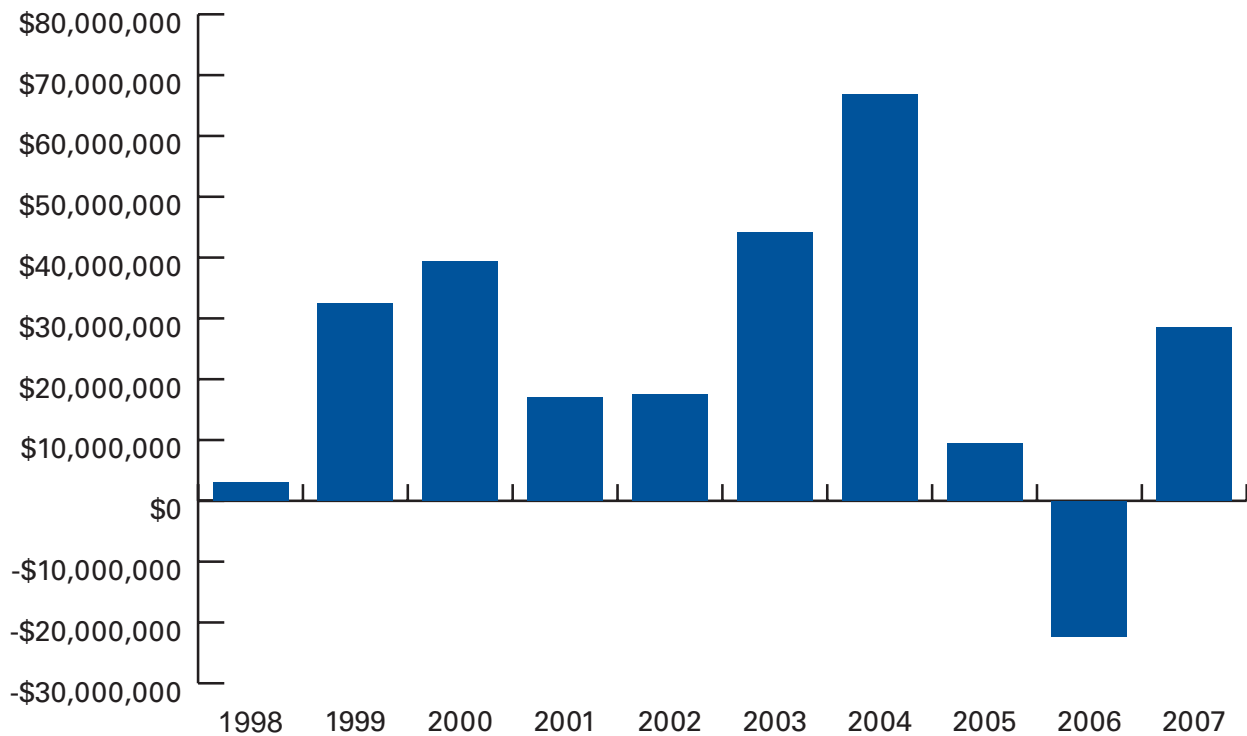
Require health plans to pass through capitated rate increases to providers.

HEALTH PLAN PARTICIPATION IN MEDICAID MANAGED CARE

In 2005, the state made total payments of \$2 billion to 6 HMOs and 3 county-based entities.

Insurers	Managed Care Enrollees
Medica	28%
Blue Cross	24%
UCare	20%
HealthPartners	11%

HMO Public Program Net Income, 1998-2007



Source: Baumgarten, A. Minnesota Managed Care Review. Report years 1999-2008

State uses out-of-date payment methods

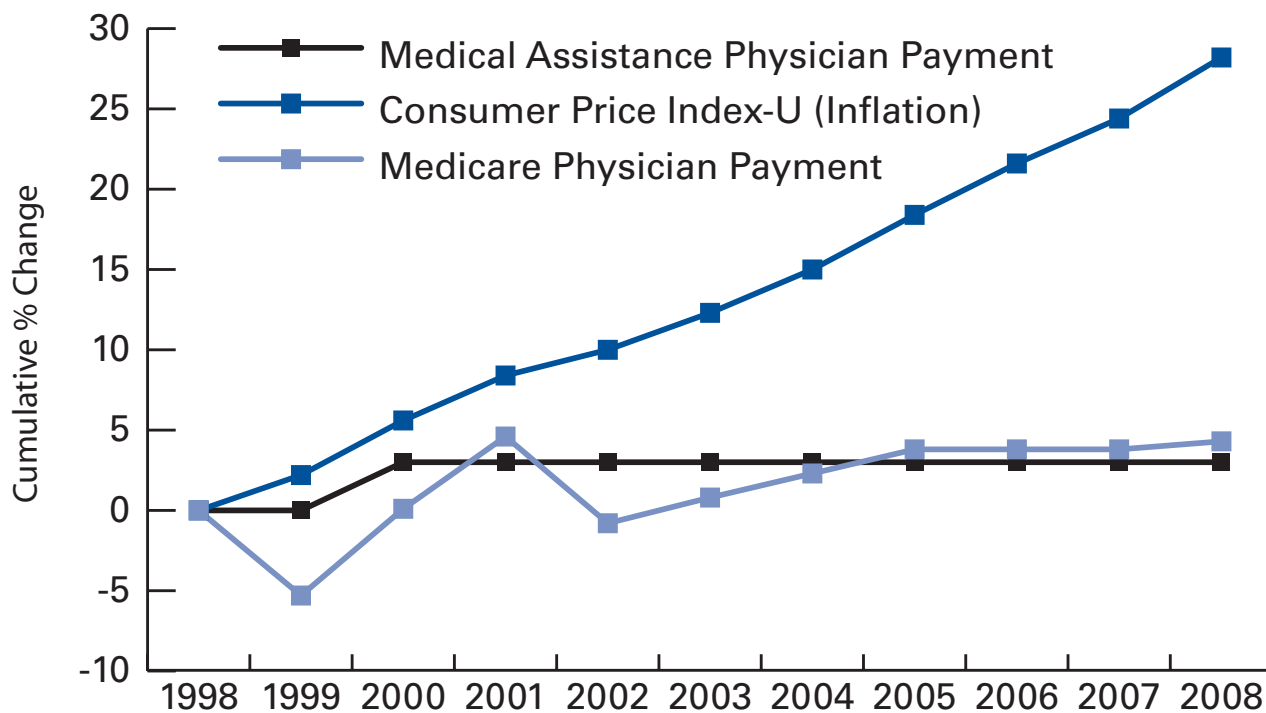
The state's payment system undermines prevention and primary care because it uses an arcane methodology from the early 1980s for computing fee-for-service payments. The Legislature required the Department of Human Services to move to a relative value unit (RVU) payment system in 2003. DHS has yet to make the change, despite the fact that it was supposed to be done by 2007 and Medicare and all other private payers use this system. Converting to an RVU-based system would shift payments towards evaluation and management of services. It would also make Minnesota's payment system more transparent and comparable to those of other payers and states.

PHYSICIAN SOLUTION:
Implement immediately a RVU-based payment system.

DHS DEFIES LEGISLATURE

As of January 2009, the Department of Human Services had not complied with a 2003 Legislative mandate to adopt an RVU-based payment system.

MN Medical Assistance and Medicare Reimbursement and Inflation Trends



Sources: Medical Assistance data based on changes in fee-for-service rates excluding targeted programmatic, code, and specialty changes; Medicare data based on changes in Medicare's conversion factor as published by the Centers for Medicare and Medicaid Services; CPI-U data from US Bureau of Labor Statistics.

DOCTORS WANT YOU TO KNOW

- Inadequate payments for MA, GAMC, and MinnesotaCare have a drastic impact on medical practices with large numbers of patients on public programs. These practices, many of them in rural Minnesota, are already struggling.
- Payments are based on the median charges from 1989. Payments for medical services in public programs have been increased across-the-board only once in the last 16 years, a 3 percent raise in 2000. Meanwhile, the cost of running a medical practice has gone up nearly 30 percent in the last 10 years.
- Inadequate payments in public programs cause more cost shifting to the private market, lead to higher premiums for the insured and place a greater burden on employers to continue to provide affordable coverage.
- While provider payments have been basically flat, payment to health plans through the Medicaid managed care program have increased nearly 80 percent in the last 10 years. Anecdotal evidence suggests that increases for higher service prices included in these payments have not always been passed through to providers.

Payment rates threaten clinics

Payment rates that do not cover practice costs are unfair and put Minnesota clinics in an untenable position.

In 2005, about 25 percent of Minnesotans received their coverage through public programs, with about 11 percent enrolled in state safety net programs and 14 percent in Medicare. However, for some urban and rural clinics, their percentage of patients on government programs is approaching 50 percent. Inadequate payment puts these clinics in a serious financial bind.

For doctors, turning these patients away isn't an option. Ethically, it just isn't palatable for physicians, and the state's Rule 101 makes denying treatment impractical, since it requires physicians to participate in public safety net programs, if they want to treat state or other public employees or patients relying on workers' compensation, which can account for up to 20 percent of a clinic's case load.

To date, Minnesota has been able to avoid a health care access problem by relying on the goodwill of providers who must shift costs to other patients to stay afloat. However, years of underfunding have left the state's health care safety net fragile, and many clinics that serve low-income Minnesotans are on the verge of folding.

One rural clinic's story

Terry Cahill, M.D., a family physician at United Hospital District Clinics of Faribault County in Blue Earth, says the state's Medicaid programs account for about 10 percent of the clinic's revenue even though enrollees in Medical Assistance, MinnesotaCare, and General Assistance Medical Care account for about 20 percent of the clinic's visits.

In his clinic, Medical Assistance pays 53 percent less than a large Minnesota insurer pays for the clinic's most commonly billed code for an office visit.

Cahill says his practice will keep accepting Medicaid patients because it is the right thing to do, but the low payment rates make it difficult for his practice to upgrade to electronic medical records or to recruit physicians to join the practice.

His clinic has coped with the low payment rates over the years by shifting costs onto private insurers, he says, but that is becoming increasingly difficult to do.

"If we had to live on these payments, we wouldn't be viable for very long," Cahill says. "We subsidize those visits with charges to other people."

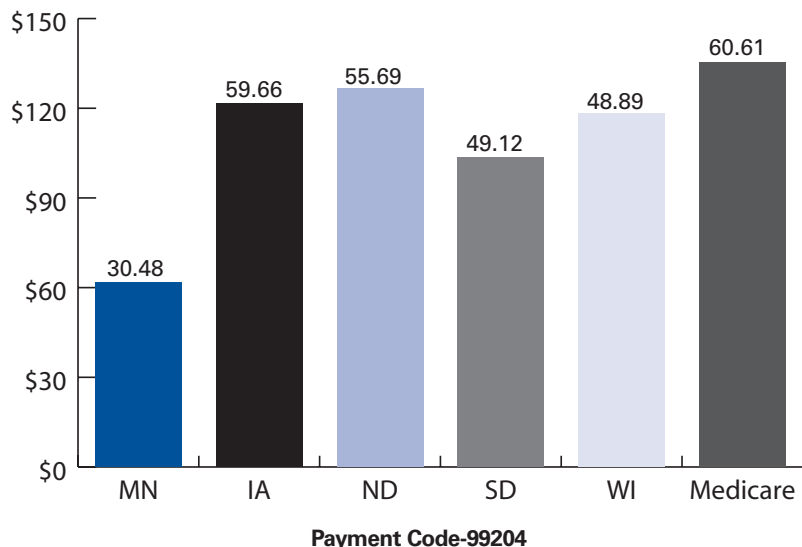


PAYMENT COMPARISON

Medical Assistance pays this Blue Earth clinic significantly less than private plans for an office visit.

Private plan	\$79.00
Medicare	\$56.88
Medical Assistance	\$37.13

Medicaid Rate Comparison for New Patient Visits



Sources: Minnesota data based on fee-for-service fee schedule published by Department of Human Services (1/1/08 effective date); data for Iowa, North Dakota, South Dakota and Wisconsin from 2007/08 American Academy of Pediatrics Medicaid Reimbursement Survey; Medicare data based on 2008 Minnesota Medicare fee schedule published by Wisconsin Physicians Service.