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Preliminary Report: The Association between Minnesota Public Health Care Programs fee-for-service Rates and Adequacy of Access to Services for Public Program Enrollees

Laws of Minnesota 2008

Chapter 364, section 11 subdivision 3

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Legislative Report

Minnesota Department of **Human Services**

The Association between Minnesota Public Health Care Programs Fee-for-service Rates and Adequacy of Access to Services for Public Program Enrollees – Preliminary Findings

The Office of the Legislative Auditor (OLA) issued a February 2008 report "Financial Management of Health Care Programs" which covered, among other items, state payment rates for health care programs. The OLA concluded in its report that the Legislature and the Department of Human Services (DHS) have not taken sufficient steps to address concerns about the adequacy and equity of Minnesota's fee-for-service rates. Based on the OLA evaluation and report, the Minnesota Legislature required DHS to report to the 2009 Legislature: "...the adequacy of public health care program for fee-for-service rates, including an identification of service areas or geographical regions where enrollees have difficulty accessing providers as the result of inadequate provider payments. This report must include recommendations to increase rates as needed to eliminate identified access problems." Laws of Minnesota 2008, chapter 364, section 11, subdivision 3.

In December 2008, the Minnesota Department of Human Services (DHS) retained Burns & Associates, Inc. (B&A), a health care consulting firm who works primarily with state Medicaid agencies, to perform an independent evaluation of the fee-for-service (FFS) provider rates. B&A was charged to:

1. Compare the FFS provider rates paid by DHS to other states' Medicaid rates

2. Examine FFS rates paid to physicians and non-physicians who deliver the same service

3. Investigate the availability of providers to FFS participants, with a focus on physician services, and report the results by region and provider specialty to determine if FFS payment rates are influencing participants' availability to practitioners

4. Survey physicians and participants in the Minnesota Health Care Program (the FFS program) and report on perceptions of limitations in members' access to care as a result of the current fee structure

B&A has completed all contract activities with the exception of the surveys which have recently been received from the field. B&A has delivered preliminary drafts of three reports to the Department of Human Services. These reports compare Minnesota FFS provider rates to other states' Medicaid rates, compare FFS physician rates to non-physician rates, and analyze fee for service enrollee access to providers.

DHS has begun to review these drafts, and has identified several areas where further clarification will be required to ensure accuracy. The full report will be provided to the Legislature following a complete review.

Burns and Associates Findings

Related to Minnesota's FFS rates compared to other states' Medicaid programs and Medicare

The fee-for-service rates from nine comparable states (Iowa, Indiana, Michigan, Nebraska, Ohio, Oregon, Washington, Wisconsin and Vermont) were compared to Minnesota's for 102 high volume unique services billed by physicians. B&A prepared a short survey to gather data from the comparison states. Only three states returned the survey – Nebraska, Ohio and Wisconsin – and these surveys were incomplete. B&A made follow-up phone calls, and obtained additional information, including fee schedules.

Because the information was incomplete, B&A used fee schedule (base rate) comparisons among the states. Minnesota currently uses a series of upward and downward rate adjustments which are not reflected in the fee schedule. It is not known if other states use similar adjustments, or if those adjustments are reflected in the various states' fee schedules. It is not possible to determine if the comparisons are valid.

Based on the obtained fee schedule rates, B&A found that the ten state comparison revealed that Minnesota's Medicaid fee-for-service rates were lower than most of the other states for most services.

- Lowest among the 10 for office/outpatient visits
- Lower than 7 out of 10 for emergency and critical care services
- Lowest among the 10 for rates paid to pediatricians for office/outpatient visits (rates paid for Early Periodic Screening, Diagnosis and Treatment (EPDST) are not included here)
- Lower than all but one state for OB/GYN services (Minnesota makes upward adjustments for these services)
- Lower than 7 out of 10 for dental services (Minnesota pays an add-on for critical access dental providers)
- In the middle of the states for psychiatry and cardiology
- Highest or near highest for selected neurology services
- Highest among the 10 for orthopedic surgery services

A 2009 study [Trends in Medicaid Physician Fees, 2003 – 2008," Stephen Zuckerman, Aimee F. Williams, and Karen E. Stockley, Health Affairs 28, no. 3 (2009) w510-w519 (published online 28 April 2009; 10.1377/hlthaff.28.3.w510)] reported that Minnesota paid physicians at 76% of the Medicare rates (all services), which was higher than the national average of 72%. Primary care services were paid at 58% of the Medicare rates (compared to the national average of 66% across all Medicaid agencies). 6 of the 9 states surveyed by B&A paid physicians at a greater percentage of the Medicare rates for all services, and all comparison states paid physicians at a greater percentage of the Medicare rates for primary care services. Although it appears that this study had greater access to information than B&A, it is not clear that all variations in payment policy are accounted for.

<u>Related to FFS rates paid for services provided and billed by both physicians and non-physicians</u>

The fee-for-service rates for sixty-seven (67) high-volume services provided and billed by both physicians and non-physicians were examined. B&A used FFS claims data for this comparison. Minnesota' statutorily directed payment policies are reflected in the claims data, and may have skewed the data. For example, Minnesota pays higher rates for services provided in community health centers, and lower rates for services provided in outpatient hospital settings. A disproportionate percentage of nurse practitioner services are from community health centers when compared with physician services, while physician services were more likely than podiatrist services to be performed in outpatient hospital settings.

The preliminary report shows that, without controlling for the place of service, among the 67 services examined by B&A, the physician payment was:

- Higher in 30 services (usually compared to nurses)
- Lower in 9 services (compared to a mixture of four different specialty types)
- The same in 28 services

Payments for the nine services where the physician rate was lower than the nonphysician rate represented only 6.4% of total physician payments in State Fiscal Years 2007 and 2008.

Related to physician participation in Medicaid fee-for-service and rates

Minnesota Health Care Programs enrollees can move between FFS and Managed Care multiple times throughout the year. The B&A analysis included FFS enrollees who were enrolled in the FFS program for at least three consecutive months during State Fiscal Years 2007 and 2008. Recipient location was based on the county of residence as of December 2008, which may not correspond to the county of residence at the time services were received.

Although physicians may practice at more than one location, and group practices may include multiple sites in multiple counties, provider records only include one address. A county can be found to have low or no availability based on the provider records, although there may be one or more providers practicing in that county.

The B&A analysis revealed areas of the state where physician participation in the Medicaid fee-for-service program is low, but did not reveal a direct linkage between low physician availability in specific regions and lower access to services by members.

Based on a ratio of physicians to FFS members, B&A found that:

- Urban areas in Minnesota have "high" (one to 100 FFS participants per physician) or "medium" (101 to 500 FFS participants per physician) availability among the "actively participating" (physicians who billed the FFS program on average more than three times per month) pool of physicians
- Ten rural counties have "low" (more than 500 FFS participants for every physician) availability among this pool of physicians
- Five rural counties have no availability (i.e., no providers)

B&A did not conclude that low provider availability equates to low access, however. Evidence supporting this finding includes:

- Among the 15 counties in the state designated as "low" or "no" primary care availability in the county for FFS participants, only one county had higher ER utilization (measured on a per 1,000 FFS member basis) than the statewide average. However, this county (Mahnomen) also had higher primary care utilization per 1,000 members as well.
- Besides Mahnomen County, for the other 14 counties, one county had similar primary care utilization as the statewide average, six counties had somewhat lower utilization, and seven counties had much lower utilization. This indicates that efforts could be made in select counties in improve provider availability to members.

A further analysis of the effect of FFS rates on enrollee access to care will be available following receipt of the physician and enrollee surveys. At that time, the Department of Human Services and Burns and Associates will prepare and submit recommendations to the Legislature.