Medicaid Reimbursement Rates for Primary Care Services

Response to HR 1 of the 2020 Second Extraordinary Legislative Session

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April 2021

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Introduction

This report has been prepared in response to House Resolution 1 (HR 1) by Representatives Echols and Thompson of the 2020 Second Extraordinary Legislative Session requesting the Louisiana Department of Health (LDH) to study the costs and benefits of setting Medicaid reimbursement rates for primary care services at levels that are at least equal to Medicare rates. Specifically, this resolution:

- Urges and requests the Louisiana Department of Health to study the costs and benefits of setting Medicaid reimbursement rates for primary care services at levels that are at least equal to Medicare rates for those services;
- Requires that the benefits to be considered in this study shall include, without limitation, reductions in net costs of overall care for patients resulting from enhanced access to and quality of primary care; and
- Requires that the findings from the study called for in this Resolution be reported to the House Committee on Appropriations and the House Committee on Health and Welfare.[1]

The full text of HR 1 can be found in Appendix A and also at www.legis.la.gov.

The following report will:

1. Briefly describe primary care;
2. Summarize an LDH-commissioned, but independently conducted, systematic review of the published research on the costs and benefits of enhanced Medicaid reimbursement rates for primary care; and
3. Describe LDH's findings from a fiscal and program impact analysis exploring increasing Louisiana Medicaid primary care rates to match Medicare rates.

Section 1 – Primary Care

HR 1 defines primary care as "routine healthcare services delivered by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients and practicing in the context of family and community; this care includes screening, assessment, diagnosis and treatment for the purpose of promoting a person's health and detecting and managing a person's disease or injury."

The American Academy of Family Practice defines primary care as including care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed health concern. It includes health promotion, disease prevention, health maintenance, counseling, patient education and diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.).

Primary care is performed and managed by a personal physician often collaborating with other health professionals (e.g., advanced practice registered nurses and physician assistants), and utilizing consultation or referral as appropriate. Primary care provides patient advocacy in the health care system to accomplish cost-effective care by coordination of health care services. Primary care promotes effective communication with patients and encourages the role of the patient as a partner in health care. A primary care practice often will serve

[1] Louisiana State, Legislature. House Resolution 1. Louisiana State Legislature, 2020 Second Extraordinary Session. Accessed December 7, 2020. https://legis.la.gov/legis/ViewDocument.aspx?d=1192223.

as the patient's first point of entry into the health care system and as the continuing focal point for all needed health care services.[2]

Section 2 – Summary of the Systematic Literature Review

In response to the passage of HR 1 in the 2020 Second Extraordinary Legislative Session, the LDH Bureau of Health Services Financing (Medicaid) commissioned an independent systematic review of the published research by its contracted external quality review organization, Island Peer Review Organization (IPRO). The purpose of the systematic review was to broadly "… evaluate the impact of increasing Medicaid fees for primary care services to match Medicare rates[3]" on a wide range of outcomes.

While LDH provided the study question and ensured that the end result was comprehensive and responsive to HR 1, IPRO's review was conducted independently. The primary outcomes IPRO analyzed in this systematic literature review study were provider participation, utilization, access, health outcomes, quality of care and cost. See the attached report from IPRO for the full text of the systematic review. The following provides a brief summary of their findings.

Subsection 2.1 – Provider Participation

IPRO found mixed evidence on the association between fee increases and providers' likelihood of accepting Medicaid-insured patients.

Subsection 2.2 – Utilization

IPRO found mixed evidence on the association between fee increases and utilization.

Subsection 2.3 – Access to Care

IPRO found that increasing fees was consistently associated with positive, but modest, effects on access to care.

Subsection 2.4 – Health Outcomes, Quality of Care and Cost Offsets

IPRO was unable to find evidence that primary care fee increases in Medicaid were associated with direct improvements in health outcomes or improved quality of care for Medicaid enrollees. IPRO was also unable to find evidence that primary care fee increases in Medicaid were associated with lowered costs for the Medicaid program.

Subsection 2.5 – Study Limitations

IPRO points out that health care access and utilization is complex and affected by multiple factors, making it difficult to isolate a causal relationship for rate increases on outcomes and utilization.

[2] "Primary Care." *AAFP Home*, Accessed January 28, 2021. www.aafp.org/about/policies/all/primary-care.html.

[3] Island Peer Review Organization. *Is an Increase in Medicaid Fees for Primary Care Services to Match Medicare Rates Associated with Increased Provider Participation, Access, Outcomes, and Cost? A Systematic Literature Review, DRAFT.* February 2021. Commissioned by the Louisiana Department of Health.

Section 3 –Fiscal and Program Impact Analysis of Matching Louisiana's Medicaid Primary Care Rates with Medicare

Prior to introducing HR 1 during the 2020 Second Extraordinary Legislative Session, House Bill 324 was filed requiring that Medicaid rates paid to physicians, physician assistants and advanced practice registered nurses for primary care services be at least equal to the Medicare rates for those same services. LDH conducted a fiscal and programmatic impact analysis of HB 324, and found that state general fund (SGF) costs in the first year of implementing this bill would be $65,398,811 for half a year's implementation (January through June, 2021) of State Fiscal Year (SFY) 2020-21, as it would take some time to get the approvals and changes made for implementation. Annualized, the SGF expenditures rise to $213,707,613 by SFY 2024-25, producing a five-year total SGF impact of $839,942,740. These amounts were reflected in the legislative fiscal note for HB 324, which can be found at https://legis.la.gov/legis/ViewDocument.aspx?d=1169007.

The intent of HB 324 is similar enough to the intent of HR 1 to use the same analysis. The following provides a summary of LDH's findings for HB 324 and describes some of the underlying assumptions and circumstances that led to the fiscal note.

Subsection 3.1 – Fiscal Impact Analysis

The fiscal impact for HB 324 was calculated using several assumptions regarding primary care, as there is no uniform way to identify these services. LDH interpreted the proposed bill to refer to all care performed by primary care providers, and utilized claims and encounter data dating from SFY 2016 to January 2020 to extrapolate the estimated fiscal impact starting in SFY 21. Implementation of HB 324 was assumed to begin January 1, 2021, to allow time needed for rulemaking, state plan amendment approval and rate certification. Comparable timeframes would need to be included for any similar legislation proposed in the future.

To meet the inclusion criteria in the fiscal impact, the services must be:

- Performed by an attending/servicing provider registered as one of the following types:
    - Physician (independent or group)
    - Doctor of osteopath medicine (individual or group)
    - Physician assistant
    - Nurse practitioner (individual or group) [grouped as APRN]
    - Certified nurse midwife [grouped as APRN]
    - Clinical nurse specialist [grouped as APRN]
- Performed by an attending/servicing provider registered with one of the following commonly associated primary care specialties:
    - General practice
    - Family practice
    - OB/GYN
    - Pediatrics
    - Internal medicine
    - Nurse practitioner
    - Physician assistant
- A professional service claim type
- In a place of service of "office" or "outpatient hospital" (i.e., no inpatient claims)

Repricing the current Medicaid fee schedule for these procedure codes is calculated by one of three methods using Medicare rates:

1. Based on the January 2020 Medicare Physician Fee Schedule (MPFS)
    a. Location region 99 for Louisiana, non-facility rates

2. Those Medicaid procedure codes not available on the MPFS were based on the most recent pricing per Louisiana Medicaid's fee schedule with a type of service 03 (adult rate) or 07 (enhanced rate for children) as appropriate, then given an increase based on the following:
    a. Added 10% for services provided to recipients between ages 0 – 15
    b. Added 25% for services provided to recipients age 16+

3. Those procedure codes not available on the MPFS or the Medicaid fee schedule, but payable in managed care, were based on the highest payment made based on the historical data pulled and:
    a. Added 10% for services provided to recipients between age 0 – 15
    b. Added 25% for services provided to recipients age 16+

The fiscal impact was calculated using both fee-for-service (FFS) claims and managed care encounters, as well as accounting for the various Federal Medical Assistance Percentages, distinguished by regular match, Children's Health Insurance Program (CHIP) match, and adult expansion match. In addition to the additional costs directly attributed to enhanced rate payments, a standard 7% increase in utilization year over year was included in the final calculations. There is no standard in estimating the annual increase. LDH chose this value to represent a potential increase in enrollment (e.g., due to population growth) as well as an increase in service utilization.

The tables below describe LDH's projected fiscal impact to the state general fund and the corresponding federal impacts assuming a January 1 implementation date. The start month varies between FFS and the managed care organizations (MCOs) due to differences in how payments are made. State match and the Federal Medical Assistance Percentages were calculated using rates as of SFY 22. As per Section 2.4 above, LDH did not identify any evidence of savings that would be anticipated to result from the proposal to increase reimbursement rates for primary care services and so no such savings were included in this fiscal impact analysis.

FFS Impact				
	Total	SGF	Statutory Dedications (MATF)	Federal
Year 1*	$ 739,176	$ 229,085	$ 30,491	$ 510,091
Year 2	$ 1,898,204	$ 524,212	$ 104,401	$ 1,373,992
Year 3	$ 2,031,079	$ 616,539	$ 111,709	$ 1,414,539
Year 4	$ 2,173,254	$ 659,697	$ 119,529	$ 1,513,557
Year 5	$ 2,325,382	$ 705,876	$ 127,896	$ 1,619,506

*Table 1. Projected FFS Impacts from HB 324. * Denotes an abbreviated fiscal year of February to June after implementation starts in January and allowing 30 days for claims lag.*

MCO Impact				
	Total	SGF	Statutory Dedications (MATF)	Federal
Year 1**	$ 267,034,050	$ 65,169,726	$ 11,015,155	$ 201,864,324
Year 2	$ 707,847,212	$ 156,995,791	$ 38,931,597	$ 550,851,420
Year 3	$ 757,396,516	$ 182,411,168	$ 41,656,808	$ 574,985,349

Year 4	$ 810,414,273	$ 195,179,950	$ 44,572,785	$ 615,234,323
Year 5	$ 867,143,272	$ 208,842,546	$ 47,692,880	$ 658,300,726

*Table 2. Projected MCO Impacts from HB 324. ** Denotes an abbreviated fiscal year of March to June due to managed care payment schedules in the following month.*

Total Medicaid Impact (FFS + MCO)				
	Total	SGF	Statutory Dedications (MATF)	Federal
Year 1*	$ 267,773,227	$65,398,811	$ 11,045,646	$202,374,416
Year 2	$ 709,745,416	$157,520,003	$39,035,998	$552,225,413
Year 3	$ 759,427,595	$183,027,707	$41,768,518	$576,399,888
Year 4	$ 812,587,527	$195,839,647	$44,692,314	$616,747,880
Year 5	$ 869,468,654	$209,548,422	$47,820,776	$659,920,232

Table 3. Combined projected fiscal impacts from HB 324.

Subsection 3.2 – Program Impact Analysis

The above expenditures are not in LDH's current budget and so LDH would need additional legislative appropriation to accomplish this change. In addition, this change would require administrative rulemaking and an updated rate certificate on for the MCOs. As far as CMS approval, this change would require, at minimum, a State Plan Amendment due to a change in reimbursement methodology. Additional administrative actions and approvals may be required by CMS.

This legislation would result in impacts to Medicaid's internal operations, specifically managed care operations, financial management and operations, processing of provider claims and associated activity (Medicaid Enterprise Systems), benefits management and compliance/State Plan maintenance/publications. However, additional staff are not initially believed to be needed to implement this legislation, and staff costs were not included in the analysis.

Subsection 3.3 – Other Noteworthy Findings

LDH searched for similar legislation in other states in the southern region and found no comparable legislation in any other states. However, the Henry J. Kaiser Family Foundation maintains an index comparing Medicaid rates in all states to Medicare rates, which provides comparable data for reference. The Kaiser Family Foundation Medicaid-to-Medicare Fee Index measures each state's FFS physician fees relative to Medicare FFS fees in each state. The index is a computed ratio of the Medicaid fee for each service in each state to the Medicare fee for the same services. Comparable Medicare fees are calculated using relative value units, geographic adjusters and conversion factor.[4]

According to Kaiser Family Foundation data, nationwide, only four states' Medicaid programs meet or exceed Medicare rates for FFS primary care (Alaska, Montana, Idaho and North Dakota) and an additional five states (Delaware, Nevada, Wyoming, Maryland and Mississippi) come close with rates ranging from 99% down to 90% of the Medicare rates.[5]

[4] "Medicaid-to-Medicare Fee Index." *Kaiser Family Foundation.* 12 Jul. 2017: https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?activeTab=map¤tTimeframe=0&selectedDistributions=primary-care
[5] Ibid.

The following presents the Kaiser Family Foundation's Medicaid-to-Medicare Fee Index for Primary Care, focusing on rates in southern states in 2016.[6]

Medicaid-to-Medicare Fee Index for Primary Care, in Southern States, 2016 ***(in descending order)***	
Mississippi	90%
Louisiana	**67%**
Alabama	65%
Arkansas	65%
Georgia	65%
Texas	58%
Missouri	55%
Florida	48%

Table 4. Medicaid-to-Medicare Fee Index for Primary Care, in Southern States. Henry J. Kaiser Family Foundation.

As shown in Table 4, Louisiana's FFS rates for primary care are approximately 67 percent of the Medicare rates, and are higher than six of our seven neighboring deep south states.

Kaiser Family Foundation also compiles a Medicaid Physician Fee Index that measures each state's physician fees relative to national average Medicaid fees.[7] The Medicaid Physician Fee Index is a weighted sum of the ratios of each state's fee for a given service to the corresponding national average fees, where the weight for each service was its share of total Medicaid physician spending among all the surveyed services. According to this index, Louisiana's overall Medicaid physician FFS fees for primary care are at the national average.

Section 4 - Conclusion

As demonstrated in the independent systematic review by IPRO, there is mixed evidence on the associations between fee increases and other outcomes. From LDH's analysis, raising reimbursement rates for primary care in Medicaid to match rates provided through Medicare would result in a significant fiscal impact to LDH.

[6] Ibid.

[7] "Medicaid Physician Fee Index" *Kaiser Family Foundation.* 12 Jul. 2017: https://www.kff.org/medicaid/state-indicator/medicaid-fee-index/?activeTab=map

Appendix A: Text of HR 1, 2020 Second Extraordinary Legislative Session

2020 Second Extraordinary Legislative Session

HOUSE RESOLUTION NO. 1

BY REPRESENTATIVES ECHOLS AND THOMPSON

A RESOLUTION

To urge and request the Louisiana Department of Health to study the costs and benefits of setting Medicaid reimbursement rates for primary care services at levels that are at least equal to Medicare rates for those services and to report findings from the study to the House Committee on Appropriations and the House Committee on Health and Welfare.

WHEREAS, the term "primary care" refers to routine healthcare services delivered by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community; this care includes screening, assessment, diagnosis, and treatment for the purpose of promoting a person's health and detecting and managing a person's disease or injury; and

WHEREAS, primary care is a vital component of any healthcare system and is essential for improving and maintaining the health of any population; and

WHEREAS, due to its interconnected problems of poor health outcomes and extensive health professional shortage areas, Louisiana has an especially pronounced statewide need for an expansion of primary care; and

WHEREAS, greater access to and utilization of routine primary and preventive care among members of any population, particularly a medically underserved one, reduces the population's need for more expensive forms of acute care; and

WHEREAS, due to the measurable effects that expanding access to primary care has in health outcome improvements and health system cost reductions, an expansion of access to primary care in Louisiana is both responsible public health policy and sound fiscal policy; and

WHEREAS, enhancing healthcare provider reimbursement rates for primary care in the Louisiana Medicaid program is a direct incentive for increasing the availability of this much-needed care in our state.

THEREFORE, BE IT RESOLVED that the House of Representatives of the Legislature of Louisiana does hereby urge and request the Louisiana Department of Health to study the costs and benefits of setting Medicaid reimbursement rates for primary care services at levels that are at least equal to Medicare rates for those services.

BE IT FURTHER RESOLVED that the benefits to be considered in this study shall include, without limitation, reductions in net costs of overall care for patients resulting from enhanced access to and quality of primary care.

BE IT FURTHER RESOLVED that the Louisiana Department of Health shall report findings from the study called for in this Resolution to the House Committee on Appropriations and the House Committee on Health and Welfare prior to the convening of the 2021 Regular Session of the Legislature of Louisiana.

BE ITFURTHER RESOLVED that the Louisiana Department of Health shall submit one print copy and one electronic copy of any report produced pursuant to this Resolution to the David R. Poynter Legislative Research Library as required by R.S. 24:772.

BE IT FURTHER RESOLVED that a copy of this Resolution be transmitted to the secretary of the Louisiana Department of Health.

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