Maine’s Medicaid Payment Shortfall

An Analysis of
Medicaid Reimbursement
to Maine Hospitals

July 2002

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I. Executive Summary

Medicaid is a critical element in Maine's health care safety net. According to the Maine Department of Human Services, in December, 2001, 183,000 individuals were enrolled in the Medicaid program, including low-income families, individuals with disabilities and low-income elderly people needing long-term care. Maine is ranked among the highest in the nation for the percent of the population eligible for Medicaid (16 percent).

Medicaid general fund expenditures represent 19 percent of Maine's budget (education funding for schools represents 27 percent). As the second largest state expenditure, Medicaid necessarily becomes the focal point for budget cuts during any state financial crisis. However, it is imperative that a system be in place that effectively meets access needs and fairly compensates providers.

The findings in this report underscore the failings of the current system. While credibly seeking to meet access needs, Medicaid is failing to ensure a strong provider network or to effectively use our limited resources efficiently.

Medicaid is jointly funded and administered by the federal and state governments. In Maine, the federal government provides approximately $2 of Medicaid funding for every dollar that the state contributes.

The Maine Hospital Association commissioned this independent analysis to determine the full extent of the Medicaid payment shortfall to Maine hospitals. The study also identified how the shortfall drives up the cost of hospital care and health insurance coverage and threatens the financial health of some hospitals.

Unfortunately, Medicaid does not reimburse hospitals for the full cost of their services. On average, Medicaid reimburses Maine hospitals just 80 cents for every $1 of care they provide to Medicaid patients.

The Medicaid shortfall at Maine hospitals amounted to $39 million in state fiscal year 2000 (the latest figures available). Coupled with the Medicare shortfall of $115 million in state fiscal year 1999 (the latest figures available), the combined shortfall represents one of the major contributors to Maine's high health insurance premium rates. The government payment shortfall ends up being shouldered by those who pay privately. Addressing the current Medicaid shortfall could reduce

hospital charges by 4.2 percent for all patients.

One of the contributing factors to the Medicaid payment shortfall to hospitals is the Medicaid reimbursement formula. The formula is outdated and inadequate for calculating the cost of hospital care today.

Medicaid reimburses inpatient hospital services based on technology and medical practices in 1983, with some adjustment for inflation. Neither the reimbursement rate nor the inflation factor reflect the dramatic changes in hospital services and increasing hospital costs. Over this 19-year period, advances in medical technology and pharmaceuticals have fundamentally altered the delivery of care and greatly affected health care costs.

Further compounding this shortfall, in 1999 the state cut a Medicaid benefit that reimbursed hospitals for the Medicare deductible and coinsurance for low-income elderly. Prohibited by federal law from billing for those amounts, hospitals were left with additional Medicaid losses.

Maine's nonprofit community hospitals are committed to treating everyone, regardless of ability to pay. But Maine's Medicaid program is currently failing to meet the needs of its network of community hospitals. Ninety-five percent of Maine hospitals lose money treating Medicaid patients. Any future proposals to reduce hospital reimbursement will only further weaken Maine's hospitals.

How is the Medicaid shortfall calculated?

The shortfall was calculated using the total cost per financial statement and Medicaid payment data. From this, Medicaid's expenses, based on its fair share of cost as derived from the actual percentage of Medicaid use of the facility (revenues charged), are then compared to actual Medicaid payments. The shortfall calculation results in a $39 million shortfall for state fiscal year 2000.

II. Major Findings

1

The Medicaid program reimbursed Maine hospitals $39 million *less* than what it cost to provide Medicaid patients inpatient and outpatient services in 2000.

- It cost Maine's nonprofit community hospitals (excluding the psychiatric hospitals and the rehabilitation hospital) $199 million to provide inpatient and outpatient services to Medicaid patients during 2000.
- Medicaid paid hospitals just $160 million for these services (80 cents for every dollar of care provided).

2

The gap between what Medicaid pays for inpatient services and what it costs to provide those services continues to grow.

The Medicaid reimbursement rate for 2002 is inadequate for three major reasons:

- Hospital inpatient reimbursement rates are based on a hospital's average cost per hospital stay in 1983.
- The range of services provided by hospitals has changed dramatically over 19 years. The 1983 calculation doesn't take into account advances in medical technology, the comprehensive changes in the way hospital care is delivered and expanding hospital-based services.
- The increases in annual Medicaid payments have not kept pace with medical inflation. These increases have been at, or more often, below inflation during this 19-year period.

3

A 1999 change to Maine's Medicaid Program increased the financial loss to Maine hospitals by an additional $6 million.

- Before 1999, the Medicaid program assisted low-income seniors through a program that paid the deductibles and coinsurances for qualified Medicare patients.
- By federal law, hospitals are not permitted to bill Medicaid seniors for these amounts. The impact to hospitals was an approximate $20 million loss. The federal Medicare program reimburses 70 percent of these bad debts, leaving a continuing loss to hospitals of $6 million.

4

Ninety-five percent of hospitals in Maine lose money treating Medicaid patients.

- 34 of 36 acute-care Maine hospitals lose money providing inpatient and outpatient care to Medicaid patients, providing services to more than 180,000 Medicaid beneficiaries.
- Medicaid and Medicare together are the primary health care payors for 28 percent of Maine's population, but participants in these two programs have double the impact on cost, consuming 56 percent of all hospital resources.

5

$56 million in additional federal matching money is available for Maine through the federal Disproportionate Share program.

- A federal program exists to provide additional money to states to assist hospitals serving a disproportionate number of low-income patients.
- $56 million in federal Medicaid matching dollars are designated for Maine if the state creates and funds its share of a state Medicaid Disproportionate Share program.

6

The Medicaid reimbursement shortfall contributes to Maine's high health insurance costs.

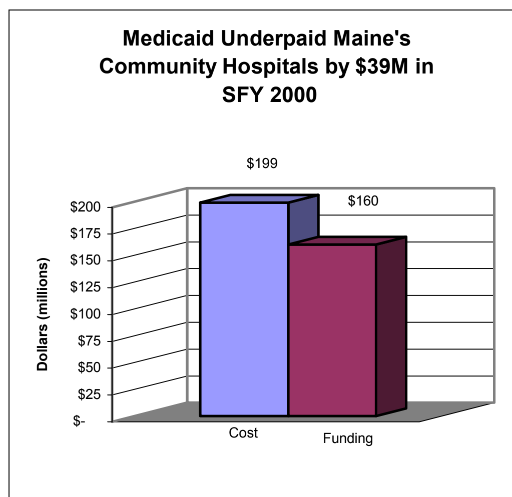
- When a nonprofit hospital spends a dollar to care for a patient, it needs to recover that dollar to continue serving its community. To make up for the revenue shortfalls in services provided to Medicare and Medicaid patients, hospitals must increase their charges to patients who do pay, either through commercial health insurance or out of their own pockets.
- Addressing the current Medicaid shortfall could reduce hospital charges by 4.2 percent. In addition, eliminating the Medicare shortfall could decrease hospital charges by an additional 12 percent. This could reduce pressure on health insurance premiums.

III. Background on Major Findings

1

The Medicaid program reimburses Maine hospitals $39 million *less* than what it costs for inpatient and outpatient services provided to Medicaid patients in 2000.

Medicaid pays Maine hospitals just 80 cents for every dollar of care hospitals provide.

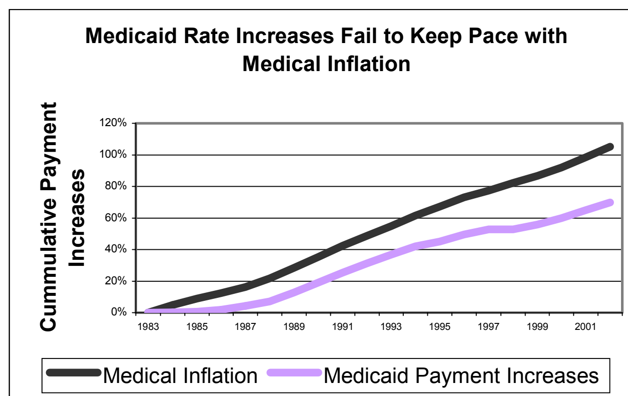


Source: Hospital financial statements, Medicaid settlement reports

2

The gap between what Medicaid pays for inpatient services and what it costs for those services continues to grow.

Payments to hospitals are based on the hospitals' average costs in 1983. Since then, Medicaid payment increases have not kept pace with medical inflation.

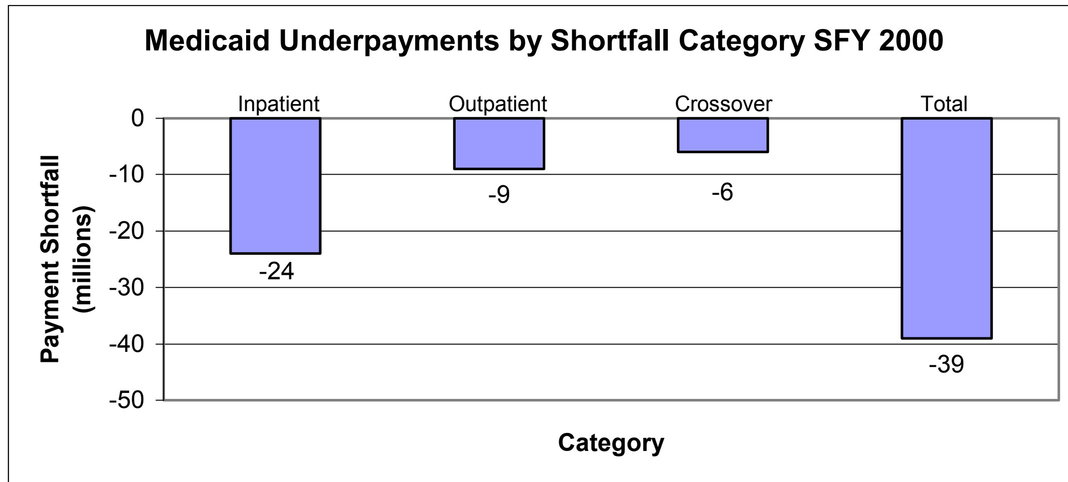


Source: Medical Inflation—Hospital Market Basket (CMS, Office of Actuary)
Medicaid Increases—Maine Medicaid

3

A 1999 change to Maine's Medicaid Program increased the financial loss by Maine hospitals by an additional $6 million.

The decision to no longer pay crossover claims (the deductible and co-insurance of low-income seniors) increased the loss to Maine hospitals by a net of $6 million.

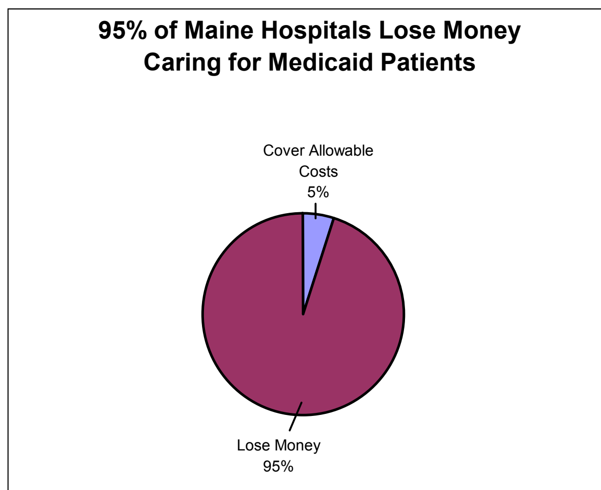


Source: Hospital financial statements, Medicaid settlement reports

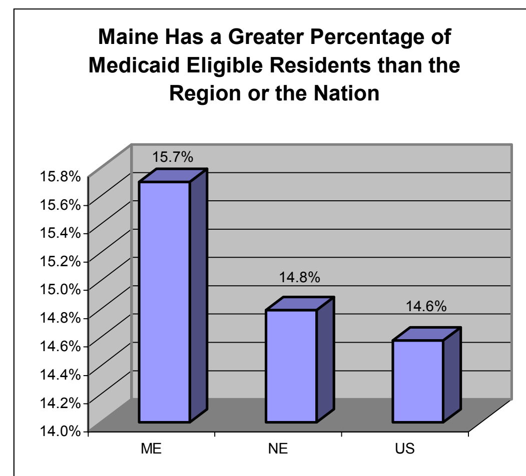
4

Ninety-five percent of Maine hospitals lose money treating Medicaid patients.

34 of 36 acute-care hospitals lose money providing inpatient and outpatient care to Medicaid patients. Maine's Medicaid population is greater than the regional and national average.



Source: Medicaid settlement reports SFY 2000

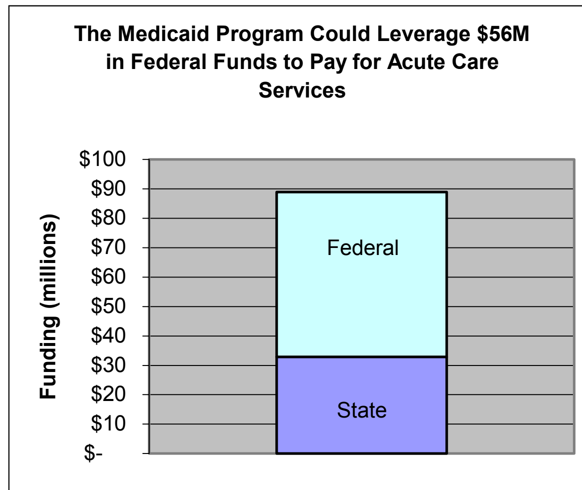


Source: Centers for Medicare and Medicaid Services

5

$56 million in additional federal matching money is available for Maine through the federal Disproportionate Share program.

By providing seed money, the state could have access to additional federal dollars to serve low-income Mainers.

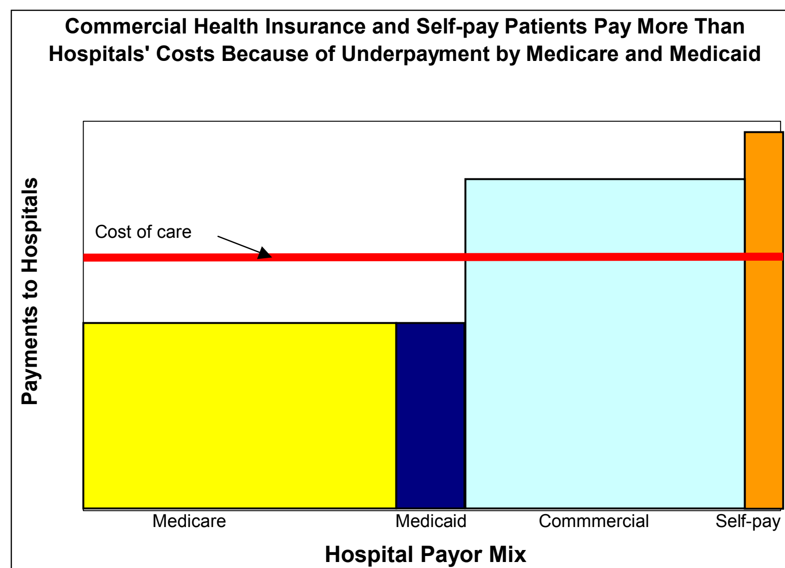


Source: American Hospital Association

6

The Medicaid reimbursement shortfall contributes to Maine's high health insurance costs.

To continue to provide seven-day-a-week, 24-hour-a-day service to Medicaid patients, hospitals are forced to cover Medicaid underpayments by shifting costs to individuals with commercial insurance or who pay out-of-pocket for hospital services.



Source: Maine Medicare and Medicaid data, hospital financial statement data

IV. Reimbursement Methodology

To understand Maine's Medicaid's reimbursement problem, one needs to understand how hospitals are reimbursed for treating Medicaid patients.

Three primary methods apply to health care reimbursement, depending on the type of service.

TEFRA Rate

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established, among other provisions, a formula to determine the target Cost per Inpatient Stay for each acute care hospital in the country. In 1983, the Maine Medicaid program adopted the TEFRA rate as the rate it would pay each Maine hospital for care provided to Medicaid inpatients. The TEFRA rate used by the Maine Medicaid program is essentially the average cost per hospital stay in 1983. In other words, the rate currently used to pay Maine hospitals is based on acuity, technology and medical practices in 1983. Hospitals receive this payment for a one-day stay or a 10-day stay. In a modest attempt to keep pace with the rising cost of pharmaceuticals, new technologies and nursing labor, the Medicaid program annually applies a slight increase to the 1983 base rate. The increase is usually below and never above the federally determined rate of medical inflation. Today, the Medicaid average inpatient payment rate is about $4,000 per case. Hospitals receive this rate for tonsil removal or heart surgery.

The following sub-categories have traditionally been reimbursed to acute care providers:

- Inpatient Hospital Services
- Outpatient Hospital Services
- Hospital-Based Physicians
- Medical Education
- Medicare Crossover

During the 20 years this reimbursement method has been in effect, technology and medical practices have changed considerably. Technological breakthroughs such as MRIs, CT scans, arthroscopic surgeries, heart catheterization, pharmaceuticals and a number of other technologies have improved outcomes, reduced rehabilitation time, and improved the quality of life for many. These breakthroughs are more expensive than devices and procedures in 1983. As a result, services reimbursed using this method, virtually every inpatient service, is under-paid. Nearly every hospital in Maine faces this payment shortfall.

Cost-Based Reimbursement

Some services, primarily outpatient services, are paid under a "Cost-Based Reimbursement" method. That is, the state Medicaid program requires hospitals to submit costs related to providing care to Medicaid patients and then reimburses hospitals for those costs. This is a more reasonable approach for reimbursing care. However, because of federal cost–funding guidelines, reimbursements exclude costs associated with uncompensated care and many community and wellness programs. Therefore, the final reimbursement to the hospital is below cost. Most outpatient services, except for laboratory testing, are reimbursed this way.

Fee Schedule

Setting a specific dollar amount for a particular service is a third method used to reimburse hospitals for acute care. Once this schedule of payment is established, it is adjusted periodically by the Medicaid program and often is based more on state budget allocations than the actual cost of the service. Outpatient laboratory services are based on this method and are reimbursed below hospital costs.

V. Conclusions

In Maine, health care is funded with a combination of private and public funds. Public funds come in the form of Medicare and Medicaid reimbursements. The private sector pays in the form of commercial insurance and self-pay. When government-sponsored public programs do not reimburse hospitals for the full cost of caring for their patients, it is left up to commercial insurers and the uninsured to cover the difference — paying 4.2 percent higher hospital charges because of the Medicaid shortfall.

It is an issue of basic fairness. Medicaid should pay the full cost of caring for its patients. Otherwise all of us pay what amounts to a hidden tax, one that appears only when our insurance bills rise to make up for what hospitals lose with every Medicaid patient they treat.

When government does not pay the full cost of caring for Medicaid patients and insurance companies balk at paying higher prices, health providers sometimes choose to stop treating Medicaid patients. Recent headlines show some physician practices have already made that choice. Patients who lose access to primary care wait and use the emergency room when they are sicker and treatment is more expensive.

Maine's hospitals are committed to treating everyone, regardless of ability to pay. But when treating Medicaid patients results in financial losses, hospitals may be forced to reduce other programs that benefit the community, prevent illnesses and promote good health, in order to cover the shortfall.

Adequately funding Medicaid requires resources. Failing to adequately fund Medicaid exacts a larger toll long-term, both financially and in terms of human suffering.

Based on the findings of Baker, Newman and Noyes' analysis, we advocate:

- Recalculating (rebasing) the fee structure for inpatient and outpatient services to reflect the range of services and technological advances that hospitals now provide.
- Anticipating the changing demographic of Medicaid patients and designing a program to address their long-term needs instead of concentrating on year-to–year budget constraints.
- Maximizing federal resources. The state should spend general fund money to obtain $56 million of federal money that is left on the table.
- Investing in preventative care. To get more bang for our Medicaid buck, Maine should fund programs that improve overall health to avoid more costly hospitalization and procedures. This way, Maine can reduce the long-term Medicaid budget growth.
- Balancing expanding coverage against adequate reimbursements for current programs to ensure a provider network that meets access needs.

Medicaid is a critical element in Maine's health care safety net, but the net is fraying. Patients are losing access to primary care. Maine hospitals need to be reimbursed for the cost of caring for Medicaid patients to continue to meet their needs and to reduce cost shifting to commercially-insured and self-paying patients.

VI. Maine's Nonprofit Community Hospitals

Maine's 39 community-governed hospitals are located throughout the state from York to Fort Kent. They range from large, tertiary care facilities to very small, rural hospitals. This report covers 36 of those hospitals, excluding MHA's two private psychiatric hospitals and the rehabilitation hospital.

The Role of the Community Hospital in Maine

Maine's community hospitals serve an expansive role meeting a wide array of community needs from the traditional inpatient hospital setting to an increasing role in outpatient services, long-term care, home health, primary care including pediatrics and obstetrics, behavioral health, public health and prevention outreach. Hospitals have effectively responded to changes in our health care delivery system, specifically in recognition of consumer needs for outpatient services.

Hospitals provide an array of community services, such as:

- Clinics for the uninsured;
- Health screenings, such as for diabetes;
- Health improvement programs, such as smoking cessation;
- Assistance in enrolling the uninsured in the state's insurance program; and
- Support for school nurses and school health education programs.

As a result of Maine's rural nature, the hospital is the anchor of the local health care delivery system. Without it, communities do not have access to physicians and other health care services. Maine does not have as many free-standing surgery centers and emergency clinics as in many other states. Nor does Maine have a state-wide public health infrastructure as most other states do. In Maine, hospitals serve those functions and do it by providing services 24 hours a day, seven days a week, to meet the needs of their communities.

MHA member hospitals operate 28-hospital-affiliated nursing facilities including both hospital-based and freestanding homes. They provide both skilled nursing facility level care for short-term rehabilitation and long-term nursing facility care. MHA member hospitals also have 18 home health agencies—about 60 percent of all the home health agencies in Maine operating throughout the state. Most of our agencies also provide hospice care. We also provide residential care, congregate housing and continuing care as we seek to meet the full spectrum of health care needs of Maine residents.

On Any Given Day At Maine's Hospitals…

...2,012 patients are hospitalized for care that will require at least one overnight stay...

...9,588 outpatient services are provided...

...1,757 people receive care in hospital emergency departments.

MHA

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