PHYSICIANS' GUIDE TO STATE LEGISLATION

CASE STUDY

ENSURING ADEQUATE MEDICAID REIMBURSEMENT: THE MICHIGAN EXPERIENCE

The Issue

Michigan physicians had been chronically underpaid for providing professional services to Medicaid beneficiaries for years, and indeed had not had a raise in fees since 1989. As a result, access to primary care services for Medicaid recipients was compromised, forcing more of them to seek such care in the ED. An increased number of nonurgent Medicaid patients, coupled with insufficient payment levels and cumbersome billing mechanisms, compromised the financial viability of many EDs and forced hospitals to either cut back on services or, in certain cases, to close their doors. Clearly, an updated, unambiguous, fair and accurate means of reimbursement for professional emergency services in Michigan was needed.

ACEP Position

"The American College of Emergency Physicians believes that ... (p)hysician services (including medically necessary post-stabilization care) ... should be compensated in a fair and equitable manner." [from the ACEP policy, "Hospital, Medical Staff and Payer Responsibility for Emergency Department Patients," approved, 1989 and revised, 1999]

Background

According to federal law, a state that participates in the Medicaid program is required to adopt reimbursement measures and procedures that are sufficient to enlist enough providers so that Medicaid recipients have at least the same access to health care services as the insured population. However, anecdotal evidence suggested that Medicare patients had problems with access to traditional primary care providers. Internists, family physicians and pediatricians who were not well paid (in a way that covered their costs) were not likely to accept Medicaid beneficiaries in their practices, therefore forcing these individuals to use the ED. The EDs in turn were required to see all patients, urgent as well as non-urgent, including those on Medicaid, as a result of the unfunded EMTALA mandate.

In the meantime, emergency physicians were faced with the constant specter of either

having claims downcoded on the often-questionable basis that the bills submitted were for levels of care not justified, or being denied payment all together for claims that Medicaid deemed not to be "clean." Since the reimbursement levels were so low to begin with, in many cases insufficient to cover the fixed costs of billing, it made no economic sense for emergency physician billing companies to re-bill Medicaid if the initial claim was rejected. And at the state level, there was considerable administrative deadweight involved in processing and re-processing claims for emergency services, therefore reducing the portion of the Medicaid budget devoted to clinical services. It should also be noted that the low reimbursement levels occurred against the backdrop of a booming economy, with record low levels of unemployment and a state budget surplus.

Legislative History in Michigan

By 1999, the state was well aware of the problem, through the constant complaints of emergency physicians, billers and hospital administrators. In the spring of that year, the state Senate Health Committee created the Medicaid Workgroup, which was made operational by legislative passage of Public Act 114. The Medicaid Workgroup consisted of representatives from the Michigan College of Emergency Physicians (MCEP), the state medical society, the state hospital association, the Michigan Association of Health Plans, and the Medical Services Administration, the state agency in charge of administrating the Medicaid program in Michigan. The charge to the workgroup was twofold: (1) to recommend reasonable reimbursement rates and (2) to develop educational materials for physicians, hospitals and billers. Meetings commenced in the fall of 1999 and were generally held once a month. A sense of collegiality lead to the sharing of billing and coding data.

Our chapter was represented by the chair of its Health Finance Committee and the chapter lobbyist. We came to the workgroup meetings well prepared, with actual claims data to document downcoding and non-payment for legitimate services. It was at one of these meetings that the concept of paying physicians on the basis of the patient's ED *disposition*, rather than the diagnosis or level of service, was introduced. Two separate payment levels were proposed: a single fixed payment for patients who were treated and released from the ED, and a separate, higher payment for patients who were treated and admitted (or observed or transferred). It was an approach to reimbursement that was notable for being simple, straightforward, practical and applicable to all EDs in the state.

At the same time, the state medical society was conducting an extensive lobbying effort for a global increase in physician payments, which culminated in Medicaid Access Day in February 2000. Physicians from all over the state, including leaders from MCEP, went to Lansing to lobby for expanded access to health services on behalf of Medicaid patients, which, as everyone noted, was contingent on adequate physician compensation. The Medicaid Workgroup did in fact recommend an 11 percent increase in payments for all physician professional services in FY 2000-2001. For the average Michigan emergency physician, this represented an additional $10-12,000 collected in his or her name.

At an early stage, MCEP recognized that it had an important ally in the Chairman of the House Appropriations Committee. Several MCEP leaders met privately with the Chairman over lunch on Medicaid Access Day. It was at this meeting that the two-tiered reimbursement methodology was formally presented. It is important to note that, long before this meeting took place, the groundwork had been laid by our state chapter lobbyist, whose persistence and dedication was instrumental in ensuring that our voice was heard. It took many more meetings and numerous phone calls before the details of the two-tiered case rate reimbursement were worked out. It became operational on January 1, 2001 and is scheduled to be reevaluated in July 2001.

One very important piece of this legislative success story cannot be neglected. At its annual Emergency Medicine Scientific

Assembly held in July, 2000, MCEP provided chapter members with an important opportunity to greet and thank the House Appropriations Committee Chairman and to wish him success in his upcoming "retirement," which we hope will be short-lived and followed by a successful election to the state Senate next year.

Arguments in Favor of This Position

Reducing time to payment of physician claims and cutting administrative waste for both the state and the emergency physician billing companies are powerful arguments in favor of a simplified, two-tiered case rate reimbursement methodology. Furthermore, compiling a significant amount of data, having an effective chapter lobbyist, and building coalitions with other like-minded professional groups are all key to a successful legislative outcome.

Arguments Against This Position

Increasing physician reimbursement has never been a popular voter issue. It may have helped that the Chairman of the House Appropriations Committee, a state representative with considerable influence over fiscal policy, was term-limited and therefore not eligible for re-election under Michigan's term limits law.

Legislative History in Other States

California pays for a portion of its emergency physician reimbursement through a statewide EMS fund administered at the county level. The income to this fund comes from surcharges applied to traffic fines and other misdemeanors.

Potential Proponent Organizations

State medical society
State hospital association
State nurses association

Potential Opponent Organizations

Managed care organizations, other third-party payers.

Although MCEP successfully lead the effort to simplify and raise the level of emergency physician reimbursement, our work is not finished. The staff and chapter lobbyist have monitored and will continue to monitor the situation as the implementation process goes forward. This would become particularly relevant should the state encounter future revenues below previous projections, which would jeopardize the Medicaid budget.

Submitted by: James C. Mitchiner, MD, MPH, FACEP (jmitch@umich.edu)

For more information on this issue, please contact one of the following:
Ken King, CAE, ACEP State Legislative Office (800/798-1822, ext. 3236; kking@acep.org
Diane Kay Bollman, Executive Director, MCEP (517/327-5700; mcep@mcep.org)