F I S C A L I M P A C T R E P O R T

SPONSOR Jennings **ORIGINAL DATE** 1/30/06 **LAST UPDATED** **HB**

SHORT TITLE MEDICAID PART B RATE REIMBURSEMENT **SB** 480

ANALYST Weber

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Non-Rec	Fund Affected
FY06	**FY07**		
	None		

(Parenthesis ( ) Indicate Expenditure Decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY06	FY07	FY08	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Total		$36,400.0	$37,500.0	$73,900.0	Recurring	General Fund
		$93,200.0	$96,000.0	$189,200.0	Recurring	Federal Medicaid

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)

SUMMARY

Synopsis of Bill

Senate Bill 480 amends section 27-2-12 NMSA 1978 to reimburse physicians, dentists, optometrists, podiatrists and psychologists for Medicaid services at a rate not less than the rate for Medicare Part B. This includes both fee-for-service and managed care reimbursements.

In addition on July 1 of each year starting in 2007 HSD shall increase the rate after taking into consideration factors that affect the cost of providing services including medical liability premiums and overhead.

Senate Bill 480 contains no appropriation.

FISCAL IMPLICATIONS

HSD reports that the average Medicaid rate is 24 percent less than the average Medicare rate. To increase the Medicaid rates to those of Medicare rates for services billed by physicians, dentists, optometrists, podiatrists and psychologists, the average Medicaid rate would have to increase 31.6 percent. For FY 2007, the Medicaid program would need additional funding of approximately $130 million of which roughly $36.4 million is state General Fund.

The calculations of fiscal impact are based on the projections for physician services, dental services, and other practitioners for FY 2007 from the fee-for-service portion. The calculations assume that 75% of the costs increase is in the managed care portion of the Medicaid program costs.

The dollar figures also assume that a rate increase would be done at the level of the procedure code. This means that rates for certain services will increase whether or not they are performed by the specific practitioners mentioned in the bill or by another type of practitioner (e.g., physician versus nurse practitioner, dentist versus dental hygienist).

The second year costs assume a 3 percent increase. The actual increase may be more or less based upon the analysis required by the bill. This analysis, which would include the cost of providing services such as liability insurance and overhead, would be costly. The Department assumes contractual costs of approximately $100,000 in the first year.

Any rate increase would need to be considered a recurring cost unless the Department reduced practitioner reimbursement in future years.

SIGNIFICANT ISSUES

HSD continues that this bill will significantly increase the cost of the Medicaid program, including the cost to the general fund. In addition, while the Medicare Part B rates are established by a consistent and validated methodology, there is not a consistent manner to reliably determine practitioner costs that would be needed to determine future year rate increases. Many practitioner costs are, to a degree, within the control of the practitioner. Guaranteeing a cost increase, hence providing an entitlement for the cost of doing the practitioner's business, appears to be a disincentive to sound practice management.

Further, establishing the limited provider class for this increase is likely to establish a precedent that will encourage other provider groups to seek fee increases which the state may not be able to afford.

There will be significant cost increases for the managed care programs as a result of their inability to negotiate reasonable rates with providers – a significant factor in controlling cost. The state will either have to meet the cost increase or modify managed care programs. One likely option is to eliminate the optional benefits that are not paid for by Medicaid, but are provided by MCOs. Examples include smoking cessation programs, health counseling and obesity and diabetes educational program.

Currently Medicaid includes gross receipts charges in the service reimbursement amount paid to providers.

In addition to fee increases paid to providers, HSD will likely have to hire a vendor to determine the portion of the annual rate increase resulting from provider operating costs. The annual study will likely include detailed provider surveys, random audits of providers to validate survey data and other actuarial activity. The complexity of the study, particularly during the first several years, will be significant. After the first several rating periods, and the survey methodology is validated, the cost may decrease.

Without an appropriation consistent with the cost increases it may be necessary to reduce eligibility or other services for the program to operate at the current funding level.

MW/nt