Issue Brief for August 2020 Universal Health Care Workgroup

Provider Reimbursement Considerations

Transitioning to a single payer system requires reevaluating provider payment policy as well employing a transition strategy that minimizes disruptions to providers and ensures enrollees have adequate access to care.

Payment Policy Considerations Discussed in the June 2020 Workgroup Meeting

- Limiting the number of payers that providers must interact with could reduce administrative costs for providers. Should provider reimbursement be lowered to reflect this efficiency gain, reducing the overall costs of moving to a single payer system?
- Transitioning to a single payer model will eliminate the variability in provider payments from each of the different payers via fee schedule consolidation. This will impact each provider differently. Should strategies be employed to mitigate these effects, and if so, which ones?
- Are there are any provider types that are universally recognized as under or overcompensated in Washington such that adjustments to their reimbursement should be assumed in the models to ensure sustainability, cost effectiveness, and fairness?
- Depending on how the fee schedules are implemented under the single payer system, unique payment arrangements or accounting tracking mechanisms will need to be put in place to preserve federal funding for populations previously covered under federal programs.

Deep Dive – Fee Schedule Consolidation

In the current system, each payer has their own fee schedule. This means that providers receive different levels of payment from payers, even for the same services. Medicaid typically pays the least. Commercial pays the highest. Medicare is somewhere in between. Under the single payer system, much (if not all) of this variation is eliminated. Table 1 below illustrates the impact of rebalancing provider reimbursement rates to the same rates as Medicare. As you can see, this would reduce expenditures by nearly 7 billion dollars annually; however, this policy would likely put many providers out of business.

Table 1: Statewide Perspective: Rebalancing to Medicare Levels of Reimbursement

	Medicaid ($ million)	Medicare ($ million)	Employer / Private ($ million)	Total
Proportion of Expenditures	23.1%	27.4%	49.5%	100.0%
Amount Expended [1]	$ 12,751	$ 15,107	$ 27,346	$ 55,204
Estimated Reimbursement as Percent of Medicare	71%	100%	180%	132.9%
Re-Distribution				
Expenditures at Medicare Rates	$ 17,959	$ 15,107	$ 15,192	$ 48,258
Funding Difference Total Expenditures	$ 5,208	$ -	$ (12,154)	$ (6,946)

% Funding Change	40.8%	0.0%	-44.4%	-12.6%

[1] Source: Washington State Institute for Public Policy data

Even if the single payer system is designed to pay out approximately the same amount of total dollars to providers as the current fragmented system (rates are set to approximately 114% of Medicare based on preliminary estimates), the impacts on an individual provider basis can be significant depending on their patient panel's current payer mix. Consider the examples in the table below. The provider with mostly commercial members sees a decrease in revenue of $264,862 per $1 million in annual revenue (Table 2). The provider with mostly Medicaid members sees an increase in revenue of $443,513 per $1 million in annual revenue.

Table 2: Individual Provider #1 (Predominately Private Coverage)

	Medicaid	Medicare	Employer / Private	Total
Revenue Proportion	5.0%	10.0%	85.0%	100.0%
Provider Revenue	$ 50,000	$ 100,000	$ 850,000	$ 1,000,000
Reimbursement as Percent of Medicare	71%	100%	180%	166.6%
Overall System Reimbursement Adjustment	61.1%	14.4%	-36.4%	
Funding Difference Total Expenditures	$ 30,558	$ 14,393	$ (309,813)	
Revised Provider Revenue	$ 80,558	$ 114,393	$ 540,187	$ 735,138
Revenue Impact				**-26.5%**
Gain / (Loss) in Revenue				**$ (264,862)**

Table 3: Individual Provider #2 (Predominately Medicaid Coverage)

	Medicaid	Medicare	Employer / Private	Total
Revenue Proportion	75.0%	15.0%	10.0%	100.0%
Provider Revenue	$ 750,000	$ 150,000	$ 100,000	$ 1,000,000
Reimbursement as Percent of Medicare	71%	100%	180%	86.3%
Overall System Reimbursement Adjustment	61.1%	14.4%	-36.4%	
Funding Difference Total Expenditures	$ 458,372	$ 21,589	$ (36,449)	
Revised Provider Revenue	$ 1,208,372	$ 171,589	$ 63,551	$ 1,443,513
Revenue Impact				**44.4%**
Gain / (Loss) in Revenue				**$ 443,513**

Mitigation Strategies to Consider for the Recommendation Report

These limited examples illustrate the concept of fee schedule consolidation and the variable impact at the individual provider level. Failure to address this dynamic could put providers out of business ultimately reducing access to care. Alternatively, some providers could see significant financial gain. Because the Workgroup is charged with providing recommendations for a "just" transition for all stakeholders, several options are provided for consideration below.

- **Phased in changes in provider specific compensation:** The State could leverage a phased approach. Using data from the all-payer claims database, the State could develop weights for each provider, based on their historical case mix, that is applied to their fee schedule reimbursement. The magnitude of the adjustment could decrease over time such that providers gradually approach the new fee schedule reimbursement levels.

  While this solution would allow providers time to adapt to a new standardized level of reimbursement, it is administratively burdensome and there may be other major concerns.

- **Alternative payment methodologies that hold providers harmless:** capitated models and other alternative payment methodologies could be used to hold revenue levels for providers relatively constant during the transition. Assuming the payment methodologies would focus on outcomes and value, the rates could naturally adjust over time to reflect performance instead of the arbitrary historical case mix.

  Broadscale implementation of alternative payment methodologies may not be possible for all providers or all provider types. Some payment methodologies are less viable for low-volume providers. This scale of value-based purchasing design and implementation would push back the broader implementation of a single payer model. It is highly administratively burdensome.

- **Do not implement a transition strategy.** If the Workgroup members believe the provider community could navigate this impact without State intervention, or believes this impact would not be significant, the Workgroup could propose not to mitigate any potential impact.