CHAPTER 5

Examining Medicaid Payment Policy

Section 1900(b)(2)(A) of the Social Security Act: MACPAC shall review and assess payment policies under Medicaid and CHIP, including i) the factors affecting expenditures for items and services in different sectors, including the process for updating hospital, skilled nursing facility, physician, Federally-qualified health center, rural health center, and other fees; (ii) payment methodologies; and (iii) the relationship of such factors and methodologies to access and quality of care for Medicaid and CHIP beneficiaries.

Chapter Summary

Medicaid is an important payer of health care services in the U.S., and like other payers, Medicaid seeks to advance payment policies that promote delivery of efficient, high-quality care. The program's unique characteristics such as its diverse population with wide-ranging health care needs, federal-state financing, and cost-sharing limitations for enrollees raise a number of challenges and considerations for developing effective payment policies.

Currently, no sources exist that systematically and comprehensively explain how states determine Medicaid payments or evaluate whether or not payments meet statutory requirements and promote value-based purchasing—ensuring access to appropriate, efficient, high-quality care at the appropriate time and in the appropriate setting. Lack of timely and reliable sources of data is also a major challenge for payment analysis. The Commission intends to develop a balanced and data-driven approach to payment evaluation that takes these multiple objectives into account and that is appropriate for the Medicaid program.

Medicaid payment policies are developed by each state with federal review limited to the general principles set forth in Section 1902(a)(30)(A) of the Social Security Act. This provision requires that provider payments be consistent with efficiency, economy, quality, and access and safeguard against unnecessary utilization. With the flexibility afforded them under federal law, states have taken a variety of different approaches to Medicaid payment. There are many questions regarding the relationship of these payment policies to access and quality and the potential role for payment innovations that best address efficiency and economy while assuring access to appropriate, high-quality services.

In this chapter we begin our initial assessment of Medicaid payment policy and outline plans for future work. Here we focus on fee-for-service (FFS) payment for hospital and physician services, highlighting federal statutory and regulatory changes that have shaped FFS payment and the resulting variation in state payment methods. We also identify considerations for evaluating Medicaid payment policy and outline our analytic approach.

CHAPTER 5

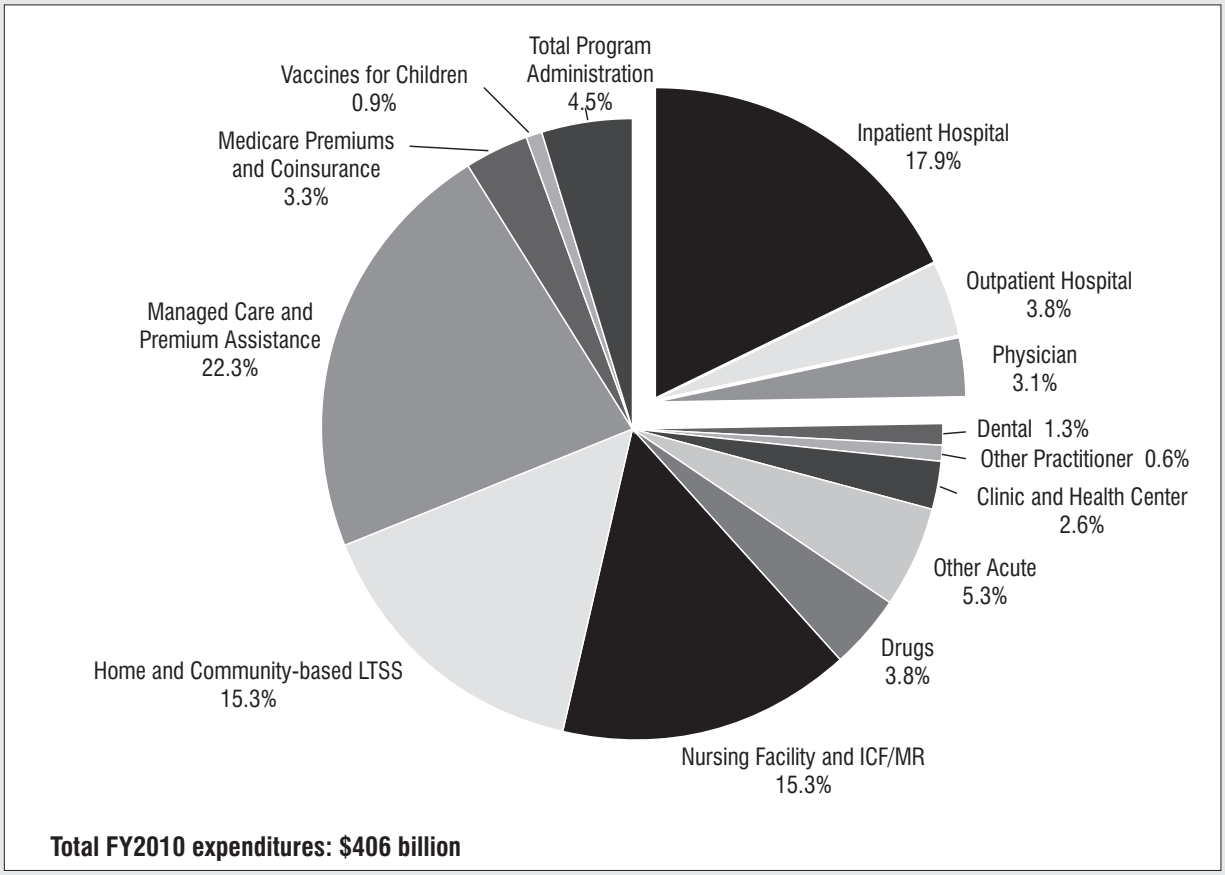
Examining Medicaid Payment Policy

The Medicaid program is a major payer for health care services in the U.S., accounting for 15 percent of total health care spending in 2009 (OACT 2010). In FY 2010 state and federal Medicaid expenditures totaled $406 billion. Medicaid is a particularly dominant payer for obstetrics, pediatrics, behavioral health, and long-term services and supports (Quinn et al. 2007). Medicaid is also a major source of revenue for safety-net providers, accounting for 35 percent of public hospital revenue and 37 percent of community health center revenue, while children's hospitals, representing less than 5 percent of all hospitals, provide about 40 percent of all inpatient hospital care for children covered by Medicaid (NAPH 2010, Rosenbaum et al. 2010, NACH and AAP 2007). Given Medicaid is a major payer and a significant expense for federal and state governments, examining payment methods and levels across states is an important undertaking. In this chapter the Commission begins an initial assessment of Medicaid payment policy and outlines our approach for future work.

The Aims of Payment Policy

With per capita U.S. spending on health care far exceeding that of other developed countries and lower indicators of health status, many health care payers are questioning whether they are getting value for their dollars invested (Farrell et al. 2008, OECD 2008). Promoting value-based purchasing, access to the appropriate amount of efficient, high-quality care, at the appropriate time and in the appropriate setting, is a fundamental goal of payment policy. Medicaid and other payers such as Medicare and commercial plans struggle with how to achieve this goal. At times, payment policies have created incentives to provide a greater volume of services rather than to improve overall value. The Medicaid program is unique in many respects; however, the program is still subject to the same underlying medical cost drivers that other payers struggle to control, such as medical practice patterns and new, high-cost technologies.

FIGURE 5-1. Distribution of Medicaid Spending, FY 2010



Note: See Tables 6 and 7 in MACStats for information on the categories of spending shown here. Collections from third-party liability, estate recovery, and other recoveries ($7 billion) are distributed proportionately among benefit categories. Percentages in MACStats Table 7 differ because that table includes benefits spending only.

Source: MACPAC analysis of CMS-64 Financial Management Report (FMR) net expenditure data as of February 2011

Medicaid Provider and Program Characteristics Important for Analysis of Payment

Although Medicaid is not alone in pursuing value-based purchasing, the program's characteristics make achieving this goal more challenging. These include:

- **Population.** Medicaid covers a diverse population with wide-ranging health care needs including children, low-income Medicare beneficiaries, and individuals with disabilities. As a result, the range of issues surrounding payment for services that Medicaid must consider is more extensive than for other payers.
- **Benefits**. Medicaid covers a broad range of services compared to other payers, reflecting the diverse needs of its enrollees. For example, Medicaid makes payments for long-term services and supports (LTSS), transportation services, and certain therapies, which other payers generally do not cover. As a result, a broad array of providers serves the Medicaid population (Box 5-1).

- **Role in health care markets.** Medicaid is a major payer for services such as LTSS, obstetrics, pediatrics, and mental health services, as well as for safety-net providers such as public hospitals and community health centers. Since Medicaid is a dominant payer for these services, Medicaid's payment decisions strongly influence where and how these services are delivered.
- **Cost-sharing limits.** Serving a low-income population, states are limited in their ability to require copayments and deductibles, tools that other payers use to manage utilization.
- **Federal-state financing.** States are required to contribute funding, and in some cases states require local governments to contribute a portion. Medicaid costs are generally highest when state revenues are at their lowest. States are required to balance their budget on an annual or biennial basis. Significant budget constraints lead states to consider payment changes, including reductions in payment levels.

The Commission will consider these factors when evaluating Medicaid payment policies. In an era of state budget deficits and with states increasingly looking to cut provider rates for potential savings, understanding the relationship of Medicaid payment to the principles of efficiency, economy, quality, and access is critical. Otherwise, states risk encouraging over-utilization and/or overpayment of some services and providers while underpaying others, supporting inefficient service delivery models, or impeding access to medically necessary, quality care.

BOX 5-1. Examples of Medicaid Provider Types[1]

Acute Care	Long Term Services and Supports	Other Service Providers
Ambulance/Air Ambulance	Home Health	Case Management
Advanced Practice Nurse	Hospice	Durable Medical Equipment
Certified Nurse Midwife	Intermediate Care Facility	Independent Laboratory
Children's Hospital	Nursing Facility	Interpreter
Community Mental Health Center	Personal Assistant	Pharmacy
Dental Hygienist		School District
Dentist		Physical Therapist
Federally Qualified Health Center		Occupational Therapist
Hospital		Speech Therapist
Physician		Transportation
Physician Assistant		
Public Health Agency Clinic		
Rural Health Clinic		

[1] State Medicaid programs may include many more discrete provider types such as optician, geneticist, psychologist, physician's assistant, etc.

The Commission's Approach to Examining Payment in Medicaid

In the Medicaid program, state flexibility to develop payment policies has led to significant variation in payment methods, reflecting individual state policy decisions, geographic differences in costs, and practice patterns. Moreover, there is no easily accessible source of state payment methods, no comprehensive analysis of which are more or less effective, and no uniform data that permit meaningful comparisons of payment levels. The Commission's efforts to examine Medicaid payment, therefore, must begin with a thorough understanding of the current payment landscape. Both the amount of payments that states make to providers and the methods that states use to distribute payments are important to consider, as is identification of those policies that most efficiently and effectively promote the provision of quality health care services to Medicaid enrollees. The Commission will work closely with states to understand their individual payment policies across various providers.

The Commission's analytic work plan includes an examination of both existing and emerging fee-for-service (FFS) and managed care payment systems and an identification of data to evaluate state payments against the principles of efficiency, economy, quality, and access set forth in Section 1902(a)(30)(A) of the Social Security Act (the Act). Our goal is to identify payment policies that account for the complexity of Medicaid enrollees and the Medicaid marketplace, and encourage access and quality while controlling the rate of Medicaid spending.

In this initial discussion we focus on Medicaid FFS payments for hospital and physician services. These services comprise a large share of Medicaid spending, as shown in Figure 5-1 and affect a large number of providers in the Medicaid program. Additionally, these services have been the subject of many federal and state policies focused on improving cost-containment and enrollees' access to care. In future reports the Commission will broaden its examination of Medicaid payment, including examination of LTSS and managed care, as well as payments to federally qualified health centers (FQHCs), rural health clinics (RHCs), and other types of providers (Box 5-2).

In this chapter the Commission:

- highlights major federal statutory and regulatory developments that have shaped FFS payment for hospitals and physicians, beginning with the foundational statutory payment requirement for all Medicaid services;
- outlines differences in current state payment policies that have resulted from flexibility under federal policy and reflect differing costs and delivery systems; and
- introduces our analytic approach to evaluating Medicaid payment policies and begins to identify the data to assess the effectiveness of Medicaid payment policies.

Medicaid Managed Care. The Commission understands that managed care plays an increasing role in Medicaid service delivery, with payments to managed care organizations (MCOs) comprising over 20 percent of Medicaid spending (Figure 5-1). Medicaid managed care is an important factor to consider in evaluating Medicaid payment

BOX 5-2. Topics for Future Consideration

In this initial discussion of Medicaid payment, the Commission focuses on FFS payment policy for hospitals and physician services. The Commission will consider the following subjects, in addition to others, in future reports:

- Long-term services and supports (LTSS), both institutional care and home and community-based services
- Federally qualified health centers (FQHCs), rural health clinics (RHCs), and other safety net providers
- Prescription drugs and pharmacy services
- Dental services
- Medicaid managed care organizations (MCO)
- State Medicaid financing, including general and dedicated revenues such as provider taxes
- State approaches to accounting for and organizing Medicaid expenditures through intergovernmental transfers (IGTs) and certified public expenditures (CPEs), and implications for provider payments
- Program integrity efforts and opportunities
- Emerging Medicaid payment models

and access issues. The chapter provides a brief description of managed care payment issues (Box 5-6), and future reports will examine these issues in greater depth.

State Financing. The Commission recognizes that the manner in which states finance their share of Medicaid program operations influences overall Medicaid payment policies. State approaches include the use of general revenues, dedicated revenue sources such as provider taxes, and the use of intergovernmental transfers (IGTs) and certified public expenditures (CPEs) from local governments, including government providers, to distribute and account for their expenditures. We intend to address how these state financing approaches relate to Medicaid payment policy.

The Foundation of Medicaid Payment for All Services

Section 1902(a)(30)(A) of the Act is the foundational statutory provision that governs federal review of state payment methodologies for all services covered by Medicaid. Added in 1968, the original provision addressed only efficiency, economy, and quality as aims of Medicaid payment. In 1989, the Congress amended the statute to incorporate the "equal access provision," previously only included in federal regulation, which identified access as a specific aim of payment (Omnibus Budget Reconciliation Act of 1989, OBRA 89, P.L. 101-239).[2] The statute now reads as follows:

[2] When the "equal access" provision was codified, the phrase "in the geographic area" was added (P.L. 101-239).

> *[A State plan for medical assistance must] (A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in Section 1396b (i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; …*

This provision has several fundamental aims that are not easily reconciled with each other: to assure that payments promote efficiency, quality, and economy; to avoid payment for unnecessary care; and to develop payment policies that promote access within geographic areas as measured by the availability of providers comparable to those available to the general population. States have flexibility in the development of payment policies consistent with these aims.

Federal regulations implementing the 1989 amendments have not been issued. A brief recently filed by the U.S. Solicitor General indicated the Administration's intent to issue such regulations in response to numerous developments related to state Medicaid provider payment policies. [3]

The key statutory and regulatory provisions that govern Medicaid payment policy today, and a timeline of major federal legislative and regulatory developments, which helps to inform these governing provisions, are outlined in the Annex to this chapter.

Payment for Hospital Services

Medicaid, including both FFS and managed care, accounted for approximately 18 percent of hospital discharges and spending nationally in 2008 (AHRQ 2011, CMS 2011). Federal payment policy for hospital services has evolved since the earliest days of the Medicaid program. Key elements have included:[4]

- early requirements to pay based on costs, mirroring Medicare;
- the Boren Amendment, which de-linked Medicaid payment from Medicare and expanded state flexibility in developing Medicaid payment policy—and its repeal, which further expanded state flexibility;
- upper payment limits based on Medicare payment levels; and
- disproportionate share hospital (DSH) payments for uncompensated costs.

Within these broad requirements states have flexibility in how they pay for hospital services. In some cases state flexibility has led to payment innovation. However, questions have emerged regarding the extent to which Medicaid payments are consistent with the principles of efficiency, economy, quality, and access.

[3] Brief for the United States as Amicus Curiae in the case of *Maxwell-Jolly v. Independent Living Center of Southern California, Inc., et al.*, U.S. Court of Appeals for the Ninth Circuit, December 2010.

[4] These elements, with the exception of DSH, also apply to institutional providers other than hospitals (e.g., nursing facilities).

The Boren Amendment

From the program's enactment, Medicaid payment policy had a particular focus on payment to hospitals and other institutional providers. In 1965, the federal statutory requirement for Medicaid payment was included in Section 1902(a)(13) of the Act, which required payment of the "reasonable cost" of inpatient hospital services.[5] During this period Medicaid hospital payment policies mirrored Medicare's and, using a process known as "retrospective cost reimbursement," states reimbursed hospitals for their reported cost of providing care.

After years of efforts to rein in hospital payments, and in response to states' demand for greater flexibility over hospital payment policy,[6] the Congress moved to de-link Medicaid payment from Medicare. Through the Omnibus Budget Reconciliation Acts of 1980 and 1981, the Congress amended Section 1902(a)(13) to broaden state payment discretion, requiring that state payment systems be "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities." These changes are known as "The Boren Amendment."

Repeal of the Boren Amendment

In the years following the amendment's enactment, many states developed new hospital payment methods. However, as costs continued to escalate and the number of providers that were paid less than the full amount of their reported costs increased, so did the number of lawsuits brought by providers against states. The suits alleged that state payment methods failed to meet the Boren Amendment's reasonableness and adequacy tests. Increasingly, states came to oppose the Boren Amendment language that had removed the Medicare payment standard. While the Boren Amendment provided more flexibility, it had a standard for sufficiency of payment, and states struggled to interpret and comply with this standard. The Congress revised the Boren Amendment as part of the Balanced Budget Act of 1997, replacing the reasonable and adequate standards with a more general requirement for a public process to determine institutional provider payments. The 1997 legislation required that states publish the proposed methodology and rates and provide an opportunity for public review and comment. These requirements remain in effect today and give providers and other stakeholders a role in Medicaid payment policy development.

Upper Payment Limits—Regulations to Promote Efficiency and Economy

Prior to the Boren Amendment, the reasonable cost requirements had essentially tied Medicaid payments to Medicare. When the Boren Amendment removed the link to Medicare, the concept of Medicare payments as an upper limit on Medicaid payment took on increased importance as a means of preventing Medicaid payment policies that would actually exceed Medicare. The statutory basis for a federal policy that would assure this upper limit was Section 1902(a)(30)(A), the Medicaid efficiency and economy statute. In 1981,

[5] The "reasonable cost" requirement was extended to nursing facilities and intermediate care facilities by the Social Security Amendments of 1972 (P.L. 92-603).

[6] Amicus brief submitted by the Solicitor General in the case of *Belshe vs. Orthopaedic Hospital* (accessed at: http://www.justice.gov/osg/briefs/1996/w961742w.txt).

BOX 5-3. Supplemental Payments and Medicaid Payment Policy

Some states make substantial payments to providers above what they pay for individual services through Medicaid rates. These additional payments fall into two categories: Disproportionate share hospital (DSH) payments to hospitals serving low-income patient populations, which accounted for nearly $18 billion (including federal matching funds) in FY 2010,[7] and "UPL supplemental payments," which comprise the difference between total base payments for services and the maximum payment level allowed under the UPL for those services. These payments are an important source of Medicaid funding for various providers. In many states, such payments may be particularly important for safety-net providers, who are more dependent on Medicaid payment as a source of revenue and less able to rely on other revenue sources to offset uncompensated care.

Because DSH and UPL payments are generally paid in lump sums, their impact on Medicaid rates for services is difficult to isolate. As a result, it is difficult to compare actual payment rates among providers, either within or across states. The Commission intends to evaluate the role of supplemental payments for providers that treat significant numbers of Medicaid enrollees and the uninsured and the impact of these payments on efficiency, economy, quality, and access.

the Secretary of Health and Human Services issued a new "upper payment limit" (UPL) regulation that prohibited states from paying "more in the aggregate for inpatient hospital services or long-term care services than the amount that would be paid for the services under the Medicare principles of reimbursement."[8]

The UPL regulations, which have been modified several times, afford states flexibility in calculating the UPL. The limit is aggregated over each provider type and class (private, state-owned, and other governmental). As a result, state payments to any individual hospital can exceed that hospital's upper limit as long as the aggregated payments to hospitals in that provider class are within the overall Medicare UPL.

Payments to Disproportionate Share Hospitals

As states were given broader discretion over hospital payment, the Congress became concerned that this shift might threaten hospitals serving large numbers of Medicaid beneficiaries and the uninsured. In response, the Congress in 1981 required states to "take into account" the situation of hospitals serving a disproportionate share of low-income patients when designing payment systems (42 U.S.C. Section 1396a (a)(13)(A)(iv)). In 1987 the Congress further strengthened the requirement to ensure the financial stability of "disproportionate share hospitals" (DSHs) by requiring states to make additional payments to such hospitals (42 U.S.C. Section 1396r-4). At first the amount of payments that could be made was left open-

[7] Based on information reported by states in the CMS-64 expenditure form for FY 2010. CMS now requires states to report the total amount of UPL payments and is working with states to improve data accuracy.

[8] HCFA 1981. The Senate had proposed similar language for inclusion in the Boren Amendment itself, but the provision was not included by the conference committee (U.S. House 1981). In earlier deliberations the Senate Finance Committee stated that "the Secretary would be expected to continue to apply current regulations that require that payments made under state plans do not exceed amounts that would be determined under Medicare principles of reimbursement." (U.S. Senate 1979, HCFA 2001).

ended. The Congress has since refined the DSH program on several occasions, most significantly in 1991 when it enacted state-specific caps on the amount of DSH funds that could be allocated, and in 1993 when it enacted hospital specific limits equal to the actual cost of uncompensated care to Medicaid enrollees and uninsured individuals.[9] In 2010, in response to anticipated increases in health insurance coverage, the Congress reduced state DSH allotments to account for an expected decrease in uncompensated care in Section 1203 of the Health Care and Education Reconciliation Act (P.L. 111-152) that followed the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148). DSH payments are intended to improve the financial stability of safety-net hospitals and to preserve access to necessary health services for low-income patients.

Current Hospital Payment Landscape

With the flexibility afforded them under federal law, states have developed a variety of payment methods for both inpatient and outpatient hospital services.

Inpatient payment methods

States have selected and CMS has approved a wide range of payment methods for hospital inpatient services. Some states use payment methods that reimburse hospitals based on their reported costs, while others pay for the number of days that a patient is in the hospital. Still others have adopted payment methods based on diagnosis related groups (DRGs), a classification system adopted by Medicare in 1983. DRGs group patients according to diagnosis, type of treatment, age, and other relevant criteria.[10] Under Medicare's inpatient hospital prospective payment system, hospitals are paid a fixed amount for treating patients in a single DRG category, regardless of the actual cost of care for the individual. As a result of receiving a fixed payment amount, hospitals have incentives to provide care more efficiently. The shift to DRGs is considered among Medicare's most successful payment reforms—better aligning payments with patients' acuity needs, reducing the number of inpatient days, and slowing growth in Medicare hospital spending (Mayes and Berenson 2006, Bachrach 2010). On the other hand, DRGs have been criticized for potentially creating incentives to discharge patients prematurely (Qian et al. 2011, Kahn et al. 1991).

In general, existing state payment methods for inpatient hospital services can be grouped into these three broad categories (Quinn and Courts 2010):

- **Payment based on DRGs**. Thirty-two states pay hospitals a fixed amount per discharge, with outlier payments for especially costly cases. However, among states using DRGs, multiple DRG algorithms are used.

[9] See, for example, the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66; Balanced Budget Act of 1997, Pub. L. No. 105-33; Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173; and in 1991, the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234).

[10] In 2007 Medicare adopted a new and more refined DRG system, Medicare Severity-Diagnosis Related Groups (MS-DRG) that recognizes the severity of illness and resource usage associated with illness severity. Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services. 2007. Medicare program; Changes to the hospital inpatient prospective payment systems and fiscal year 2008 rates. Federal Register 72, no.162 (August 22): 47130-48175.

- **Per diem.** Nine states pay hospitals a per diem amount, typically the same amount for each inpatient day.
- **Cost reimbursement**. Five states pay for inpatient services based on each individual hospital's reported costs.

Outpatient hospital payment

Similar to those used for inpatient services, payment methods for outpatient services include payment based on reported costs; payment based on the volume of services provided; and, in a few cases, payment based on the bundle of services commonly associated with a particular patient condition. States usually take one of four broad approaches to FFS payment for hospital outpatient services (Quinn and Courts 2010):

- **Cost reimbursement**. Twenty-two states pay for outpatient services based on each individual hospital's reported costs.
- **Ambulatory patient classification (APCs) groups**. Eight states employ the APC system used by Medicare, in which individual services are classified into one of 833 APCs based on clinical and cost similarity. All services within an APC have the same payment rate. A single visit may have multiple APCs and multiple separate payments (MedPAC 2007).
- **Enhanced ambulatory patient groups (EAPGs)**. Three states have adopted EAPGs for outpatient care. EAPGs bundle ancillary and other services commonly provided in the same medical visit; payment is based on the complexity of a patient's illness.
- **Other fee schedules**. Eighteen states pay for most outpatient services using other fee schedules.

Recent Hospital Payment Provisions

PPACA includes a number of Medicaid hospital payment provisions that aim to improve quality, address access to care issues, and test new health care delivery approaches through a variety of demonstrations. Many of these approaches, such as bundled payments and accountable care organizations (ACOs), are also being tested in Medicare. Effective July 1, 2011, Section 2702 of PPACA prohibits state Medicaid agencies from paying for services that relate to health care-acquired conditions (HCACs), preventable conditions resulting from treatment. On February 17, 2011, the Secretary of HHS issued a proposed rule that defines HCACs for the Medicaid program (CMS/HHS 2011). The proposed rule examines current state policies that address HCACs and reviews and considers the conditions identified in Medicare regulations on this policy, which became effective in 2008. The proposed rule would also grant states the flexibility to expand beyond the conditions identified by Medicare regulations.

PPACA authorizes the following demonstration projects to test various payment models:

- **Bundled payments.** Section 2704 authorizes a four-year demonstration for up to eight states, beginning January 2012, to evaluate the use of bundled payments for improving integration of care around Medicaid enrollees' hospitalization. This demonstration will focus on certain conditions for which the quality of care could be improved.

- **Medicaid global payments for safety-net hospitals**. Section 2705 establishes the Medicaid Global Payment System Demonstration Project, for up to five states to operate between FY 2010 and FY 2012, which will transition eligible safety-net hospital systems or networks from FFS payment structures to global capitated payment models.
- **ACOs for pediatric providers.** Section 2706 authorizes eligible pediatric providers to form ACOs and share in financial incentives. The demonstration begins January 1, 2012 and ends December 31, 2016.

PPACA also created the Center for Medicare and Medicaid Innovation to test innovative payment and service delivery models while preserving or enhancing the quality of care furnished to individuals.

Hospital Payments and the Principles of Efficiency, Economy, Quality, and Access

The nature of the various hospital payment methodologies used by states leads to questions regarding the extent to which they are consistent with the principles of efficiency, economy, quality, and access. Individual state decisions in applying these methodologies can affect their effectiveness. For example, states use a variety of DRG-based methods. Although in Medicare, DRGs have been effective in relating payments to patient acuity and in slowing growth in hospital spending, it is uncertain to what extent the different DRG-based methods reflect the complexity of the Medicaid population (Quinn 2008). On the other hand, some states' inpatient hospital payment methods are based on costs or per diem payment. Other payers, including Medicare, have largely abandoned these methods because they encourage greater utilization of services. Escalating costs for hospital services and the extent to which inpatient care could be provided more appropriately and efficiently in other clinical settings also remain to be addressed.

Many states have recently taken steps to evaluate how they pay for hospital care and have explored adopting payment methods intended to better balance efficiency, economy, quality, and access. In doing so, many states have noted that they lack information and data on the effectiveness of these various methods, including those created by PPACA, as well as other state efforts to refine their payment policies. Thus, evaluating hospital payment policy begins with a deeper understanding of these state-level details as well as the identification of data suitable for drawing informed conclusions about the effectiveness of these policies.

Payments for Physician Services

Medicaid physician services are covered medical services provided by physicians in a variety of settings including clinics, community health centers, and private offices.[11] The Medicaid statute also authorizes payment for services provided by other health care professionals such as certified nurse practitioners and nurse-midwives, and states have differing requirements as to what extent

[11] The Medicaid provisions of the Social Security Act define "physician" based on the Medicare definition in Section 1861(r)(1) "as a doctor of medicine or osteopathy legally authorized to practice medicine."

BOX 5-4. Safety-Net Providers Serve as a Major Source of Care for Medicaid Enrollees

Safety-net providers serve a substantial number of uninsured and Medicaid patients. These providers typically include public hospitals, community health centers, community behavioral health centers, local health departments, and other clinics. In some communities, teaching and community hospitals, private physicians, and ambulatory care sites are also safety-net providers.

Because they serve a higher proportion of Medicaid enrollees as well as a higher proportion of uninsured people, safety-net providers are particularly affected by Medicaid payment policies. Nationally, 35 percent of public hospital revenues and 37 percent of community health center revenues are from Medicaid (NAPH 2010, Rosenbaum et al. 2010). In the case of some individual providers, these percentages are much higher. Additionally, because they often serve a higher proportion of uninsured individuals, these providers are generally less able than other payers that serve a more insured population to absorb costs of uncompensated care. As a result, the following policies have been adopted to address these providers' financial stability:

- **Payments to disproportionate share hospitals (DSHs).** The DSH program was established in 1987 for hospitals serving a disproportionate share of uninsured and Medicaid individuals. DSH payments are in addition to payments hospitals receive for Medicaid-covered services. They are intended to improve the financial stability of safety-net hospitals and to preserve access to necessary health services for low-income patients.
- **Required payment methodology for FQHCs and RHCs.** Community health centers and clinics in rural areas meeting certain requirements qualify for special reimbursement for health care services covered by Medicaid. Although the Congress has changed the payment methodology over time, state Medicaid programs generally reimburse these health centers based on service costs. Most recently, the Consolidated Appropriations Act of 2001 (P.L. 106-554) established a prospective payment methodology based on service costs in a base year and trended forward using factors included in statute.
- **Discounted outpatient prescription drugs.** The 340B program was established in 1992 to provide eligible safety-net providers access to discounted prescription drug pricing for outpatient services.[12] Discounted pricing is not available for inpatient services.

As the Commission begins to examine the relationship of Medicaid payments to the statutory principles of efficiency, economy, quality, and access, it will conduct analyses of these safety-net providers and their impact on patient populations.

[12] The 340B Drug Pricing Program resulted from enactment of the Veterans Health Care Act of 1992 (P.L. 102-585), which is codified as Section 340B of the Public Health Service Act.

these professionals are paid based on physician fee schedules. States generally have flexibility under federal law to determine payment to physicians, and there is no UPL comparable to that for institutional providers. Faced with difficult tradeoffs to balance budgets, states frequently consider and implement changes in physician fee levels. In state fiscal year 2010 for example, 20 states reduced physician payments, while 8 states increased them (KFF 2010). These changes—payment reductions in particular—often lead to questions regarding the adequacy of Medicaid payments. In some cases, physicians and other providers have gone to the federal courts to contest payment reductions (Box 5-5).

Statutory Requirements for Access to Obstetrical and Pediatric Services

In addition to the requirements included in Section 1902(a)(30)(A), OBRA 1989 included a provision, for "assuring adequate payment levels for obstetrical and pediatric services." This additional requirement was intended to address access concerns as a result of eligibility expansions for children and pregnant women in the 1980s (Mitchell 1991).[13] Under this provision, states were required to demonstrate compliance with the equal access provision for pediatric and obstetrical services. This is the only time in the history of the Medicaid program that states were statutorily required to report measures to demonstrate compliance with the equal access provision.

This provision required states to submit annual Medicaid state plan amendments (SPAs) that specified payment rates for obstetrics and pediatrics as well as "additional data as will assist the Secretary in evaluating the State's compliance with such requirement" in order to be considered compliant with the requirements of Section 1902(a)(30)(A). As part of this requirement, in March 1990 the Health Care Financing Administration (HCFA) (now known as the Centers for Medicare & Medicaid Services) issued draft instructions and standards for demonstrating access to pediatric and obstetrical care, including requirements for data at a sub-state level:

1. At least 50 percent of obstetrical practitioners and at least 50 percent of pediatric practitioners are full Medicaid participants or there is full Medicaid participation at the same rate as Blue Shield participation;[14]
2. Medicaid FFS payment rates are equal to at least 90 percent of the average FFS amount of private insurers; or
3. Other documentation of equal access, including other measures of participation, recipient surveys, or equal visit utilization rates (PPRC 1993).

States relied on these draft instructions to demonstrate compliance through their Medicaid State Plans, though they generally found it difficult to measure access based on the proposed requirements. In its 1992 annual report to the Congress, the Physician Payment

[13] Statutes expanding eligibility for pregnant women and children include: Deficit Reduction Act of 1984 (P.L. 98-369), Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), Omnibus Budget Reconciliation Act (OBRA) of 1986 (99-509), OBRA 1987 (100-203), Medicare Catastrophic Coverage Act of 1988 (100-360), and OBRA 1989 (P.L. 101-239) that required state Medicaid programs to cover pregnant women and children under 6 up to and including 133 percent of the Federal Poverty Level. OBRA 1989 also expanded EPSDT services for children under age 21.

[14] Full participation means accepting all Medicaid patients who present themselves for care.

BOX 5-5. Federal Court Activity on Medicaid Payment Adequacy

As states increasingly turn to provider payment rate reductions to address budget issues, providers are turning to the courts to assert that these reductions are not consistent with requirements under Section 1902(a)(30)(A) of the Social Security Act. In many cases, courts have noted that providers did not have the right to sue under this section, but several federal appellate courts have found that the providers were entitled to challenge these payment reductions. A consistent theme among most cases is that state rate-setting based solely on budget constraints is particularly vulnerable to challenge under Section 1902(a)(30)(A).

Many of these cases address whether the reductions adversely affect enrollees' access to care and meet the "equal access" requirement that payments "are sufficient to enlist enough providers." Court decisions are split as to whether Section 1902(a)(30)(A) requires states to demonstrate that the payment rates produce a certain result (e.g., sufficient provider supply) or to follow a certain process to assure that payments are consistent with this provision. The focus of these cases has been on whether overall payment levels, and not payment methods, meet these requirements.

Recently, the Supreme Court has agreed to hear arguments in a case involving Medicaid provider payment reductions, Independent Living Center of Southern California v. Maxwell-Jolly (2010). The court will consider whether the Supremacy Clause confers on beneficiaries and providers the right to challenge the sufficiency of Medicaid provider payments under Section 1902(a)(30)(A).

Review Commission (PPRC) noted that the draft instructions were insufficient to provide HCFA with the ability to enforce the statute and that "HCFA could help the states meet this requirement by developing measures of access appropriate to the Medicaid population and providing technical assistance to implement appropriate monitoring systems." In its 1993 report, PPRC reported that state Medicaid programs generally lacked the data required to make the required assurances. For example, few were able to identify physicians who did not participate in Medicaid and proprietary fee information for private payers was not accessible. According to the report, one state's officials resorted to calling every pediatrician, family physician, and obstetrician in the State to identify the percent of participation (PPRC 1993).

In 1997, the Congress repealed the provision. At the time of its repeal, a State Medicaid Director letter noted the significant administrative burden on both states and HCFA in complying with these requirements.[15]

Inter-State Variability in Physician Payments

In general, states have broad flexibility to determine payments for physician services. State Medicaid programs, like Medicare and commercial payers, typically pay physicians and other clinicians using a fee schedule (Mayes and Berenson 2006). These fee schedules are often based on the concept of "relative value," whereby various physician services or procedures have different values based on the resources involved in performing a

[15] A September 17, 1997 letter from HCFA to State Medicaid Directors noted that "we realize the difficulties that were encountered in obtaining data needed for the Ob/Ped SPAs."

TABLE 5-1. Medicaid Fee Indices for Office Visits, 2010

State	Fee Index	State	Fee Index	State	Fee Index	State	Fee Index
US	1.00	ID	1.47	MO	0.94	PA	0.95
AL	1.12	IL	0.94	MT	1.67	RI	0.51
AK	2.77	IN	0.82	NE	1.16	SC	1.28
AZ	1.43	IA	1.13	NV	1.16	SD	1.10
AR	1.01	KS	1.33	NH	1.06	TX	0.91
CA	0.67	KY	1.13	NJ	0.93	UT	1.07
CO	1.33	LA	1.24	NM	1.34	VT	1.35
CT	1.44	ME	1.04	NY	0.96	VA	1.27
DE	1.70	MD	1.24	NC	1.43	WA	1.29
DC	1.76	MA	1.25	ND	2.35	WV	1.17
FL	0.79	MI	0.74	OH	1.02	WI	0.99
GA	1.07	MN	0.69	OK	1.55	WY	1.70
HI	0.96	MS	1.48	OR	1.21		

Note: Indices are based on the weighted sum of the ratios of each state's fee for a given service to the fee's national average, using Medicaid expenditure weights derived from claims files. A more detailed methods section is included in the Annex to the chapter.

Source: Urban Institute 2010 Medicaid Physician Survey

procedure or service. Resources include physician work, practice expense, and liability insurance. If one procedure is more complex and time consuming than another, then this procedure code will be given more "value." Alternatively, some Medicaid programs pay a percentage of the physician's charges, with those charges usually subject to audit for reasonableness.

While fee schedules are the predominant method of payment, the basis for each fee schedule varies, and there is considerable variation in fees across states. Recent analysis conducted for the Commission demonstrates this variation for office visits.[16] The data in Table 5-1 show each state's FFS payment rates for office visits relative to the national Medicaid average, represented as an index value of 1.00. (For example, Arkansas' fees are one percent higher than the national average while Wisconsin's are one percent lower than the national average.)

These data illustrate the variation in physician payments for Medicaid services, which reflect many factors in delivering care in different parts of the U.S. and state policy decisions on fee levels. Office visit payments in the highest paying state are more than five times higher than those in the lowest paying state. It should be noted that these data include FFS rates only. Similar comparison data for Medicaid managed care payments are not readily available. This is our initial review of physician fee levels, and the Commission intends to conduct additional analyses in the future including to compare Medicaid fees to those of other payers (e.g., commercial, Medicare).

[16] Office visit CPT codes included in the index include the following: 99203: Office Visit, New Patient, 30 Minutes; 99204: Office Visit, New Patient, 45 Minutes; 99213: Office Visit, Established Patient, 15 Minutes; 99214: Office Visit, Established Patient, 25 Minutes.

Recent Legislative Activity Regarding Medicaid Physician Payment

Section 1202 of the Health Care and Education Reconciliation Act (P.L. 111-152) that followed PPACA requires states to pay 100 percent of the Medicare payment rate for primary care services provided by physicians with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine participating in Medicaid during calendar years 2013 and 2014. The law provides 100 percent federal funds for the difference between a state's primary care payment amount in Medicaid and the Medicare payment amount during these two years. Primary care services, as defined in the statute, include certain categories of procedure codes as well as services related to immunization administration.[17] Medicaid managed care plans must also make payments to physicians consistent with the new minimum payment amounts.

PPACA also included other provisions that will affect physicians and encourage changes in the health care delivery system through payment policy changes. Many of these provisions were highlighted earlier in our discussion of hospital payment policy. One such change in Section 2703 of PPACA, Health Homes for Individuals with Chronic Conditions, allows states (beginning in January 2011) to implement health homes for Medicaid enrollees with certain chronic conditions such as asthma, diabetes, substance abuse, mental health conditions, and heart disease. These "homes" are designated providers or a team of health professionals including (but not limited to) physicians who coordinate and manage these enrollees' care, including making any necessary referrals to specialists. This provision authorizes separate payments to providers for this care management and allows states to receive higher federal match (90 percent) for up to two years.

Physician Payments and the Principles of Efficiency, Economy, Quality, and Access

State and federal policy makers are faced with significant questions regarding the link between physician payment and issues of access and quality. For example, while the physician office visit data presented earlier show geographic variation in payments, it is unclear how these payments affect efficiency, economy, quality, and enrollees' access to care. Evaluating these effects requires additional data and analysis.

We plan to continue and expand our analysis of physician payment issues in the coming year. We will also examine data sources available to the Commission for this analysis. As the repeal of the OBRA 1989 requirements demonstrated, the collection of data for evaluating physician payment and for assessing the link between payment and access is challenging. The wide variation in physician payments, the requirement to pay 100 percent of the Medicare amount for primary care services, and recent federal court involvement in Medicaid payment (Box 5-5) underscore the need to evaluate payment policies. The Commission also intends to explore new and emerging payment approaches such as health homes, bundled payments, and quality incentives.

[17] Procedure codes include those for services in the category designated Evaluation and Management in the Healthcare Common Procedure Coding System (established by the Secretary under Section 1848(c)(5) as of December 31, 2009, and as subsequently modified); and services related to immunization administration for vaccines and toxoids.

BOX 5-6. Medicaid Managed Care Payment

In an effort to slow Medicaid spending and improve access to care, many states looked to various forms of managed care in the 1990s as a mechanism for delivering services to enrollees (GAO 1993). One of these forms, risk-based managed care, relies on health plans assuming financial risk for providing a defined group of services to enrollees for a fixed rate. According to CMS, almost half of all Medicaid enrollees (and a higher portion of CHIP enrollees) were in a risk-based health plan in 2009. Twenty-five states had more than fifty percent of their Medicaid enrollees in these types of plans in 2009.

Most states establish payment rates for different demographic groups and usually adjust for age, sex, geographic region, maternity care, and program carve-outs that address services not typically covered by insurers (e.g., behavioral health). To set managed care rates, some states use FFS claims data, while an increasing number of states use encounter data (data which capture health services delivered in a risk-based environment). To fine-tune payments more precisely, some states also adjust rates based on enrollees' anticipated health care spending, called "risk adjustment." Health status data are gathered from FFS medical claims or encounter data.

Federal regulations do not include standards for the type, amount, or age of the data used by states to set managed care payment rates. However, Section 1903(m)(2)(A) of the Act requires that states' payment rates be actuarially sound. In 2002 CMS issued regulations requiring that Medicaid managed care rates be developed in accordance with generally accepted actuarial principals and practices, be appropriate for the population and services, and be certified by qualified actuaries (42 CFR 438.6(c)(1)(i)(2009)). The regulations also require states to submit documentation to CMS that demonstrates compliance with requirements and includes a description of the rate-setting methodology and the data used to set rates. A recent study by the Government Accountability Office (GAO), however, found that CMS's oversight of states' compliance with actuarial soundness requirements and data quality for rate setting was inconsistent and could be improved (GAO 2010).

Looking Forward

The Medicaid payment landscape has been shaped by decades of federal and state efforts to maintain state flexibility around payment policy while containing spending and monitoring access to care. Despite these efforts, the Medicaid program still faces a number of significant policy questions that will guide the Commission's efforts in the coming years. The most fundamental questions include:

- What is the relationship of payment to access and quality?
- Which payment innovations best address efficiency and economy while promoting access to quality services and appropriate utilization?

The Commission will begin to answer these questions by creating a baseline of information that includes state payment policies across providers for both FFS and Medicaid managed care. Currently there is no easily accessible source of state payment methods, and the Commission intends to work with states in this endeavor. After establishing this preliminary understanding of the Medicaid payment landscape, the Commission will consider the following types of analyses:

- Evaluate the impact of the required increase in primary care fees and consider how these payment increases should be passed on to Medicaid managed care plans and from plans to providers.
- Evaluate the impact of particular payment policies for improving efficiency, economy, and quality and increasing availability of providers as appropriate.
- Examine the impact of state financing approaches and supplemental payments on providers, payment policy, and states' ability to adopt payment innovations.

This work will help inform the Congress, states, and CMS regarding those payment policies and innovations that might best promote access to necessary and higher-quality services while slowing the growth of health care spending. However, our ability to assess the extent to which these policies are successful is complicated by variability in payment methods, underlying costs, delivery systems, and practice patterns. Evaluation of payment will vary by provider type and must also account for program integrity and the extent to which inappropriate utilization or fraud occurs.

Moving forward, the Commission will be examining program integrity issues along with other determinants of efficiency, economy, quality, and access. The Commission intends to develop a balanced and data-driven approach to payment evaluation that is appropriate for the Medicaid program.

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Chapter 5 Annex

BOX 5A-1. Key Statutory and Regulatory Provisions Governing Medicaid Payment

Medicaid Provider Payment Provisions under the Social Security Act

Public process for determination of institutional payment rates	1902(a)(13)(A)
Hospice payment requirements and room and board payments for hospice patients in nursing facilities or ICFs-MR	1902(a)(13)(B)
Primary care physician payments equal to Medicare for 2013-2014	1902(a)(13)(C)
Procedures for making nursing facility payment data and methodologies available to the public	1902(a)(28)(C)
Payment methods and procedures to safeguard against unnecessary utilization, consistent with efficiency, economy, and quality, and provide access equal to the general population	1902(a)(30)(A)
Audit requirement to ensure proper payments if payments are based on costs	1902(a)(42)
Authority to provide non-emergency transportation through a competitively bid broker contract	1902(a)(70)(B)
Payment for inpatient hospital services to children under the age of 6 in disproportionate share hospitals	1902(s)
Payment for services provided by Federally Qualified Health Centers and Rural Health Clinics	1902(bb)
Upper limits based on customary charges for inpatient hospitals and based on Medicare payment for diagnostic tests; also rebate requirement for outpatient drugs	1903(i)
Payments for Medicaid managed care organizations	1903(m)
Payment to hospital providers of nursing facility services	1913
Payment for Indian Health Service providers	1911
Competitive bidding for laboratory services and medical devices	1915(a)(1)(B)
Payment for inpatient hospital services provided by disproportionate share hospitals	1923
Payment and rebate requirements for outpatient drugs	1927
Ceiling on payment amounts for home and community care	1929(e)(1)
Payment for Programs of All-Inclusive Care for the Elderly (PACE)	1934(d)
Payment for health homes for individuals with chronic conditions	1945(c)
Prohibition on payment for health care-acquired conditions	Section 2702 of the PPACA

BOX 5A-1, Continued

Medicaid Provider Payment Regulations

Contracts with health insuring organizations	42 CFR 434.40
Medicaid managed care: Contract requirements	42 CFR 438.6
Medicaid managed care: State Plan requirements	42 CFR 438.50
Payments for reserving beds in institutions	42 CFR 447.40
Restrictions on payments to providers to offset bad debts	42 CFR 447.57
State plan requirements to describe payment policy and methods	42 CFR 447.201
Audits required if payment based on costs	42 CFR 447.202
Documentation of payment rates	42 CFR 447.203
Encouragement of provider participation (equal access)	42 CFR 447.204
Public notice of changes in statewide methods and standards for setting payment rates	42 CFR 447.205
Payment for inpatient hospital and long-term care facility services (including UPLs)	42 CFR 447 Subpart C
Payment adjustments for hospitals that serve a disproportionate number of low-income patients	42 CFR 447 Subpart E
Payment methods for other institutional and non-institutional services (including UPLs)	42 CFR 447 Subpart F
Payment for drugs	42 CFR 447 Subpart I

TABLE 5A-1. Timeline of Major Federal Medicaid Payment Policy Developments

Year	
1965	Social Security Amendments of 1965 (P.L. 89-97) ▶ Create the Medicaid program as a federal-state partnership codified under Title 19 of the Social Security Act. ▶ Section 1902(a)(13) requires hospital payments to be based on "reasonable cost."
1968	Social Security Amendments of 1967 (P.L. 90-248) add Section 1902(a)(30)(A), requiring states to "assure that payments are not in excess of reasonable charges consistent with efficiency, economy, and quality of care."
1972	Social Security Amendments of 1972 (P.L. 92-603) ▶ Repeal "maintenance of effort," allowing states to reduce expenditures from one year to the next. ▶ Require in Section 249 that payments to nursing facilities and intermediate care facilities be on a reasonable cost-related basis. ▶ Require that payments for inpatient hospital services do not exceed customary charges.
1977	Health Care Financing Administration (HCFA) is created to administer Medicaid and Medicare.
1980	Omnibus Budget Reconciliation Act of 1980 (P.L. 96-499) "Boren Amendment" ▶ Removes requirement to pay nursing facilities according to Medicare cost principles. ▶ Instead requires payments to be "reasonable and adequate" to meet the costs of "efficiently and economically operated" facilities.
1981	Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) expands Boren Amendment requirements to hospitals, removing requirement to pay according to Medicare cost principles. ▶ Removes "reasonable charges" limitation from 1902(A)(30)(A). ▶ Allows for additional payments to hospitals serving a disproportionate share of Medicaid and low-income patients, later known as disproportionate share hospitals ▶ Permits 1915(b) freedom-of-choice waivers allowing, for example, states to pursue mandatory managed care for certain Medicaid populations.

Table 5A-1, Continued

Year	
1982	Tax Equity and Fiscal Responsibility Act (TEFRA, P.L. 97-248) expands states' options for imposing cost sharing requirements on Medicaid beneficiaries and services. ▶ Establishes a risk-based prospective-payment system for HMOs participating in Medicare and facilitates their participation. ▶ Requires HHS to submit a plan for prospective payments to hospitals and nursing facilities.
1983	Social Security Amendments (P.L. 98-21) establish a prospective payment system (PPS) for inpatient hospital services based on diagnosis related groups (DRGs).
1985	Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 85, P.L. 99-272) requires Medicare disproportionate share hospital adjustments for hospitals serving low-income patients.
1986	COBRA 85 requires that hospice payments be in the same amounts and use the same methodology as Medicare and allow for a separate room and board payment for hospice patients residing in nursing facilities or ICFs.
1987	Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) ▶ Requires that payment methods for nursing facilities take into account the cost of complying with newly enacted quality requirements. ▶ Adds Section 1923 of the SSA, strengthening DSH requirements and outlining payment methods.
1988	Regulations establish separate UPLs for state-owned and non-state-owned inpatient hospitals, nursing facilities, and ICFs-MR.
1989	Omnibus Budget Reconciliation Act of 1989 (OBRA 89, P.L. 101-239) ▶ Adds requirement to 1902 (a)(30)(A) (previously established only by regulation) that payments be sufficient to attract enough providers to ensure that covered services will be as available to Medicaid beneficiaries as they are to the general population. ▶ Establishes specific reporting requirements for payment rates for obstetrics and pediatrics to allow the Secretary to determine the adequacy of state payments for these services. ▶ Requires coverage and full reimbursement of "reasonable cost" of FQHCs. ▶ Requires room and board payment for hospice patients residing in nursing facilities equal to 95 percent of the nursing facility rate. ▶ Establishes the Resource-Based Relative Value Scale (RBRVS) for physician payments under Medicare, replacing charge-based payments.

Table 5A-1, Continued

Year	
1990	Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) ▶ Establishes the prescription drug rebate program requiring "best price" rebates to states and federal government. ▶ Modifies Boren to require that the cost of implementing 1987 nursing home quality reforms be taken into account. ▶ Creates additional flexibility in design of DSH payment methods.
1991	Medicaid Voluntary Contribution and Provider-Specific Tax Amendments (P.L. 102-234) ▶ Restrict the use of provider donations and provider taxes as non-federal share. ▶ Prohibit HCFA from restricting IGTs of state or local tax revenues. ▶ Place national and state-specific ceilings on special payments to DSH hospitals.
1992	Veterans Health Care Act of 1992 (P.L. 102-585) creates the 340B Drug Pricing Program providing eligible safety net providers access to discounted prescription drug pricing for outpatient services.
1993	Administration begins approving Section 1115 demonstration waivers under which states expand use of Medicaid managed care. Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) places facility-specific ceilings on DSH payments.
1997	Balanced Budget Act of 1997 (BBA 97) (P.L. 105-33) ▶ Permits mandatory managed care without obtaining a waiver. ▶ Requires managed care payments to be actuarially-sound. ▶ Codifies and reduces state-specific DSH allotments. ▶ Repeals OBRA 89 requirements for state reporting on obstetric and pediatric payments. ▶ Repeals the Boren Amendment and instead requires State agencies to use a public process to determine payment rates for inpatient hospitals, nursing facilities, and ICFs-MR. ▶ Begins phase-out of cost-based reimbursement for FQHCs and RHCs and added supplemental payments for the difference between Medicaid managed care and fee-for-service payments. ▶ Requires HCFA to develop five new Medicare prospective payment systems, including for inpatient rehabilitation hospitals; skilled nursing facilities; home health agencies; outpatient hospitals; and outpatient rehabilitation.

TABLE 5A-1, Continued

Year	
1999	Balanced Budget Refinement Act (BBRA) of 1999 ▶ Slows phase-out of cost based reimbursement for FQHCs and RHCs. ▶ Increases DSH allotments for several states.
2000	The Medicare, Medicaid, and CHIP Benefits Improvement and Protection Act (P.L. 106-554) ▶ Directs the Secretary of HHS to issue regulations tightening upper payment limits (UPLs). ▶ Creates a new PPS for FQHCs and RHCs and establishes a "floor" for payments. ▶ Modifies DSH funding amounts.
2001	Regulations implementing BIPA UPL requirements become final, and ▶ Impose three separate UPL categories (state-owned, non-state government owned, and private) for inpatient hospitals, nursing facilities, and ICFs-MR. ▶ Add parallel UPL requirements for outpatient hospital and clinics.
2002	CMS promulgates regulations to implement actuarial-soundness requirements established in BBA 97. CMS creates the National Institutional Reimbursement Team (NIRT) with responsibility for the review of institutional reimbursement methodologies. CMS creates non-institutional Provider Team (NIPT) to review non-institutional reimbursement, including physicians.
2003	The Congress raises state-specific DSH allotments for FY 2004 for all states and through FY 2009 for "low-DSH states." CMS begins to require states to answer five questions as part of the state plan amendment (SPA) approval process, requiring details on supplemental payment methodologies and UPL calculations.

TABLE 5A-1, Continued

Year	
2005	Deficit Reduction Act (P.L. 109-171) ▶ Changes the basis of federal upper limit (FUL) for multiple-source drugs from lowest published price to "average manufacturer price" (AMP). ▶ Improves collection of rebates on physician-administered drugs. ▶ Adds children's hospitals as a covered entity in the 340B drug discount program. ▶ Includes other drug-related provisions.
2007	Revised UPL regulations would have limited payments to public providers to the cost of providing services. The final regulation was never made effective, however, and was eventually rescinded.
2009	American Recovery and Reinvestment Act of 2009 (P.L. 111-5) includes temporary DSH allotment increase for FY 2009-10.
2010	Medicaid payment provisions under the Patient Protection and Affordable Care Act (P.L. 111-148) ▶ Prohibit Medicaid payments for health care-acquired conditions. ▶ Include funding for bundled payments demonstrations, global payment demonstrations for safety-net hospitals, pediatric accountable care organization demonstrations, and a demonstration project to provide Medicaid payment to institutions for mental disease in certain cases. ▶ Fund (for two years) primary care physician payments that are at least 100% of Medicare. ▶ Establish a new Center for Medicare and Medicaid Innovation to support pilot programs for innovative payment and delivery arrangements in Medicare and Medicaid.

Note: See also Kaiser Family Foundation timeline www.kff.org\medicaid\medicaid_timeline

Methods Used in the Medicaid Physician Fee Survey

The Urban Institute has conducted surveys of Medicaid physician fees since 1993, with the most recent data collected as of December 2010 (Zuckerman et al. 2009, Zuckerman et al. 2004, Norton and Zuckerman 2000). While the surveys include a range of services, the data presented here are only related to office visits.[18] Data were collected from all 49 states and the District of Columbia that have a fee-for-service component in their Medicaid programs (Tennessee does not have a fee-for-service component).

The data collection procedures established in prior survey years were followed, with one notable difference in 2010. Whereas 2008 reimbursement rates were collected through a combination of surveys completed by state Medicaid officials and fee schedules downloaded from state Medicaid websites, in 2010 all 49 states and the District of Columbia provided fee data online, eliminating the need for surveys and saving a tremendous amount of time in the data collection process. Some states adjust their reimbursement rates for specific physician specialties, services, or populations to meet policy objectives. For example, a number of states reimburse physicians at a higher rate for services provided to children. If a state had multiple fees for the same service, a simple average was computed to obtain a single service fee for each state.[19]

After collection, the 2010 data were examined to identify and validate any fees that increased or decreased by a large amount since 2008 and fees that were unusually high or low as compared to the national average for that service. Once analysts had validated the data, they calculated a national average fee for each service. The national average fee is a weighted average of the fee paid by each state, where the weight for each state was the state's share of national Medicaid enrollment (derived from the 2007 Medicaid Statistical Information System, the most recent available data). Last, they constructed a Medicaid Fee Index that measures each state's fees relative to national average Medicaid fees. This index is the weighted sum of the ratios of each state's fee for a given service to the fee's national average, using Medicaid expenditure weights derived from claims files used in prior years of the study. Although the Medicaid Fee Index was computed for all surveyed Medicaid services, the version presented in this Report is based only on four types of office visits.

[18] Office visit CPT codes included in the index include the following: 99203: Office Visit, New Patient, 30 Minutes; 99204: Office Visit, New Patient, 45 Minutes; 99213: Office Visit, Established Patient, 15 Minutes; 99214: Office Visit, Established Patient, 25 Minutes.

[19] Ideally, we would compute each fee as the weighted average of the share of the service billed at each rate in the state. However, computing the correct weights is not possible without state-level claims data.