

The Medicaid Fee-for-Service Provider Payment Process

In most cases, Medicaid fee-for-service (FFS) provider payment is triggered by the submission of a claim by a provider indicating that a service has been provided. However, just as state-specific policies and procedures lead to variation in payment rates, there is also variation among states in the specific processes for paying providers of Medicaid services. In this respect, Medicaid is similar to the private insurance market, in which different payers have different payment procedures for specific providers and services.

The following fact sheet provides an overview of Medicaid FFS provider payment, including the typical claims submission and payment process, as well as additional non-claims-based payment processes. It also briefly describes post-payment review processes and the use of payment data for administrative purposes including program analysis and program integrity. In fiscal year (FY) 2016, 51 percent of total Medicaid benefit spending was attributable to FFS programs (MACPAC 2018). This fact sheet also briefly addresses payment for services under managed care.

Claims-Based Payments

Figure 1 illustrates the FFS claims payment process generally used by state Medicaid programs to pay enrolled providers for services to eligible Medicaid enrollees. To be enrolled as a Medicaid provider, a provider needs to apply to the state in which the provider intends to provide services. Providers' enrollment applications are then screened by states to verify that providers meet state and federal enrollment criteria.

After completing an approved or authorized service, an enrolled provider submits a claim to the state Medicaid agency. Claims are subject to approved rates and a variety of data checks before payment is made to the provider. Following payment, various audit and review processes may be conducted to verify that the payment was correctly determined.

Authorization

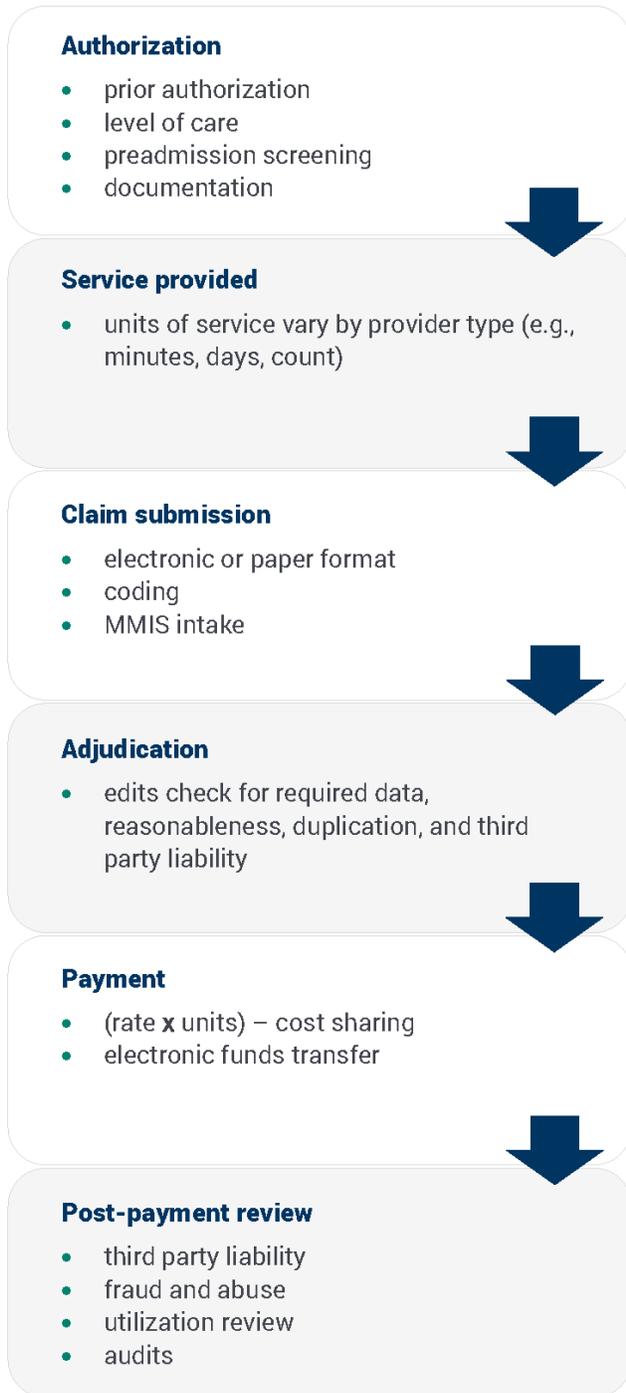
State and federal policies include a wide variety of requirements that providers must comply with in order to receive payment for services. Several of the most common of these authorizing requirements are listed below.

Prior authorization. For many services, providers must first obtain approval to provide a service to be eligible for payment. The most common type of approval, known as prior authorization, is intended to



assure that the service is both covered by the Medicaid program and appropriate for the enrollee who is to receive the service. Prior authorization is commonly associated with medical equipment and certain

FIGURE 1. Typical Claims-Based Provider Payment Process



prescription drugs, and is also used by states for many other services including certain physician procedures and non-emergency hospital admissions. For home and community based services (e.g., personal care), prior authorization is used to determine the maximum amount of services that an individual may receive in a given time period (e.g., 80 hours per month).

Level of care determination. Authorization for many long-term services and supports (LTSS) requires that enrollees meet a certain threshold in order for providers to receive payment for services. For example, nursing facility services and many home and community-based alternatives to nursing facility services require that individuals meet an institutional level of care meaning that they need services on a daily basis and provided on an inpatient basis consistent with Medicare requirements (42 CFR 440.40). States have flexibility in implementing this requirement and, as a result, level of care criteria and thresholds vary across states. Most states use a combination of clinical information and information regarding an individual’s activities of daily living (e.g., mobility, eating, and toileting) in making level of care determinations (Hendrickson and Kyzr-Sheeley 2008).

Preadmission screening and resident review. Preadmission screening and resident review (PASRR) is intended to prevent the inappropriate institutionalization of individuals with serious mental illness or developmental disability. PASRR determinations are required for any individual seeking admission to a

Medicaid-certified nursing facility, and residents of such facilities, regardless of payer. A Level I screen is conducted to identify whether such an individual has mental illness or an intellectual disability. If so, a Level II screen is conducted to determine whether the individual requires care in a nursing facility, needs specialized services, and whether a home- and community-based setting is an appropriate option (CMS 2018a).

Ongoing documentation. In addition to authorization processes prior to service delivery, in order to be eligible for Medicaid payment providers often must comply with ongoing documentation of services that are provided and planned, as well as the medical necessity of services. Such information is often captured through individual care plans, as well as assessments that measure the relative acuity of individuals including the Minimum Data Set for nursing facility residents and the Outcome and Assessment Information Set for home health care. In the case of inpatient hospital stays, providers may be required to seek authorization to continue hospitalization beyond a previously authorized length of time.

Claim submission

Once a service has been provided, providers typically submit claims to the state Medicaid agency for payment.¹ Most claims are submitted electronically in a standardized format consistent with the requirements of the Health Insurance Portability and Accountability Act (P.L.104-191) and federal regulations, including the use of a provider's national provider identifier (45 CFR 160 and 162).²

Each claim contains a record of the services provided and these services are reported using billing codes. Physician and clinic services, for example, are commonly reported using Current Procedural Terminology (CPT) codes that are developed and maintained by the American Medical Association. Hospital services are often reported using a variety of codes that describe the patient's condition and procedures performed. These codes are then used by a state to determine payment. In the case of inpatient services, for example, a grouper is often used to convert the codes into a diagnosis-related group (DRG), and the hospital is paid an amount based on the DRG. Services that are not related to a particular procedure or diagnosis (e.g., nursing facility stay) are typically reported using revenue codes that indicate the service type and location. In the case of federally qualified health centers (FQHCs) and rural health clinics (RHCs), which are paid a fixed amount per encounter, providers typically submit encounter claims identifying the patient and containing a generic code indicating that the patient was seen. The encounter claim may also include information regarding specific services furnished. The state processes that claim to verify that a covered service was furnished to an eligible individual.

In some cases these codes are used together (e.g., CPT code and revenue code) to report additional detail about when, where, or by whom a particular service was provided. Claims also typically require a patient's diagnosis to be reported, even in cases where the diagnosis may not directly impact payment. In certain cases, the presence of a particular diagnosis code may allow a claim to be paid without prior approval. In other cases, diagnosis codes may be useful for analyses of program operations and treatment patterns.

Because the codes reported on a claim may directly impact whether a claim is denied and the amount that is paid, providers have a strong incentive to ensure that miscoding does not result in underpayment. On the other hand, a potential risk associated with code-based payment may be the incentive to upcode, or



report codes for more complex procedures that result in higher payment. As a result, state and federal agencies conduct various payment oversight and review activities to monitor provider coding.

Each state is required to have a mechanized claims processing and information retrieval system, commonly known as a Medicaid Management Information System (MMIS) (§ 1903(r) of the Act) and 42 CFR 433.113). States are provided enhanced federal matching payments for Centers for Medicare & Medicaid (CMS) certified systems: 90 percent for their design, development, and installation; and 75 percent for the ongoing operation of certified systems (§ 1903(a)(3) of the Act).³ Many states have contracted with vendors for MMIS operation, while others maintain MMIS operations in-house (CMS 2018c).

Adjudication

In order to be processed by an MMIS, claims must contain basic information including the service provider's ID number, recipient ID number, the services provided (e.g., billing code), and the dates of service.⁴ Upon receipt of a claim, an MMIS typically verifies that the claim is in the correct format and that all of the information required for processing is included.

Once a claim is accepted by an MMIS, a series of automated checks, known as edits, are applied to determine whether the claim should be paid, denied, or suspended for further review. A state MMIS may include thousands of individual edits that ensure that valid data are included in the proper fields on claims and to compare the data on a current claim being processed to prior claims for the same individual. Federal requirements for prepayment review, typically enforced through system edits, are articulated in several sources including:

Federal regulation. Includes requirements to verify enrollee eligibility and provider authorization, checks for logical consistency, checks for whether a duplicate or conflicting claim had already been paid, verification of payment amounts, and checks for third-party liability (TPL), which is discussed later in more detail (42 CFR 447.45(f)).

The State Medicaid Manual. Requires that a certified MMIS include edits for proper field content, accuracy of data, and reasonableness of data. The manual also requires a number of specific checks to verify recipient and provider eligibility, prevent duplicate payments, and verify the accuracy of submitted charges (CMS 2018d).

The CMS Medicaid Enterprise Certification Toolkit. Checklists in the toolkit for evaluating and certifying a state's MMIS expand upon the list of edits contained in both regulation and the Medicaid manual (CMS 2018e).

The National Correct Coding Initiative. The National Correct Coding Initiative (NCCI) is a CMS program of edits and coding policies that was originally implemented for the Medicare program in 1996.⁵ Federal statute now requires states to use compatible NCCI methodologies to process Medicaid claims filed on or after October 1, 2010 (§ 1903(r) of the Act). NCCI edits consist of two types of edits:



- procedure-to-procedure edits, which define pairs of codes that should not be reported together for a variety of reasons, and
- medically unlikely edits, or units-of-service edits, which define the number of units of service beyond which the reported number of units of service is unlikely to be correct (e.g., claims for removal of more than one gallbladder).

Health care-acquired conditions. Effective July 1, 2011, federal statute prohibits state Medicaid agencies from paying for services that relate to health care-acquired conditions (HCACs) (§ 2702 of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended). In June 2011, the Secretary of the U.S. Department of Health and Human Services issued final regulations that define HCACs to include Medicare’s current list of hospital acquired conditions and serious adverse events. The regulations also allow states to expand to other settings and other conditions for non-payment with CMS approval. The regulations also require that states implement provider self-reporting through claims systems (42 CFR 434, 438, and 447).

Based on the wide variety of edits, claims may be denied for various reasons, including that the recipient was not eligible for Medicaid, the service provided was not authorized, the limit for a service had been exceeded, the service that was provided was not covered by the program, or the claim was submitted too late. In some cases an MMIS may also suspend claims that may require manual review prior to releasing the claim for payment or denial.

Through a process known as coordination of benefits, claims are also checked against information regarding other sources of coverage that a person might have. Medicaid is intended to be the payer of last resort and states are obligated to determine the legal liability of third parties (§ 1902(a)(25)(A) of the Act). If TPL is established (including for Medicare), the Medicaid program is not responsible for payment and typically denies and redirects the claim to the liable third party.⁶ TPL checks are also conducted following payment of a claim, as discussed below.

Payment

Federal statute requires that 90 percent of practitioner or shared health facility claims that require no follow-up to be paid within 30 days, and 99 percent within 90 days (§ 1902(a)(37) of the Act).⁷ In most cases providers are paid through electronic funds transfer as claims are received and adjudicated. The actual payment amount for claims is determined based on the rate for the services provided, the number of units of service provided, and the amount of cost sharing and or TPL that are identified. The actual amount paid to a provider based on submitted claims can generally be summarized as the following:

$$\text{Payment} = (\text{rate} \times \text{units}) - \text{cost sharing} - \text{TPL}$$

Payment rates are determined by the state for each service in accordance with its approved Medicaid state plan, and the units for payment vary by provider type. Physicians are often paid based on a fee schedule that contains a payment amount for each procedure. As previously mentioned, however, FQHCs and RHCs are paid an amount per encounter, regardless of the number or type of services provided.⁸ Nursing facilities are commonly paid for each day of residence. Inpatient hospitals may be paid in a



number of ways including a fixed amount depending upon an individual's diagnosis (i.e., DRG), the number of inpatient days, or a percentage of charges. Many home and community-based services are paid based on the duration of care in increments of time (e.g., 15-minute increments).

Payments are reduced by the amount of any enrollee cost sharing obligations, or amounts for which a third party is liable. One example of cost sharing is co-pays which enrollees may be required to pay directly to a provider in order to receive a particular service. For example, physician office visits may require a co-pay of \$3, which is deducted from the amount that a state pays a provider under its fee schedule.⁹ Cost sharing may also include amounts that users of LTSS must pay toward their services each month. Similar to co-pays, these amounts are deducted from the claim payment amount.¹⁰

Additional Payment Processes

In addition to the standard claims-based FFS payment process there are several other mechanisms by which providers may receive Medicaid payment. These include supplemental payments, the use of certified public expenditures (CPEs) by public providers, payments for Medicaid managed care enrollees, and payment for Medicare cost sharing obligations.¹¹ Note that the CPE process for provider payment allows public providers to share in the non-federal financing of the Medicaid program. Other provider-based financing approaches that are not necessarily directly tied to payment include intergovernmental transfers and provider taxes.

Supplemental payments

In some cases, Medicaid providers receive payments that are not directly associated with the submission of claims. These payments, collectively known as supplemental payments, include disproportionate share hospital (DSH) payments made to hospitals that serve a disproportionate share of Medicaid enrollees and the uninsured, as well as supplemental payments made to hospitals and other providers that are calculated so that aggregate payments to the class of providers is under a regulatory upper payment limit (UPL).

Federal statute requires states to take into account the situation of hospitals serving a disproportionate share of low-income patients when designing payment systems and to make additional payments to such hospitals (§§ 1902(a)(13)(A)(iv) and 1923 of the Act).¹² DSH payments are subject to hospital-specific limits equal to the actual cost of uncompensated care to Medicaid enrollees and uninsured individuals, as well as overall state-specific allotments described in Section 1923. In FY 2016, Medicaid made a total of \$19.7 billion in DSH payments (\$8.5 billion in state funds and \$11.2 billion in federal funds).

Federal regulations limit aggregate Medicaid payments to institutional providers, such as hospitals and nursing facilities, to the amount that would have been paid under Medicare payment principles (42 CFR 447). Because base Medicaid payments are typically less than this UPL, states may calculate the difference, and make periodic lump sum payments to some or all providers (e.g., quarterly or annually) as long as aggregate payments are below the UPL.¹² These payments can result in total payments to particular providers that significantly exceed the cost of furnishing Medicaid services. Some states also



make supplemental payments to non-institutional providers, for example, physicians employed by state university hospitals.

Certified public expenditures

A CPE is a funding and payment mechanism by which a public provider makes an expenditure under the state's approved Medicaid state plan. A CPE equals 100 percent of a total computable Medicaid expenditure. The provider is certifying that the initial funds expended are public funds being used to support the full cost of providing the service, and therefore eligible for federal financial participation (FFP). There are currently limited federal requirements regarding CPEs, and the processes for certification vary among states and provider types. CPEs are most commonly used by school districts to certify the cost of providing services to Medicaid-eligible children. In some states CPEs are also used by other public providers including community mental health centers, public health departments, and hospitals.

Since CPEs represent actual expenditures that are eligible for FFP under the approved Medicaid state plan, they must be supported by payment methodologies that recognize the claimed CPEs as expenditures under the plan. Typically, such payment methodologies recognize actual costs, and in those instances CMS requires providers to document the actual cost of providing services, typically determined through a statistically valid time study, cost reporting, and reconciliation (CMS 2009). Providers that use CPEs may still be expected to submit claims so that a state's MMIS can verify eligibility and maintain a record of services provided. However, the format of these informational claims and the level of information that they contain may vary.

Payment for Medicare cost sharing

Providers also may submit claims to state Medicaid programs for payment of the Medicare cost-sharing obligations of individuals enrolled in both Medicare and Medicaid (dually eligible beneficiaries). For dually eligible beneficiaries, Medicaid may be responsible for deductibles and coinsurance payments for Medicare-covered services (for individuals who are not qualified Medicare beneficiaries, only if the services are Medicaid covered services furnished by a Medicaid participating provider). Claims for Medicare cost sharing are commonly referred to as crossover claims as they typically cross over automatically from the Medicare claims processing contractor. Providers may also submit them directly to states. When adjudicating crossover claims, states may either pay the full amount, or pay the lesser of the cost sharing or the difference between the amount Medicaid would have paid for the service and the amount already paid by Medicare (§ 1902(n) of the Act).¹³

Medicaid managed care and care coordination payments

Payment methodologies for Medicaid managed care enrollees may be on a risk or non-risk capitation basis from a state to a contracted managed care entity for a contractually defined benefit package. Capitation payments, typically processed through the MMIS, are made to contracted managed care entities on a periodic basis (usually monthly) for each individual enrolled in the plan regardless of whether or not they actually use services. Individual providers then submit claims to and receive payments from the managed care entities for services covered under managed care through a process very similar to the claims-based FFS payment process between states and providers. States are required to make supplemental payments



for services furnished to managed care enrollees by FQHCs, to ensure that the aggregate payment equals the per visit rate the FQHC would otherwise receive under FFS (§ 1902(bb)(5) of the Act).

States may also make small capitation payments directly to providers (usually primary care providers) in exchange for care coordination services. Providers in these primary care case management programs also continue to submit FFS claims as described earlier.

Post-Payment Review

A variety of post-payment reviews are commonly conducted by state and federal administrators to correct under and overpayments, identify potential fraud and abuse, and support other operational analyses. Providers may also conduct their own post-payment reviews to assure payment accuracy and preempt recovery efforts. If errors are identified, providers can typically correct them through the submission of claim adjustments.

Post-payment review of claims is required by federal regulations, both to identify potential fraud and abuse and to assure appropriate utilization (42 CFR 447.45 and parts 455 and 456). Post payment claims review is also conducted to identify potential TPL that may not have been identified prior to payment. Each state's MMIS is also required to have a surveillance and utilization review subsystem to facilitate the identification and investigation of inappropriate utilization (CMS 2018f).

In addition to system-based post-payment claims review, states are required to have programs in place to manually review certain claims and associated provider documentation to assure proper utilization and payment. Utilization review criteria contained in federal regulations detail specific requirements for review of various medical services including prescription drugs (42 CFR 456). In each of these cases, if overpayments are identified, states seek to recover the overpayments from providers and must return any associated FFP to the federal government. States are also required to establish contracts with Recovery Audit Contractors to identify underpayments and overpayments, and to recoup overpayments on a contingency basis (§1902(a)(42)(B) of the Act).

Federal statute also requires audits of any provider that is reimbursed on a cost-related basis (§ 1902(a)(42) of the Act). Institutional providers, for example, are often paid at rates based upon financial data reported to the state in cost reports. Audits of reported costs can result in changes to a provider's calculated rate, and may trigger recovery or additional payment for all services that were paid at the incorrect rate. There are also cases where providers are paid an interim rate and payments are reconciled upon finalizing cost reports for the period for which the payments were made. In the meantime, interim payments are made and a settlement process occurs once actual costs are finalized.

DSH payments are subject to annual audits required by federal statute (§ 1923(i) of the Act). Audits are required to be conducted by an independent organization and include data regarding individual hospitals' uncompensated care costs as well as total Medicaid payments, including supplemental payments.¹⁴



There are several ways in which overpayments can actually be recovered by a state including through claims adjustments, offsets to future provider payments, or through a direct payment. In all cases where post-payment review results in a potential recovery of overpayments, providers are entitled to an appeals process.

Use of Claims and Other Payment Data for Additional Purposes

Aside from triggering payments, Medicaid claims create a valuable source of information regarding program operations. By documenting the services provided and base amount paid for each service, claims can be used by program administrators and researchers to understand the factors and trends driving program expenditures as well as to identify potential fraud, waste, and abuse. Managed care encounter data, which include a record of services provided to managed care enrollees, can also supplement FFS claims data to provide a more complete picture of the program.

The two primary sources of administrative data regarding Medicaid payments include the CMS-64 and the Medicaid Statistical Information System (MSIS). The CMS-64 is a record of total Medicaid spending that is submitted quarterly by states to CMS for the purpose of claiming FFP. While all payments (including supplemental payments) are included, CMS-64 data are aggregated by payment type and do not provide individual claims-level information. MSIS, on the other hand, is a database of detailed claims-level data that states are required to submit quarterly. It is important to keep in mind, however, that supplemental payments including UPL payments and DSH are not captured within claims data; thus, analysis of MSIS data may not provide a complete picture of total provider payments. Further, analysis of individual services using MSIS is limited by the fact that the data do not currently include complete service level information for Medicaid managed care enrollees. In addition, service-level detail may not be available in MSIS for providers such as FQHCs and RHCs that do not report this level of detail on their claims.

CMS is updating the MSIS data requirements and developing a new data set referred to as the Transformed Medicaid Statistical Information System (T-MSIS). The T-MSIS data set, which will be submitted monthly by each state, contains enhanced information about beneficiary eligibility, beneficiary and provider enrollment, service utilization, claims and managed care data, and expenditure data. The T-MSIS data set is expected to address some of the limitations of the MSIS data set but will not be available for use by program administrators and researchers until 2019.

Endnotes

¹ In certain cases claims may be submitted by providers to entities other than the Medicaid agency (e.g., a mental health agency), which pays the provider directly and then submits its own claims to the Medicaid agency to obtain federal match.

² Historically claims were submitted in hardcopy format and CMS system certification requirements outlined in the *State Medicaid Manual* still require this option (CMS 2018b).



³ As indicated by the CMS *Medicaid Enterprise Certification Toolkit*, “In the absence of Federal certification, Medicaid systems are not authorized to receive enhanced Federal matching funds for their operation” and instead would be subject to the general administrative matching rate of 50 percent.

⁴ The full list of required data elements is contained within the CMS *State Medicaid Manual* at Section 11375.

⁵ For initial implementation of NCCI for Medicaid, edits apply to practitioners, ambulatory surgical centers, outpatient hospitals, and durable medical equipment. CMS plans to explore expanding the list of edits to include additional services (HHS 2011).

⁶ Section 1917(b) of the Social Security Act also requires states to have programs for the recovery of payments (primarily payments for long-term services and supports) from an individual’s estate. This estate recovery process is separate from TPL and the provider payment process.

⁷ Claims that do not require additional information to be adjudicated are commonly known as clean claims. The Social Security Act also allows the Secretary to waive the prompt pay requirement if a state is found to have exercised good faith in trying to meet the requirement.

⁸ In some states, certain services (e.g., dental) may be carved-out from the encounter payment and paid separately on an FFS basis through claims.

⁹ Section 1916(a)(3) of the Social Security Act requires that Medicaid cost-sharing generally be nominal. Also, providers are generally unable to deny services on account of an individual’s inability to pay the cost sharing amount (42 CFR 447.53).

¹⁰ If a person is eligible for Medicaid LTSS based on spend-down, the provider may be paid with out-of-pocket funds until the person has spent-down to Medicaid eligibility, at which point Medicaid begins to pay for services.

¹¹ We use the term public to refer generically to governmentally owned or operated providers that share in the non-federal financing of a state’s Medicaid program through CPEs.

¹² CMS requires states to report the total amount of UPL payments on the CMS-64 and is working with states to improve data accuracy.

¹³ The Balanced Budget Act of 1997 (P.L. 105-33) added this provision.

¹⁴ For additional information regarding DSH audits see Medicaid Disproportionate Share Hospital (DSH) Payments (<https://www.medicaid.gov/medicaid/finance/dsh/index.html>).

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