Federal Requirements and State Options: Provider Payment

States have considerable flexibility to design their own Medicaid payment methods and set their own payment rates (Table 1). States make direct payments to providers under fee-for-services arrangements; they make capitation payments to managed care plans. In addition, states can also make supplemental payments to certain classes of providers. In general, federal statute requires Medicaid provider payments under fee for service to be consistent with the principles of efficiency, economy, and quality of care, and sufficient to provide access to care equivalent to the general population (§ 1902(a)(30)(A) of the Social Security Act (the Act)). In managed care, capitation payments also must be actuarially sound, meaning that they cover reasonable, appropriate, and attainable costs in providing covered services to enrollees in Medicaid managed care programs.

Fee for Service

In fiscal year 2015, the majority of Medicaid benefit spending (54 percent) was under fee for service (MACPAC 2016a). States employ a variety of different methods to establish fee-for-service payment rates for various types of Medicaid services. More details about the specific payment methodologies that states use are available in MACPAC's compendia of Medicaid payment policies for inpatient and outpatient hospital services, physician services, and nursing facilities, and Medicaid payment of Medicare cost sharing.

Inpatient hospital services. As of April 2014, most states (36) paid for inpatient hospital services using diagnosis-related groups (DRGs), a classification system adopted by Medicare in 1983. Under this method, hospitals are paid a fixed amount per discharge, with payments for extraordinarily costly cases, referred to as outlier payments. Ten states paid for inpatient hospital services based on the number of days that a patient was in the hospital (a per diem rate), and 5 states used some other method, such as cost-based reimbursement. In addition, all states make some adjustments to base payment rates for certain types of hospitals (for example, government-owned hospitals, children's hospitals, and critical access hospitals), and across different geographic areas to reflect differences in the underlying cost of care in rural and urban areas. States often adjust payments to account for outlier cases. In addition, states frequently make additional incentive payments to hospitals for activities such as reducing readmission rates, adopting electronic health records, or improving efficiency (MACPAC 2016b).

Outpatient hospital services. As of November 2015, 13 states used a fee schedule, 16 states used a cost-based system, and 19 used a bundled-payment approach to pay for outpatient hospital services. Common types of bundled-payment approaches for outpatient hospital services included ambulatory patient classification (APC) groups, which is a grouping system used by Medicare, and enhanced ambulatory

patient groups (EAPGs), which bundle ancillary and other services that are often provided in the same medical visit. States frequently adjust outpatient hospital payments to account for hospital type, geography, and provision of services out of state. States also may exempt certain types of outpatient services, such as clinical lab services and partial hospitalizations, from the typical methodology used to establish outpatient payments (MACPAC 2016c).

Nursing facility services. As of October 2014, most states (30) paid nursing facilities based on their reported costs. However, 12 states established prices for nursing facilities, which are typically based on the costs for a group of facilities. States often adjust base facility rates according to factors such as acuity or case mix, peer groups, and high-need patients. Many states make incentive payments related to quality of care or efficiency (MACPAC 2016d).

Physician services. As of October 2013, 22 states paid physicians based on the resource-based relative value scale (RBRVS), which is a system that was initially developed for Medicare that assigns a relative value to every physician service based on the complexity of the service, practice expense, and malpractice expense. Seventeen states paid physicians as a percentage of Medicare rates and 10 states had developed a state-specific fee schedule for physician services. States also frequently adjust base payment rates based on factors such as patient age, geography, provider type, and site of service. Incentive payments may be made to physician services that meet quality benchmarks, or for services provided in academic health centers, primary care case management programs, and health homes (MACPAC 2016e).

Federally qualified health center services. States have less flexibility to establish payment rates for federally qualified health centers (FQHCs). Federal statute requires states to pay FQHCs under a prospective payment system (PPS) that established a fixed, per-visit rate based on the health center's costs. States can develop alternative payment methodologies (APMs) for FQHCs, but the APM must pay the health center at least what it would have received under the PPS rate.

Medicaid payment of Medicare cost sharing. For enrollees dually eligible for Medicaid and Medicare, state Medicaid programs can pay the full amount of Medicare cost sharing or the amount that Medicaid would have paid for the same service, if lower. States can establish different policies for different types of Medicaid services, such as hospital, physician, and nursing facility services. As of December 2016, most states (36) paid the lesser of the Medicare cost sharing amount or the amount that Medicaid would have paid for inpatient hospital services; 10 states and the District of Columbia paid the full amount of Medicare cost sharing; and the remaining 4 states adopted another policy that was a combination of these approaches (MACPAC 2017a).

Outpatient prescription drugs

While states are not required to cover outpatient prescription drugs, all of them do, and therefore must pay for outpatient drugs according to federal rules and within limits (42 CFR 447.500-522). Payments for outpatient prescription drugs are affected by rebates that states receive from drug manufacturers and the requirements of the federal Medicaid drug rebate program. Created under the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508), the law ensures that Medicaid receives a net price that is consistent with the lowest or best price for which manufacturers sold the drug (§ 1927(a)(1) of the Act).

Fee-for-service payments to pharmacies reflect two components: 1) an amount to cover the estimated cost of the drug, known as the ingredient cost, and 2) an amount to cover the pharmacist's overhead and services to fill the prescription, known as the dispensing fee. Federal rules require that the ingredient cost reflect pharmacies' actual acquisition cost (AAC) (42 CFR 447.518(a)(2)). States have flexibility to establish their own dispensing fees based on a variety of factors, such as the type of pharmacy, prescription volume, or type of drug. In most states, the dispensing fee is between $2 and $6 per prescription. To ensure that Medicaid is a prudent purchaser of drugs, federal and state policies have instituted upper limits on payment for drugs that have a generic equivalent, known as multiple source drugs. Additionally, a payment limit is applied to all drugs to ensure that Medicaid does not pay more than the price generally available to the public.

In addition to the payments that states make to pharmacies, Medicaid prescription drug spending also reflects rebates that states receive from drug manufacturers. In exchange for federal Medicaid rebates, state Medicaid programs must generally cover a participating manufacturer's drugs although they may limit the use of some drugs through preferred drug lists, prior authorization, or quantity limits. The federal Medicaid rebate is based on a specific formula defined in statute, which means that every state receives the same federal rebate amount for each unit of a particular drug regardless of how much they pay the pharmacy. In addition to the federal rebates, states can negotiate with manufacturers to obtain supplemental rebates for what they determine to be therapeutically equivalent drugs. As of September 2016, most states (46 states and District of Columbia) have negotiated supplemental rebates with drug manufacturers on top of the federal rebates (CMS 2016a).

More information on Medicaid payment and rebates for outpatient prescription drugs is available in MACPAC's issue brief, Medicaid Payment for Outpatient Prescription Drugs.

Supplemental payments

In addition to establishing base payment rates, states often make supplemental payments to providers, which are typically lump-sum payments that are not directly tied to particular services. States are required to make disproportionate share hospital (DSH) supplemental payments to hospitals that serve a high share of Medicaid and low-income patients. In addition, states can also make non-DSH supplemental payments to providers up to the upper payment limit (UPL) of what Medicare would have paid in the aggregate for services provided to a particular class of providers. In determining whether and how much money to allocate to UPL payments, states start by calculating the difference between the UPL for services provided by a class of institutions and the aggregate amount Medicaid paid for those services under fee for service. States then target the amount of the difference—or some portion of it—to a subgroup of institutions, allocating it among eligible institutions based on state-defined criteria that sometimes, but not always, include Medicaid days, visits, or discharges. There are no provider-specific limits, therefore individual providers may receive more than their reported Medicaid costs as long as the aggregate payments to all providers in their class do not exceed the aggregate UPL. (However, payments for inpatient hospital services may not exceed a provider's customary charges to the general public for services.)

States have considerable flexibility to determine which providers are eligible to receive DSH and UPL payments. States can make DSH payments to any hospital that has a Medicaid inpatient utilization rate of

at least 1 percent, a standard which virtually all hospitals meet (MACPAC 2017c). UPL payments can be made to any Medicaid enrolled provider. DSH payments are limited by annual federal allotments to each state. In addition, DSH payments to a hospital cannot exceed the hospital's uncompensated care costs for Medicaid and uninsured patients. In fiscal year 2018, federal DSH allotments are scheduled to be reduced by $2 billion (approximately 17 percent) (MACPAC 2017d).

Additional background about the history of DSH payment policy is included in MACPAC's *Report to Congress on Medicaid Disproportionate Share Hospital Payments* (MACPAC 2016g). Additional information about UPL supplemental payments is included in Chapter 6 of the Commission's March 2014 *Report to the Congress on Medicaid and CHIP,* Examining the Policy Implications of Medicaid Non-Disproportionate Share Hospital Supplemental Payments.

Managed Care

Under Medicaid managed care, states pay Medicaid managed care organizations a capitated payment for each person enrolled in the plan and the plan is responsible for paying providers for the services that an enrollee requires. Capitation for comprehensive managed care plans rates are based on a state's fee-for-service payment rates and are required to be actuarially sound to cover the costs of the services provided.

An actuarially sound payment may cover a small range and states have some flexibility to establish specific capitation rates within this range. For example, states can use an administered-pricing approach and set the payment rates at an amount within the actuarially certified range. The state could choose to pay at the higher end of the range, perhaps to attract multiple managed care plans to a county that offers few choices, or pay at the lower end if there is substantial competition among highly qualified plans. The state could also choose to allow managed care plans to bid within the range and award contracts to health plans that best meet the state's desired combination of attributes and price.

States can also use performance incentives—either withholds from the capitation payments or bonuses on top of the capitation payments—that are contingent on meeting contract requirements or quality thresholds. Federal rules limit payment incentives to no more than 105 percent of the approved capitation rates (42 CFR 438.6(b)). In addition, the contract between the state and managed care plan must specify the time period and measures that will be used for the incentive, which should support the state's overall quality strategy. The incentive cannot be renewed automatically nor conditioned on participation in intergovernmental transfer agreements, and must be available to both public and private contractors. Similar requirements apply to withhold arrangements, although the contracts must ensure that the capitation payment minus any portion of the withhold that is not reasonably achievable remains actuarially sound.

CMS's managed care rate setting regulations were updated in 2016 with a new rule that added to the existing requirements for developing and documenting capitation rates (42 CFR 438.4). States must update the capitation rates and rate certification (including supporting data and documentation) each year and obtain new approval from CMS before the new rates become effective. After the rates have been approved, a state can adjust a rate cell by 1.5 percent up or down without requiring a new approval. This

allows states some flexibility for small programmatic changes. However, if there are significant new developments that have major impacts on actuarial soundness, states must obtain a new federal approval before changing the capitation rates by more than 1.5 percent.

In general, managed care plans are not required to follow Medicaid fee-for-service rules for making Medicaid payments to providers. For example, for outpatient prescription drugs, managed care plans are not required to pay for ingredient costs based on the actual acquisition cost; instead, managed care plans must make payments sufficient to ensure appropriate access for their enrollees (CMS 2016b). One exception is the requirement to pay FQHCs at the PPS rate, which applies equally in managed care and fee for service delivery systems.

Because managed care payments are expected to cover the full costs of services covered under the contract, states cannot make additional non-DSH supplemental payments under Medicaid managed care without a Section 1115 demonstration (discussed below).

Waivers

Some states have sought Section 1115 demonstrations to continue making supplemental payments under managed care, including uncompensated care pools and delivery system reform incentive payments (DSRIP). Uncompensated care pools provide payments for care provided to the uninsured, and DSRIP payments incentivize providers for meeting quality and access milestones. In FY 2015, states made $11.9 billion in Section 1115 waiver authority supplemental payments (MACPAC 2016f).

More information about DSRIP programs, including MACPAC's findings from interviews and site visits of DSRIP programs is available in the first chapter of the Commission's June 2015 *Report to Congress on Medicaid and CHIP* , Using Medicaid Supplemental Payments to Drive Delivery System Reform.

TABLE 1. Federal Requirements and State Options: Summary of State Flexibilities Related to Provider Payment

Types of provider payments	Federal statutory and regulatory requirements	State plan options
Fee-for-service payments	• State payments must be economic, efficient and sufficient to ensure access to care (§ 1902(a)(30)(A)). • State payments for institutional services (hospitals, nursing facilities, etc.) and outpatient and clinic services cannot exceed UPL, that is, a reasonable estimate of what Medicare would have paid in the aggregate (42 CFR 447.272, 42 CFR 447.321). • State payments for clinical diagnostic lab services cannot exceed what Medicare would pay on a per test basis (§ 1903(i)(7)). • States must pay FQHCs a fixed, per visit rate that is similar to Medicare prospective payment system (PPS) rates (§ 1902(bb)). • States must pay tribal health facilities a rate that is specified by the Indian Health Service in order to receive 100 percent federal funding for services provided in tribal health facilities (§§ 1905(b),1911).	• States can establish different payment methodologies, such as paying providers per visit (e.g., per diem payments) or paying providers based on the patient's clinical condition (e.g., DRGs). • States can provide shared savings and quality-based incentive payments (42 CFR 447.200, CMS 2012a, CMS 2012b, CMS 2013). • States can set different payment rates for certain classes of providers as defined by the state (e.g., special payment rates for public or teaching hospitals, rural vs. urban providers) (§ 1902(a)(30)(A)).
Outpatient prescription drugs	• States must pay for outpatient drugs according to federal rules and within limits (42 CFR 447.500–522). Specifically, states typically pay pharmacies the lowest of: – the acquisition cost (estimated or actual) plus	• States can negotiate supplemental rebates with drug manufacturers.

TABLE 1. (continued)

Types of provider payments	Federal statutory and regulatory requirements	State plan options
	dispensing fee; – the Medicaid federal upper limit plus dispensing fee; – the state maximum allowable cost plus dispensing fee; or – the pharmacy's usual and customary charges. • States are eligible for rebates from drug manufacturers based on a specific formula defined in statute (§1927).	
Supplemental payments	• State payments and UPL supplemental payments to hospitals and nursing facilities cannot exceed a reasonable estimate of what Medicare would have paid in the aggregate (42 CFR 447.272, 42 CFR 447.321). • States are required to make DSH payments to hospitals that serve a high share of Medicaid and other low-income patients (referred to as deemed DSH hospitals) (§1923(b)). • DSH payments are limited based on federal DSH allotments (42 CFR 447.298).	• States can determine which providers receive supplemental payments and how much to pay them, within the federal limits (§ 1902(a)(30(A)).

TABLE 1. (continued)

Types of provider payments	Federal statutory and regulatory requirements	State plan options
Managed care payments for services	• State capitation rates to managed care plans are required to be actuarially sound, which means that they are sufficient to cover all reasonable and appropriate costs for the services covered (42 CFR 438.4). • States cannot direct managed care plans to make payments to particular providers (42 CFR 438.6). • For FQHCs and tribal health facilities, states must pay providers the difference between the managed care payment rate and the state's fee-for-service payment rate (§ 1902(bb)(5) and § 1932(h)).	• States can establish specific capitation rates within the range of rates that are certified as actuarially sound. • States can establish performance incentives for managed care plans, such as withholds from the capitation payments or bonuses on top of the capitation payments that are contingent on meeting contract requirements or quality thresholds (42 CFR 438.6(b)). • States can establish minimum fee schedules for providers in managed care (42 CFR 438.6). • State can require that managed care plans participate in quality-based incentive programs (42 CFR 438.6).

Notes: FQHC is federally qualified health center. DSH is disproportionate share hospital. UPL is upper payment limit. DRG is diagnosis-related groups.
Sources: MACPAC analysis of the Social Security Act and the *Code of Federal Regulations*, CMS 2012a, and CMS 2012b.

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