# Medicaid Physician Fee-for-Service Payment Policy

## Overview

Medicaid physician services are defined as covered medical services provided by physicians in a variety of settings, including clinics, community health centers, and private offices. The Medicaid statute also authorizes payment for services provided by other health care professionals, such as certified nurse practitioners and nurse-midwives. In fiscal year (FY) 2015, Medicaid spending on physician and clinical services, as well as other practitioner services was about $70,259 million, or about 14.1 percent of total program spending (MACStats 2016).

States have broad flexibility to determine payments for physician services. MACPAC has documented state-specific methodologies in *State Medicaid Fee-For-Service Physician Payment Policies* (MACPAC 2017).

## Basis of Payment

State Medicaid programs, like Medicare and commercial payers, typically pay physicians and other clinicians using a fee schedule that establishes base payment rates for every covered service. States often apply a variety of adjustments and incentives to the base payment rates, as described below.

### Base payment rates

State Medicaid programs that pay physicians on a direct, fee-for-service basis generally use one of three methods for establishing base payment rates (fee schedules): the resource-based relative value scale (RBRVS), a percentage of Medicare's fee, or a state-developed fee schedule using local factors.

- **RBRVS.** This system, initially developed for the Medicare program, assigns a relative value to every physician procedure based on the complexity of the procedure, practice expense, and malpractice expense. The relative value is multiplied by a fixed conversion factor to determine the amount of payment (i.e., the payment for a procedure with a relative value of 3.0 will be twice the payment for a procedure with a relative value of 1.5). The conversion factor is a fixed dollar amount, such as $50 per relative value unit. With this conversion factor, a provider will be paid $150 for a procedure with a relative value of 3.0. State Medicaid programs can use the relative value units and conversion factors established by Medicare or apply their own conversion factors and then update or change the factors when appropriate. As of November 2016, 23 states used the RBRVS system.

- **Percentage of Medicare.** This system adopts the Medicare fee schedule, which is based on RBRVS, but pays Medicaid providers a fixed percentage of the Medicare amounts. The Medicaid fee schedule in a state would then be updated automatically whenever Medicare adjusts its physician payment amounts. The amount Medicaid pays is typically less than 100 percent of the Medicare amount. As of November 2016, 15 states paid physicians a percentage of the Medicare fee schedule.
- **State-specific factors.** States can develop their own physician fee schedules, typically determined based on market value or an internal process. States may develop fee schedules when there is no Medicare or commercial equivalent or when an alternate payment methodology is necessary for programmatic reasons (e.g., to encourage provider participation in certain geographic areas). As of November 2016, 12 states used local factors to develop physician fee schedules.

## Payment adjustments

States adjust base physician payment rates according to a variety of factors. These include:

- **Provider type.** Some states develop separate fee schedules for primary care physicians, mid-level professionals (e.g., nurse practitioners, physician assistants, or nurse midwives), and specialists. A state may pay mid-level practitioners a percentage of the physician fee schedule, or pay specialists an additional amount for certain services.
- **Geography.** Some states adjust payments for different geographic areas, generally to reflect significant underlying differences in the cost to provide care in rural versus urban areas.
- **Site of service.** States may adjust payment rates to account for the service site (e.g., physician's office or in an institutional facility).
- **Patient age.** States can develop separate fee schedules for adults and children, particularly for physician services for which there is no adult equivalent (e.g., neonatal critical care) or where the pediatric protocols for an office visit are significantly different from adult protocols.
- **Out-of-state providers.** States often choose to pay out-of-state providers the lesser of the state's fee schedule, the provider's billed charges, or some other amount (e.g., the provider's home state Medicaid fee schedule or the Medicare fee schedule).

As of November 2016, all but two states specified some type of adjustment to the base physician fee schedule. The most common adjustments were for advanced practitioners (a provider type) and site of service.

## Additional payment

States may also make incentive or add-on payments to physicians. Common add-on payments include:

- **Health home.** States can offer an incentive or add-on payment for Medicaid physicians practicing in a designated health home (as described in Section 1945 of the Social Security Act). As of November 2016, 23 states made additional payments to providers certified as health homes.

- **Quality or pay-for-performance.** States can offer incentive or pay-for-performance (P4P) payments if a physician meets certain quality benchmarks, such as reductions in emergency department use or compliance with diabetes treatment protocols. As of November 2016, eight states made P4P or quality incentive payments to some physicians.
- **Primary care case management.** Many states have implemented primary care case management (PCCM) programs, in which enrollees are assigned to a primary care provider who receives a small additional payment each month to assume responsibility for coordinating the enrollee's care and assure access. As of November 2016, 22 states had a PCCM program.
- **Academic health center.** Some states make additional payments for professionals practicing in an academic health center to account for the higher average acuity of their patients. As of November 2016, 26 states made an additional payment to professionals practicing in an academic health center.

States may also develop incentives for physicians to promote local goals, which may not fit into any of the above categories. Ten states had other incentive payment policies as of November 2016.

Finally, while Medicaid rules impose many limits on enrollee cost-sharing, states are allowed to require cost sharing for some physician and professional services. Enrollee cost sharing is considered part of the total payment to the provider for the service, although the amount the state pays stays the same, even if the enrollee is not subject to cost sharing or fails to pay it. As of November 2016, 31 states imposed some type of cost sharing on Medicaid physician services.

## Physician Payment Process

In most cases, physician payment is triggered when the provider submits a claim indicating that a service has been provided. There are many state and federal requirements that providers must comply with in order to receive payment for services, including federal regulations (42 CFR 440–456); state statutes and regulations; and billing instructions in state-specific provider manuals. Generally, physicians have discretion in determining which covered services are medically necessary. Some states require that providers or beneficiaries must first obtain prior authorization for certain services, to assure that the service is both covered by the Medicaid program and appropriate for the enrollee who will receive the service. Evidence of the prior authorization must be included on the claim to be eligible for payment.

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

Each claim contains a record of the services provided and these services are reported using billing codes. Physician services are commonly reported using Current Procedural Terminology codes that are developed and maintained by the American Medical Association.

Because the codes reported on a claim may directly affect 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, that is, report codes for more complex procedures that result in higher payment.

A variety of pre- and postpayment reviews are conducted by state and federal administrators to correct under- and overpayments and identify potential fraud and abuse. For physician payments, many payment oversight and review activities focus on provider coding, due to the concerns noted above. Providers may also conduct their own post-payment reviews to assure payment accuracy and preempt recovery efforts and submit claim adjustments if needed to correct errors.

## Payment Policy Issues

Federal rules do not prescribe how physicians should be paid or how much they should be paid, but only require that Medicaid payment policies should promote efficiency, economy, quality, access, and safeguard against unnecessary utilization. While fee schedules are the predominant method of Medicaid physician payment, the basis for each fee schedule varies and there is considerable variation in fees across states. For more information on MACPAC's framework for evaluating provider payment policy, see Chapter 7: A Framework for Evaluating Medicaid's Provider Payment Policy in MACPAC's March 2015 *Report to Congress on Medicaid and CHIP* (MACPAC 2015a).

In developing physician payment policies and fee schedules, states generally try to balance economy (setting payment rates at a reasonable level compared to costs) with access (implementing payment policies that attract sufficient numbers of providers or providing additional payments to promote access to certain provider types). States are increasingly seeking to incorporate quality incentives into physician payment arrangements, including incentives for participation in a health home or P4P payments for meeting quality benchmarks.

Congress included a temporary exception to these rules in the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended), which required states to pay Medicare rates for certain primary care services in 2013 and 2014 when they were furnished by primary care physicians. For more information, see *An Update on the Medicaid Primary Care Payment Increase* (MACPAC 2015b).

The temporary increase in physician payment rates was provided in part because Medicaid fee-for-service (FFS) payment rates for physician services are often much lower than those paid by other payers, raising concerns that low fees affect physician participation in Medicaid, and thus access to care (Decker 2012, Cunningham and May 2006). On average, Medicaid FFS physician payment rates are two-thirds of the rates Medicare pays, although this varies greatly by state and service. While other factors, such as administrative burden, are also known to affect physician participation, research has consistently shown an association between low payment rates (relative to other payers) and lower levels of physician participation.

Providers often question the adequacy of Medicaid payments, particularly when states reduce rates. In some cases, physicians and other providers have contested payment reductions in federal court. However, on March 31, 2015, the U.S. Supreme Court precluded future lawsuits when it decided that that Medicaid

providers do not have the right to sue Medicaid agencies regarding payment rates under the Supremacy Clause of the Constitution or under 1902(a)(30)(A) of the Social Security Act.[1]

On January 4, 2016, the Centers for Medicare & Medicaid Services implemented new regulations that created a standardized, transparent process for states to follow prior to proposing Medicaid provider payment rate reductions or changes in the provider payment structure for services provided on a fee-for-service basis (42 CFR 447). States are now required to consider input from providers, beneficiaries, and other stakeholders when evaluating the potential impacts of rate changes. In addition, states need to analyze the effect that rate changes may have on beneficiary access to care and then monitor the effects for at least three years after the changes are effective.

## Endnotes

[1] *Armstrong v. Exceptional Child Center, Inc.*,135 S. Ct. 1378 (2015)

## References

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