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Medicaid Reimbursement Policy

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Summary

Under Medicaid law, states have considerable freedom to develop their own methods and standards for reimbursement of Medicaid services. Congress has periodically intervened to modify the broad guidelines within which states operate, and the Centers for Medicare and Medicaid Services (CMS) has used its regulatory authority to restrict certain state practices. Actual payment methodologies, however, are still left largely to the discretion of the states.

Medicaid reimbursement policies play a central role in determining whether beneficiaries have access to services of adequate quality, as well as the nature of the services they receive. Because some providers, such as "safety-net" hospitals and clinics and nursing facilities are heavily dependent on Medicaid funding, payment levels can have broad effects on the delivery system and community access to care. In addition, because Medicaid is a major component of state and federal spending, decisions about reimbursement policies can have significant budgetary effects.

For both hospitals and nursing homes, Medicaid payment rates in many states are below the actual costs facilities incur in providing care to Medicaid patients. Payment rates for other kinds of providers, such as physicians or dentists, cannot be directly compared to costs; however, Medicaid is often paying less for comparable services than Medicare or private insurers. Medicaid payment shortfalls have a variety of possible consequences. Providers may engage in "cost-shifting," raising charges to private payers to make up their losses. In addition, the need to subsidize Medicaid patients may reduce their ability to fund care for people with no coverage at all. Some providers may adopt cost-cutting measures that potentially affect quality. Others may refuse to accept Medicaid patients or limit the number they will treat, since Medicaid law has no requirement prohibiting providers from doing so.

This report provides a snapshot captured primarily through state plan amendments approved through November 2002, of the methods states use to establish payment rates for most major types of providers serving Medicaid clients. It also explores some of the critical issues affecting Medicaid payments rate setting. Where available, Medicaid rates are compared to other payers such as Medicare and private insurance. This report will not be updated.

To assist Congress to review policy alternatives and understand the current status of Medicaid programs, the Congressional Research Service (CRS) is producing a series of reports on various aspects of Medicaid. This report is one in that series. This series will address Medicaid programs and policies comprehensively by covering background subjects including eligibility policy, benefits, and delivery systems and demonstration projects as well as analytic reports such as Medicaid's role for low-income individuals, long-term care, and dual eligibles. Each of the reports includes a discussion of current issues, background information, data and analysis.

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Introduction

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Medicaid reimbursement policies play a central role in determining whether beneficiaries have access to services of adequate quality, as well as the nature of the services they receive. In addition, because some providers — such as "safety-net" hospitals and clinics and nursing facilities — are heavily dependent on Medicaid funding, payment levels can have broader effects on the delivery system and community access to care. Finally, because Medicaid is a major component of state and federal spending, decisions about reimbursement policies can have significant budgetary effects.

Organization of This Report

This report[1] begins with a summary of basic federal requirements applicable to payments for all services and an overview of major developments in federal Medicaid reimbursement policy over the last 20 years. This overview provides a historical context for current policies and highlights some issues that have been perennial concerns for federal and state policymakers.

The next four sections of the report provide a detailed discussion of Medicaid reimbursement for four basic categories of services or providers:

- Acute care, including hospital inpatient and outpatient services, services of physicians and dentists, and services of certain federally defined categories of health centers and clinics;
- Long-term care, including care in nursing facilities, intermediate care facilities for the mentally retarded (ICFs-MR), and home and community-based care;
- Managed care organizations (MCOs), which accept financial responsibility for a range of covered services in return for a fixed monthly payment per Medicaid enrollee; and
- Prescription drugs.

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[1] The CRS project liaison for this report is Jean Hearne, Specialist in Social Legislation in the Domestic Social Policy Division. She can be reached at extension 7-7362.

For each service type, these sections summarize states' payment methodologies, review current or recent policy issues, and, to the extent data are available, compare Medicaid payments to providers' costs or to payments by other third parties.

The final section of the report describes special federal payment rules for some specific classes of providers and explains how Medicaid payments coordinate with Medicare for individuals eligible for benefits under both programs.

Use of State Plan Documents

Most of the state-by-state comparisons of payment methodologies in this report are based on Medicaid state plans and state plan amendments (SPAs). The state plan for medical assistance is the basic document each state initially submitted in order to obtain approval of its Medicaid program. Major policy changes are reflected in SPAs that must also be approved by CMS. SPAs can be approved retroactively, meaning that a state can implement a policy before CMS has acted on its submission (at the risk of a denial of federal funding if the SPA is ultimately disapproved).

CMS maintains a database of state plans and SPA documents on its Web site.[2] Full state plans were captured in late 2000, with subsequent plan amendments added to the database as approved. SPAs reviewed for this document include all those approved through November 7, 2002. What this report provides, then, is a snapshot of payment methodologies under each state plan as approved on that date. These will not necessarily be the methodologies actually in use in November 2002, because approval of amendments can be retroactive.

Some state plan documents relating to reimbursement methods are lengthy and complex, and some states have filed numerous SPAs that repeatedly modify the same sections of the plan. While every effort has been made to track the changes and identify the most current approved policy, there are undoubtedly errors or omissions. In a very few cases, it was impossible to ascertain a state's policy for a particular service from the state plan, and state regulations or other documents were consulted. In these cases, which are identified in notes to the tables, the policy described may be the one in effect at the time the state documents were obtained, rather than in November 2002.

Overview

Basic Federal Rules

Three basic federal statutory requirements apply to payment for all types of services.

- Methods and procedures for making payments must be such as to assure that payments are "consistent with efficiency, economy, and quality of care."

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[2] The database can be accessed at [http://www.cms.hhs.gov/medicaid/stateplans].

CMS relies on this provision as a general authority to regulate state reimbursement methodologies. In particular, this provision is the basis for the upper payment limit (UPL) regulations, which require that Medicaid payments for a class of institutional providers not exceed, in the aggregate, the amount that would have been paid for comparable services under Medicare principles. Recent revisions in the UPL rules have had a major effect on state finances; this issue is discussed further below.

- Payments must be "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 explicitly connects the level of Medicaid payment rates with the willingness of providers to serve Medicaid beneficiaries. While payment levels are not the only factor affecting provider participation, there has been a tension between cost containment and access to care throughout the history of Medicaid.

- Providers must accept Medicaid reimbursement as payment in full, except for any beneficiary cost-sharing amounts provided for by the state plan or any amount due from a medically needy beneficiary with a spend-down liability.[3]

This means that a provider cannot bill a beneficiary when Medicaid's allowed payment is less than the provider's charge for a service. In contrast, Medicare allows limited balance billing by physicians and some other providers. Private insurance rules vary; plans with networks commonly restrict balance billing by network providers and permit it for out-of-network services.

There is an additional set of basic rules for payment of institutional services, including hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICFs-MR). Rates must be determined through a public process. States must publish proposed and final rates, including justifications and underlying methodologies; and providers, beneficiaries, and the public must be given an opportunity to comment.

Beyond these general rules, actual payment requirements or methodologies are prescribed by law for only a few types of providers, such as disproportionate share hospitals (DSHs, those serving a high proportion of low-income patients), federally qualified health centers (FQHCs, which are Public Health Service grantees and similar entities), and hospices. There are also specific rules relating to payment for prescription drugs. All of these rules are described in later sections of this report.

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[3] A Medicaid applicant who is in a state providing optional coverage of the medically needy population and whose income or resources exceed the limits established by the state may "spend down" to eligibility by using the excess funds to pay medical bills.

Major Policy Developments, 1980-2003

Over time, federal Medicaid reimbursement policy has focused on different, and sometimes conflicting, policy goals, such as cost containment, state flexibility, and access to care. Congress has set specific minimum or maximum levels of reimbursement for some types of services, while providing only general guidelines for others. It has sought to foreclose some payment schemes that have the effect of shifting financial burdens from states to the federal government. It has acted to protect some specific classes of providers, while enhancing states' ability to bargain with others.

This section provides a brief overview of major developments in Medicaid reimbursement policy over the last two decades. It is not meant to be a legislative history, but merely to highlight key issues and some of the shifts in congressional priorities and concerns.

The Boren Amendment

Until 1980, state Medicaid programs were required to follow Medicare reimbursement principles in paying institutional providers — hospitals and nursing facilities. Under the Medicare rules in effect at that time, this meant that states were required to use a retrospective reasonable cost system. States continued to have to assure that rates provided access to care. Payment amounts were determined after services were rendered and were based on the actual costs incurred by the provider in furnishing those services. In what is known as the "Boren amendment," the Omnibus Reconciliation Act of 1980 (P.L. 96-499) repealed this requirement for nursing facility services, freeing states to establish new methodologies of their own. The Omnibus Budget Reconciliation Act of 1981 (OBRA 81, P.L. 97-35) applied the amendment to inpatient hospital services.

The new rules provided simply that payment rates for hospitals and nursing facilities had to be "reasonable and adequate" to meet the costs of "efficiently and economically operated" facilities. For hospitals, the law also required payment adjustments for disproportionate share hospitals (DSHs). Nearly all states responded to the new flexibility by shifting from retrospective to prospective payment systems for both hospital and nursing facility services. Under prospective payment systems, rates may be set in advance and may not be related to the actual costs providers incur in furnishing services; or the state may set ceilings and pay the lesser of actual costs or the ceiling amount. States' interest in these systems stemmed from concerns that providers paid on a full cost basis had no incentive to perform efficiently and might furnish unnecessary services.

While the Boren amendment gave states the flexibility to develop new payment systems, it also established a benchmark against which those systems were to be measured: the state was required to find, and to provide assurances satisfactory to the Secretary, that its Medicaid rates were reasonable and adequate. In 1990, the Supreme Court affirmed that facilities had a right to seek judicial review of the reasonableness and adequacy of Medicaid rates (*Wilder v. Virginia Hospital Association*, 496 U.S. 498, 1990). The Wilder decision merely settled the question

of whether the Boren amendment conferred rights on providers that could be enforced in court. Even before this decision, hospitals in some states had obtained court judgments that Medicaid payments were inadequate. Following Wilder, numerous states faced suits by hospitals and nursing homes. Congress ultimately responded by repealing the "reasonable and adequate" test in the Balanced Budget Act of 1997 (BBA, P.L. 105-34). Some hospitals have continued to file suits, relying on the requirement, still in the statute, that payments for all types of providers be sufficient to assure access to care.

OBRA 81 Waivers

OBRA 81 authorized the Secretary to waive specified requirements of Medicaid law so that states could operate innovative service programs. Two types of waivers were originally permitted: Section 1915(b) freedom-of-choice waivers, under which states could require beneficiaries to obtain services through a primary care case manager or a managed care plan, or from a limited set of contracting providers; and Section 1915(c) home and community-based services waivers, under which states could provide special services (generally non-medical personal care and supportive services) to limited populations of beneficiaries who would otherwise need institutional care.[4] Both types of waivers require periodic CMS approval and are subject to cost-effectiveness tests. Congress has since authorized several other waiver options.

A number of states have used Section 1915(b) freedom-of-choice waivers to operate selective contracting systems, under which beneficiaries needing a specified service are restricted to a limited set of providers whose payment rates are established by bidding or negotiation. **Table 1** lists the selective contracting programs in effect as of September 2003.

[4] The waivers are commonly referred to by the sections of the Social Security Act that set rules for them.

Table 1. Selective Contracting Waivers, 2003

State	Service
Arkansas	Non-emergency transportation
California	Inpatient hospital
Florida	Non-emergency transportation
Georgia	Non-emergency transportation
Kentucky	Non-emergency transportation
Louisiana	Mail order pharmacy[a]
New York	Non-emergency transportation
Oregon	Non-emergency transportation
Texas	Inpatient hospital, psychiatric hospital
Utah	Non-emergency transportation
Washington	Inpatient hospital

Source: CMS descriptions of waiver programs, available at [http://www.cms.hhs.gov/medicaid/waivers/waivermap.asp.]

a. Asthma and diabetes pharmaceuticals and supplies.

Every state except Arizona has one or more home and community-based programs, serving the aged, persons with disabilities, and/or persons with mental retardation or developmental disabilities. Payment for waiver services is discussed later in this report.

Prescription Drug Rebates

Medicaid programs are major purchasers of prescription drugs, chiefly because of their role in providing drug coverage to low-income aged and disabled people. Other large-volume purchasers, such as private insurers, pharmaceutical benefit managers (PBMs), and hospital buying groups, often get substantial discounts or rebates from drug manufacturers. To assure that Medicaid programs received similar benefits, the Omnibus Budget Reconciliation Act of 1990 (OBRA 90, P.L. 101-508) required manufacturers to give rebates to states for drugs paid for by Medicaid. The rebate formulas are designed to assure that states pay the lowest price offered by the manufacturer to any other high-volume purchaser. In return, the state must generally cover all the drugs marketed by the manufacturer.

There is ongoing debate over how the rebates are calculated and whether Medicaid programs really are getting the "best price." Rebates reduced Medicaid drug spending by 20% in 2001.[5] Still, spending for drugs is one of the fastest growing components of Medicaid budgets. Restricting drug spending has been a major focus of recent state cost containment efforts (see the last part of this section).

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[5] See **Table 37**.

Disproportionate Share Hospital (DSH) Payments, Provider Donations, and Provider Taxes

In response to the 1981 requirement that hospital payment systems take account of the situation of DSHs, some states developed plans to make supplemental payments to these hospitals. These plans potentially conflicted with the Secretary's regulation capping aggregate Medicaid reimbursement at Medicare levels. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272) prohibited the Secretary from limiting states' payment adjustments to DSHs. Until 1987, states were free to establish their own criteria for classifying facilities as DSHs and to develop their own reimbursement methods for these hospitals. The Omnibus Budget Reconciliation Act of 1987 (OBRA 87, P.L. 100-203) defined certain facilities that states had to designate as DSHs and set minimum payment requirements for them. These requirements, which have since been amended several times, are described in the discussion of inpatient hospital reimbursement, below.

The COBRA provision that prohibited the Secretary from limiting DSH payments meant that these were the only Medicaid payments not subject to any form of upper limit. Beginning in the late 1980s states began to exploit this loophole by developing various financing schemes intended to draw extra federal matching funds. A state might make an extra payment to a hospital, claim federal matching, and then recapture part or all of the payment by taxing the hospital. Alternatively, the hospital might agree to donate part of the extra payment to the state. Or, in the case of a hospital operated by state or local government, the money could be recovered through an intergovernmental transfer — a transfer of funds from another state agency to the Medicaid program or from local government to the state.

Table 2 illustrates how a typical provider tax or donation program might work in a state whose federal matching percentage was 60%. The state pays the hospital $100. The state reports the payment to CMS and receives $60 in federal matching funds. The hospital gives back $80 — either as a donation or because the state imposes a "provider-specific" tax on its payments. The hospital is still ahead by $20, and the state has gained $40 to spend on other Medicaid services or simply absorb into its general fund. A state could potentially operate its entire Medicaid program with no actual state expenditures.

Table 2. Effect of a Typical Provider Donation or Tax Program

(state with 60% federal matching rate)

	State government	Hospital	Federal government
State pays hospital $100	$ (100)	$100	
State reports payment to CMS, receiving matching fund	$60		$(60)
Hospital donation or tax paid to state	$80	$(80)	
Net gain/loss (sum of transactions one to three)	$40	$20	$(60)

Source: Congressional Research Service.

While these schemes could be used with any kind of provider payment, the use of the DSH loophole was attractive because the state could pay (and then recover)

any amount at all. DSH payments rose from an estimated $569 million in 1989 to a projected $8 billion, or 12% of total Medicaid spending, by 1992.

The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) prohibited the use of most provider donations and phased out the use of provider taxes that were not "broad-based" — that is, taxes that were levied against a provider's Medicaid receipts and not receipts from other sources. The Act did not restrict the use of intergovernmental transfers, on the grounds that the federal government had no authority to regulate these arrangements, but instead sought to limit potential federal exposure by capping the total amount of DSH payments.

Beginning in 1992, national aggregate DSH payment adjustments during each fiscal year were limited to 12% of total Medicaid spending for that year. "High DSH" states, those whose payments were already above the 12% limit, were allowed to increase their payments by no more than the projected growth in their overall Medicaid spending. Other states were allowed larger increases, with each state receiving an allocation calculated to assure that aggregate national payments did not exceed the national cap. The BBA replaced this system of calculating DSH limits with fixed annual limits for each state. These limits, and subsequent amendments, are described in the discussion of inpatient hospital reimbursement, below.

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93, P.L. 103-66) further limited DSH payments by capping payments to any single facility. The sum of regular and DSH payments to a hospital could not exceed the sum of the hospital's costs for treating Medicaid beneficiaries and uninsured patients.

Growth in Managed Care

States have been contracting with health maintenance organizations (HMOs) or similar prepaid capitated plans to enroll Medicaid beneficiaries since the late 1960s.[6] OBRA 81 made it easier for states to enter into these contracts and also authorized a different form of managed care, primary care case management (PCCM). Under these programs, beneficiaries' services were still paid on a fee-for-service basis, but were coordinated by a primary care physician. Using a freedom-of-choice waiver, states could require beneficiaries to participate in PCCM or to choose between PCCM and a prepaid plan. Enrollment in managed care arrangements grew steadily through the 1980s and early 1990s.

By 1996, 40% of beneficiaries received at least some services through some form of managed care.[7] The BBA gave states greater flexibility to contract with health maintenance organizations (HMOs) or similar managed care organizations (MCOs) and to require beneficiaries to enroll in these plans or PCCM programs

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[6] Capitated plans receive a fixed per capita payment (usually monthly), in exchange for which they accept financial risk for providing a defined scope of services to each enrolled beneficiary.

[7] CMS, *Managed Care Trends*, 1991-1996, at [http://www.cms.hhs.gov/medicaid/managedcare/trends1.asp] as of Sept. 2003.

without a waiver. By mid-2002, the proportion of beneficiaries in some form of managed care had reached 58%.

Table 3 gives Medicaid enrollment figures as of June 2002. Forty percent of enrollees were in some form of full-risk arrangement; that is, a capitated plan provided their basic Medicaid services. Another 14% were in PCCM programs, receiving care on a fee-for-service basis, while 25% were in prepaid health plans, almost all of which provide only one type of service, such as behavioral health care, dental care, or non-emergency transportation. (Note that enrollees in these special plans can also be in an MCO or PCCM program.) In sum, then, 60% of beneficiaries were still receiving most or all of their services on a fee-for-service basis.

Table 3. Medicaid Beneficiaries and Medicaid Managed Care Arrangements, June 2002

	Beneficiaries (thousands)	Percentage
Full-risk arrangements	16,168	40.2
Commercial MCO	9,734	24.2
Medicaid-only MCO	5,723	14.2
Health insuring organization	511	1.3
PACE and other	199	0.5
Primary care case management	5,615	14.0
Prepaid health plan	10,166	25.3
No managed care	17,030	42.4
Total	**40,175**	

Source: *CMS, Managed Care Enrollment by Program Type,* June 30, 2002, at [http://www.cms.hhs.gov/medicaid/managedcare/plansum2.pdf], as of Sept. 2003.

Notes: This table provides *duplicated* figures by plan type. The total number of enrollees includes 8,830,530 individuals who were enrolled in more than one managed care plan.

PACE stands for programs of all-inclusive care for the elderly. Under the PACE programs, Medicare and state Medicaid programs make integrated capitation payments for preventive, acute and long-term care services to MCO-like organizations that furnish services to frail elderly people.

Upper Payment Limits (UPLs)

Since the 1970s, federal regulations have required that total Medicaid payments for a service type, such as hospital or nursing facility services, could not exceed the amount that would have been spent for the same services under Medicare reimbursement principles. The UPLs originally applied in the aggregate; a state could, for example, pay one hospital more than Medicare would have paid and another hospital less, so long as total payments did not exceed the limit.

After the use of provider taxes and donations was limited in 1991, states could still recover Medicaid payments made to governmental providers through intergovernmental transfers. States' ability to use these mechanisms was limited by the cap on total DSH payments and on DSH payments to any one facility. However, states found that they could draw extra Federal matching funds by exploiting the fact that UPL limits were aggregate rather than facility-specific.

Table 4 illustrates how what came to be known as "enhanced payment" programs worked. Private hospitals have actual costs of $80 million, while county-owned hospitals have costs of $20 million. The state pays private hospitals 80% of their costs, or $64 million, meaning that it can pay the county hospitals $36 million and still be within the aggregate UPL of $100 million. (The shortfall in payments to the private hospitals might be made up through DSH payments, which do not count toward the UPL.) The state claims $60 million in federal reimbursement, and the county hospitals return the excess payment to the state. While the state has nominally spent $40 million on hospital services, it has actually spent only $24 million, while the county hospitals have been paid their full costs. The federal government has spent $60 million to the state's $24 million; in effect, the federal share of hospital spending is 71% instead of 60%.

Table 4. Typical Enhanced Payment Program

(state with 60% federal matching rate; millions of dollars)

	Cost under Medicare principles	Medicaid payments	Federal matching	Nominal state spending	Intergovernmental transfer	Net state spending
Private hospitals	$80	$64	$38.4	$25.6		$25.6
County hospitals	$20	$36	$21.6	$14.4	$16.0	$(1.6)
Total	**$100**	**$100**	**60.0**	**40.0**		**$24.0**

Source: Congressional Research Service.

By FY2000, 28 states had adopted enhanced payment programs, making an estimated $10.3 billion in extra payments to hospitals, nursing facilities, and, in one state, community mental health centers. The DHHS Office of the Inspector General estimated that states were drawing $5.8 billion in excess federal matching payments through these programs.[8]

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA, P.L. 106-554) required the Secretary to adopt a new regulation that would establish three separate UPLs for each category of institutional care (hospital, nursing facility, ICF-MR, and clinic): one for state facilities, one for private facilities, and one for non-state governmental facilities.[9] The Act specified that there was to be a five-year transition period for programs operating under a state plan or state plan amendment approved or in effect before October 1, 1992.

In January 2001, the Clinton Administration published a final rule that limited payments to 100% of the UPLs for state and private facilities and 150% for non-state

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[8] U.S. Department of Health and Human Services (HHS), Office of the Inspector General, *Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers*, A-03-00-002 16, Sept. 2001.

[9] A separate UPL for state facilities had been established by regulation in 1987, but private and non-state public facilities had been left under a single UPL, allowing for programs like the one illustrated.

governmental facilities. To lessen the fiscal shock to states that had become dependent on the extra Federal matching, states making payments above the 150% limit were allowed a transition period to phase down to the limit. The length of the phase-down depended on when the state had adopted its plan. (**Table 5** reflects modifications in the transition periods adopted in a final rule published in September 2001.)

Table 5. Transition Periods for Compliance with Upper Payment Limits

	Group 1A	Group 1B	Group 2	Group 3
Group definition	Plan effective on or after October 1, 1999 and approved before January 22, 2001	Plan effective on or after October 1, 1999, submitted before March 13, 2001, and approved on or after January 22, 2001	Approved plan effective after October 1, 1992 and before October 1, 1999	Approved plan effective on or before October 1, 1992
Base period for determining amount of excess payments that must be phased out	**State fiscal year 2000**			
When phase-out begin	March 13, 2001		SFY2003	First state fiscal year that begins after September 30, 2002, i.e., SFY2003 or SFY2004
Percentage reduction in excess payments each year of the phase-out	Not specified; states must be in compliance by end of phase-out period		Excess payments must be reduced in 25% increments over each of four years SFY2003-SFY2006	Excess payments must be reduced in 15% increments over each of five years SFY2004-SFY2008[a], plus 15% reduction for the portion of SFY2009 occurring before October 1,2008 with the final 10% reduction achieved as of October 1, 2008
When phase-out ends — date by which full compliance with UPLs is required	September 30, 2002	November 5, 2001 or one year from effective date of plan, whichever is later	End of SFY 2006	September 30, 2008

Source: CRS Report RL31021, *Medicaid Upper Payment Limits and Intergovernmental Transfers: Current Issues and Recent Regulatory and Legislative Action*, by Elicia Herz.

a. This schedule applies to states that begin the phase-out in SFY2004. For states that begin the phase-out in SFY2003, the schedule is modified accordingly (i.e., the process begins in SFY2003). See row labeled "when phase-out begins."

In January 2002, the Bush Administration issued a new final rule that reduced the UPL for non-state governmental facilities to the same 100% applicable to state and private facilities. The transition periods for states paying above 150% were modified only slightly, except that they now had to reach 100% instead of 150% by the end of the period — meaning larger cuts in payments and federal matching at each step. (States that were paying more than 100% but less than 150% of the UPL were allowed no transition to bring their payments within the 100% limits.) The change was projected to save $9 billion in federal funds for FY2002-FY2006.

Table 6 shows CMS's preliminary analysis of state enhanced payment programs and their phase-out periods, as of January 22, 2004.

Table 6. State Enhanced Payment Programs by Provider Type and Preliminary Transition Period in Years

(as of January 22, 2004)

	Inpatient hospital	Outpatient hospital	Nursing facility
Alabama	5[a]	5[a]	5[a]
Alaska	2		
Arkansas		2	
California	8		
Georgia	5[a]		
Illinois	8	8	
Iowa			2
Kansas			2
Louisiana			2
Michigan		1, 5[b]	5
Missouri	1		2
Nebraska			8
New Hampshire			5
New Jersey			2
New York			5
North Dakota			5
Oregon			5
Pennsylvania			8
South Dakota			2
Tennessee			2
Virginia			1
Washington	1		5
Wisconsin			2,8[b]
Programs	7	5	19

Source: CMS communication to the Congressional Research Service (CRS), Feb. 17, 2004.

Note: One and two-year transition periods have expired.

a. May not qualify for a transition period.
b. Two programs with different phase-outs.

State Fiscal Problems and Medicaid Cost Containment

Because of revenue shortfalls resulting from the economic downturn and rising spending pressures, most states have faced serious budget imbalances beginning in FY2002. They have responded by cutting expenditure growth, raising revenues, and drawing on reserve funds. For FY2004, two-thirds of states plan expenditure increases of less than 5%, and 19 plan to spend less in FY2004 than in FY2003.[10]

A recent survey has found that every state and the District of Columbia took some measures to control Medicaid spending growth in FY2003 and that each plans further measures for FY2004. **Table 7** shows the types of cost containment measures implemented in FY2002 and FY2003 and planned for FY2004. Nearly every state has reduced or frozen payment rates for some types of providers. Most have also acted to control prescription drug spending; as will be discussed in the section on drug payment, below, these measures have not always involved changes in payment methods. States have so far been slightly less likely to drop coverage of beneficiaries, reduce benefits, or increase copayments paid by beneficiaries for services.

Table 7. Number of States Undertaking Medicaid Cost Containment Strategies, FY2002-FY2004

	FY2002	FY2003	Planned FY2004
Controlling drug costs	32	46	44
Reducing/ freezing provider payment	22	50	49
Reducing/restricting eligibility	8	25	18
Reducing benefits	9	18	20
Increasing copayments	4	17	21

Source: V. Smith, et al., *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004*, Kaiser Commission on Medicaid and the Uninsured, 2003.

Table 8 shows the major service types for which states plan rate changes for FY2004. States are more likely to freeze or decrease payments to hospitals and physicians, and more likely to increase payments for nursing homes and MCOs. In the case of nursing home rates, the survey authors note that some states have statutory requirements for annual inflation increases. Another possible factor is that

[10] National Governors Association and National Association of State Budget Officers, *The Fiscal Survey of States 2003*, June 2003.

nursing homes and MCOs with Medicaid contracts may rely much more heavily on Medicaid than other providers and may be unable to cost-shift to other purchasers.

Table 8. Number of States Planning Rate Changes for Selected Services, FY2004

	Increase	Freeze	Decrease
Hospitals	19	22	10
Physicians	11	35	3
Nursing homes	29	13	6
Managed care organizations (MCOs)	20	14	5
Any of these	37	47	22

Source: V. Smith, et al., *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004*, Kaiser Commission on Medicaid and the Uninsured, (Washington, 2003).

It should be emphasized that the information in this report generally reflects payment methods and payment levels in effect before most states faced budget shortfalls. Many states that improved their provider payments during periods of economic growth may now have cut back. General payment methodologies — how states decide the relative amounts paid to different providers for different services — may or may not have been affected. However, states that have not changed methodologies may achieve savings by imposing uniform cuts, or simply by granting rate increases below the rate of inflation in the cost of goods and services providers must buy. Therefore, the discussions in this report of the adequacy of Medicaid payment to assure access or quality may not reflect current conditions.

Acute Care

Hospital Services

Medicaid payments for hospital services take three forms:

- Payments for services to individual inpatients and outpatients,
- Lump-sum disproportionate share hospital (DSH) payment adjustments, and
- In states with UPL plans, additional lump sum distributions.

In FY2001, DSH payments made up close to one-third of all direct payments to general or community hospitals (including inpatient and outpatient payments), and half of payments to inpatient psychiatric facilities. (See **Table 13**) Comparable figures for UPL plans are not available. However, the HHS Office of the Inspector General estimated that total UPL payments to hospitals for inpatient and outpatient services were about $4.5 billion in FY2000. This would have been 14% of total inpatient non-DSH and outpatient spending in that year.

This section describes states' basic methodologies for establishing payments for individual inpatients and outpatients. It then summarizes current rules relating to DSH and UPL payments and provides data on the size and distribution of these payments. Finally, it reviews available evidence on the extent to which Medicaid payments meet hospitals' costs for Medicaid beneficiaries, as well as whether DSH or UPL supplements help hospitals that treat uninsured patients.

Inpatient Payment Methods

All states now use some form of prospective system as their basic method for setting inpatient hospital payments. That is, payment amounts per day or per case are fixed at the start of a year and are generally not subject to retrospective adjustment on the basis of actual costs incurred. States may establish a different rate for each participating hospital, may use one rate for all hospitals in a defined peer group, or may have one statewide rate. Two-thirds of the states have adopted some form of case mix adjustment, under which reimbursement varies according to the intensity of services required or the expected resources used by each individual patient. These adjustments, discussed further below, can be applied regardless of the state's method for setting basic rates.

Some states' systems allow additional reimbursement for "outliers," patients whose costs or length of inpatient stay are significantly higher than the average for comparable patients. Medicaid law requires states with prospective systems — effectively all states now — to make outlier adjustments for high-cost or long-staying infants under one year old in any hospital, and for children under six in a DSH hospital.[11]

Table 9, based on an analysis of state Medicaid plans, shows the method in use and approved by CMS as of November 2002. The table classes states according to whether hospitals receive hospital-specific rates, receive rates set for a whole group of hospitals or for all hospitals in the state, or are paid under some other method. For states using some form of case mix adjustment, the table indicates the method. Finally, where applicable, it identifies the facility characteristics states use in establishing peer groups of hospitals.

Several general points about the table and the accompanying discussion should be noted:

- The systems described in the table and in the following discussion are those used for most acute general hospitals in the state. States may use different modes of payment for particular classes of facilities. For example, states may use prospective payment for acute general hospitals and a reasonable cost system for psychiatric, rehabilitation, or other specialized hospitals. Some general hospitals — for example, those that are state-owned, or small hospitals in rural areas — may receive special treatment. In addition, states that

[11] The provision, in Section 1902(s) of the Social Security Act, also prohibits imposition for such cases of any day limit or (for infants) any dollar limit in the state plan.

negotiate rates with preferred providers under a selective contracting system may have a separate payment methodology for emergency or other services obtained outside that system.

- Many states that use peer-group or statewide payment systems provide hospital-specific add-ons for certain categories of costs, such as capital costs (interest, depreciation, and other costs related to owning a physical facility) and graduate medical education costs (costs directly or indirectly related to training residents).
- In two states, Arizona and Tennessee, nearly all beneficiaries are enrolled in MCOs, and some other states have very high rates of MCO enrollment. The methods shown are for cases in which the state pays a hospital directly (for example, because a beneficiary is in an aid category exempt from MCO enrollment), not the methods used by MCOs in paying their contracting hospitals.

Table 9. Basic Payment Methodology, Inpatient Hospital Services, 2002

State	Basic payment methodology							Method of case mix adjustment (if any)	Facility characteristics used to define peer groups	Notes
	Hospital specific rate				Peer group or statewide rate					
	Subject to rate of increase limits only	Subject to peer group ceiling	Subject to statewide ceiling	Blend of hospital-specific and statewide rate	Peer group rate	Statewide rate	Other payment method			
Alabama							Selective contracting			Regional hospital coalitions receive per eligible amount
Alaska	x									
Arizona						x		Admission type		Only for services outside AHCCCS
Arkansas			x							
California							Selective contracting			Rates negotiated with each contractor
Colorado		x						Diagnosis-related group (DRG)	Location, specialty	
Connecticut	x									
Delaware	x									
District of Columbia				x				DRG		
Florida		x							County	
Georgia					x				Specialty	Hospital loss limited to 10%
Hawaii		x						Admission type	Teaching, number discharges	
Idaho	x									Hospitals <41 beds guaranteed cost, larger guaranteed 85% of cost
Illinois					x			DRG		
Indiana						x		DRG		

	Basic payment methodology									
	Hospital specific rate				Peer group or statewide rate					
State	Subject to rate of increase limits only	Subject to peer group ceiling	Subject to statewide ceiling	Blend of hospital-specific and statewide rate	Peer group rate	Statewide rate	Other payment method	Method of case mix adjustment (if any)	Facility characteristics used to define peer groups	Notes
Iowa				x				DRG		
Kansas					x			DRG	Urban/rural, size	
Kentucky		x							Size, Medicaid volume, specialty	
Louisiana					x				Size, teaching, specialty	
Maine	x									
Maryland							All-payer			State rate-setting commission sets hospital-specific rates
Massachusetts						x		DRG		Bonus for hospital with lower costs or lower rate of increase
Michigan						x		DRG		Bonus for hospital with lower costs
Minnesota	x							Collapsed DRGs		
Mississippi		x							Size	
Missouri	x									
Montana						x		DRG		
Nebraska					x			DRG	Urban/rural, size	
Nevada						x		Admission type, length of stay range		
New Hampshire						x		DRG		

	Basic payment methodology									
	Hospital specific rate				Peer group or statewide rate					
State	Subject to rate of increase limits only	Subject to peer group ceiling	Subject to statewide ceiling	Blend of hospital-specific and statewide rate	Peer group rate	Statewide rate	Other payment method	Method of case mix adjustment (if any)	Facility characteristics used to define peer groups	Notes
New Jersey						x		DRG		
New Mexico					x			DRG	4 types	Teaching, referral, regional, community
New York				x				DRG	Geography, teaching, size	
North Carolina			x					DRG		
North Dakota			x					DRG		
Ohio					x			DRG	Geography, specialty, size	
Oklahoma						x		8 care levels		
Oregon			x					DRG		Lower rate of increase for hospital with higher profit margin
Pennsylvania	x							DRG		
Rhode Island							Multi-payer (see note)			Maxicap: state and Blue Cross negotiate rates with hospital association
South Carolina						x		DRG		Hospital-specific per diem for infrequent or highly variable DRGs
South Dakota			x					DRG		
Tennessee	x									Only for services outside TennCare
Texas							Selective contracting			Rates negotiated with each contractor
Utah	x							DRG		Statewide rate used for low variability or low-cost DRGs

	Basic payment methodology									
	Hospital specific rate				Peer group or statewide rate					
State	Subject to rate of increase limits only	Subject to peer group ceiling	Subject to statewide ceiling	Blend of hospital-specific and statewide rate	Peer group rate	Statewide rate	Other payment method	Method of case mix adjustment (if any)	Facility characteristics used to define peer groups	Notes
Vermont					x			Admission type	Teaching, size	Shared savings when costs below rates
Virginia						x		DRG		
Washington							Selective contracting	DRG		DRG weight times fixed amount negotiated with each contractor
West Virginia					x			DRG	Urban/rural, size	
Wisconsin					x			DRG	Location, specialty	
Wyoming			x					10 care levels		Incentive for cost below ceiling
Number of states using method	10	5	6	3	10	11	6	33 (27 DRG)		

Source: Medicaid state plans and amendments approved as of Nov. 7, 2002, except as follows: Alabama Medicaid Administrative Code, at [http://www.medicaid.state.al.us /MANUALS/AdminCode/ad_ch_37.htm], as of Aug. 20, 2003. Maryland Health Services Cost Review Commission, *Report to the Governor Fiscal Year 2001*, at [http://www.hscrc.state.md.us/hscrc_publications/pdfs/gov_report_2001_1.pdf], as of July 31, 2003. Nevada Medicaid Rates and Cost Containment Unit Rate Matrix, at [http://dhcfp.state.nv.us/pdf%20forms/RateSummary_03-17-03.pdf], as of Aug. 1, 2003. Rhode Island Medicaid Program, *Annual Report, Fiscal Year 2002*, at [http://www.dhs.state.ri.us/dhs/reports/MA_AnnualReport_2002.pdf], as of Aug. 20, 2003.

Notes: AHCCCS = the Arizona Health Care Cost Containment System, the managed care program that serves most Medicaid beneficiaries in Arizona.

DRG = diagnosis-related groups. DRGs represent a system of classifying any inpatient stay into groups for purposes of payment. DRG systems relate the type of patients a hospital treats to the costs incurred by the hospital. According to this classification system, patients who have similar diagnoses and undergo similar procedures are placed together in the same diagnosis-related group. DRG definitions may also take into account other patient characteristics, such as common sex, age, and discharge status. [http://167.7.127.236/hd/termsdef.html.]

Hospital-Specific Rates. In 24 states, fixed per diem or per case payment rates are established for each hospital, using historic data on that hospital's Medicaid costs and some form of fixed update factor for inflation. A hospital whose costs rise faster than the update will therefore lose money. Some states use an objective inflation index, such as CMS-released estimates of price changes for a "market basket" of goods and services commonly purchased by hospitals. Often, however, annual updates are set by legislation and regulation and may be higher or lower than actual inflation. Oregon uses update factors that vary inversely with each hospital's operating margin (or profit); the effect is to grant lower increases to hospitals earning a profit on their Medicaid patients.

Of the states using hospital-specific rates, five use peer group ceilings; the hospital's rate is based on the lesser of its own costs or some percentile of costs for similar hospitals. Hospital characteristics used to establish peer groups include size, location, presence of a teaching program, specialized services (for example, pediatric hospitals), and volume of Medicaid services. Six states use a statewide ceiling for all general hospitals, based on a percentile of all hospitals' costs or, in the case of Arkansas, a legislatively fixed per diem limit ($675 for 2002). Finally, three states use a blend of hospital-specific and peer group or statewide experience to set payment ceilings. For example, the operating cost component of Iowa rates is based on 50% of the hospital's cost and 50% of the statewide average.

One effect of systems using ceilings is that, while a hospital with costs above the ceiling will lose money, a hospital with costs below the ceiling will receive a rate derived from its base-year costs. It can earn a profit only if it can reduce its costs still further; it is not rewarded for being more efficient than its competitors. Wyoming provides incentive payments to hospitals with costs below the statewide ceiling. Two states, Georgia and Idaho, limit the losses that can be incurred by hospitals.

Peer Group or Statewide Rates. In 21 states, a fixed rate is set for an entire class of hospitals or for all hospitals in the state. In most of these states, part or all of the fixed rate is adjusted (as in Medicare's inpatient prospective payment system, or PPS) for higher or lower labor costs in the hospital's market area. In fixed rate systems, unlike ceiling systems, a hospital with costs below the rate can realize a profit. Three states, Massachusetts, Michigan, and Vermont, provide additional bonuses to lower-cost hospitals.

Use of Case Mix. Nearly two-thirds of the states have adopted some form of case mix adjustment, under which reimbursement varies according to some measure of the intensity of services required or the resources used by each individual patient. Most of these use the diagnosis-related groups (DRGs) developed for Medicare hospital reimbursement. Patients are assigned to one of 540 DRGs on the basis of admitting diagnosis, procedures performed, presence of complications, or other characteristics.[12] Each DRG has an assigned weight — for example, 0.8889 for an uncomplicated appendectomy or 9.7823 for a liver transplant-which is then multiplied by the fixed rate established for the hospital. So, if a hospital's standard

[12] Not all of the 540 codes are actually in use.

rate were $5,000, it would be paid $4,445 for the appendectomy and $48,912 for the liver transplant.

Because Medicaid patients may be different from Medicare patients, the weighting factors established for DRGs under Medicare may not be appropriate for Medicaid reimbursement. Most states using DRGs have developed their own weights on the basis of Medicaid-specific data. Some states use alternative DRG classification systems, such as the DRGs developed for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or New York's All Patient DRGs. These groupings add additional categories for types of patients, such as maternity cases or newborns, rarely treated under Medicare. Minnesota has collapsed the DRGs into a smaller number of diagnostic categories.

Some states that have not adopted DRG classifications nevertheless modify reimbursement according to the type of patient served. Some of these use admission types — for example medical/surgical, maternity, psychiatric — while others assign cases to a limited number of level-of-care groupings. Nevada additionally adjusts its per case rates using length-of-stay ranges.

Other Methods. Four states have used 1915(b) freedom-of-choice waivers to develop hospital contracting systems, while two states have systems under which Medicaid and other payers use common reimbursement methods.

Selective Contracting. Under Section 1915(b), a state may receive a waiver of Medicaid requirements, including the requirement that beneficiaries be allowed a free choice of medical providers, in order to allow the development of innovative delivery or reimbursement systems. One of the available options for states is to limit program participation (except for emergency services) to providers who meet reimbursement, quality, and utilization standards approved by the state. Certain payment rules cannot be waived under this option, including requirements for additional payment to disproportionate share hospitals (see below) and requirements for prompt payment to providers.

Alabama, California, Texas, and Washington have used this authority to restrict the inpatient hospitals from which beneficiaries may obtain services. (Illinois operated a similar system until 1991.) Alabama's program is statewide. In the other states the waiver applies only in selected counties or areas; however, a large share of beneficiaries live in the covered area. Except in emergencies or other exceptional cases, these beneficiaries may use only hospitals selected for participation through a system of competitive negotiation. In California and Texas, reimbursement rates for the participating hospitals are established in the course of the negotiation. In Washington, what is negotiated is the hospital's "conversion factor," a fixed dollar amount that is multiplied by the weighting factor for a DRG to produce a final payment amount for each case.

Under Alabama's Partnership Hospital Program, groups of hospitals in a geographic area form a prepaid inpatient health plan that is reimbursed on a capitated (fixed per beneficiary per month) basis; the plan in turn makes payments to its participating hospitals. All Medicaid beneficiaries are automatically enrolled, except

those who are also Medicare beneficiaries and certain pregnant women participating in a separate Maternity Care program.[13]

Multi-payer Systems. Beginning in the 1970s, several states established "all-payer" hospital rate-setting systems. In these systems, all insurers or other payers in the state, including Medicare and Medicaid, agreed to pay uniform rates or use a standard reimbursement methodology for inpatient services. Only one state, Maryland, still has an all-payer system in which Medicare participates.[14] A state rate-setting commission sets each hospital's allowable prices for specific service units, such as a day of routine care or a particular laboratory test. The prices are set at levels expected to result in a target average charge per case for each facility. A key feature of the system is that every payer contributes to hospitals' costs for treating uninsured patients.

In Rhode Island, the state and Blue Cross jointly negotiate with the state hospital association an annual statewide ceiling (the "Maxicap") on reimbursable expenses for the 12 voluntary hospitals in the state. Within this ceiling, an operating budget is developed for each hospital, and rates paid by Medicaid and Blue Cross are set to meet these budgets.

Administrative Days/Swing Beds. Under Medicare, small rural hospitals may enter into "swing bed" agreements with CMS, under which beds may be used either for inpatient hospital care or for care equivalent in intensity to that furnished by a nursing facility. Costs are allocated and reimbursement adjusted to reflect the level of care furnished to each patient. A Medicaid program may also allow for swing beds, but only in hospitals that have entered into a Medicare swing bed arrangement. The state may develop a specific payment methodology for swing bed days of care at the nursing facility level or may pay at a rate based on average payments for comparable services in freestanding nursing facilities. The swing bed program assists hospitals that are underused and also helps to meet local shortages of nursing facility beds.

Sometimes a hospital which is not a swing bed facility will provide care to a patient at the nursing facility level of intensity because a place cannot be found for the patient in an appropriate facility and the patient cannot be discharged. The days of inpatient care received by patients in this situation are known as "administrative days." Prior to 1997, Medicaid payment for an administrative day was limited to the statewide average Medicaid payment rate for a day of care in a skilled nursing facility. Most states have continued this practice despite the repeal of the provision in the BBA.

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[13] Note that, because the plans provide inpatient services only, they are not subject to the Section 1903(m)(2) requirements for Medicaid managed care organizations.

[14] To retain the Medicare waiver, a system must hold cumulative growth in cost per Medicare admission from 1981 to the present at or below national average growth.

Outpatient Payment Methods

Because hospitals furnish a wide variety of services on an outpatient basis — from emergency room visits to surgery to diagnostic tests — many states use several different payment methodologies. For example, a state might pay a flat per-visit fee for a clinic visit, use a fee schedule for surgery, and pay on a cost basis for some specialized services. Because states vary in their service definitions, there is no ready way of comparing methods for particular services across states. **Table 10** attempts to identify the "principal" payment approach in each state, with notes on variants in some states, without depicting the full complexity of state systems.

About half of the states still base outpatient reimbursement largely on hospital-specific costs. Of these, 15 pay actual costs or prospective rates based on historic costs with a limit on annual increases. One state, Florida, uses a peer group ceiling comparable to those common in inpatient hospital and nursing facility payment. Another 11 states pay a fixed percentage of actual costs; that is, their systems explicitly pay each facility less than its costs. One goal of such systems may be to discourage use of hospitals for services that could be rendered in a noninstitutional setting.

Sixteen states use fee schedules, varying payment by the surgical or other procedures performed. For at least some services, several states pay the same rates regardless of whether the service is performed in a hospital or in a physician's office. Again, the aim is to avoid incentives for use of the more costly setting.

Only four states have adopted systems comparable to Medicare's new prospective system for outpatient hospital services. Under this system, services are classified into one of 383 ambulatory patient classifications (APCs), groups of services expected to require comparable resources. As in the inpatient DRG system, payment for each APC is at a fixed rate times a weight that reflects resource use for the APC relative to that of other APCs. One state has adopted Medicare's system directly; others use their own classification system or prices.

Of the remaining states, Maryland uses the same all-payer system, and Rhode Island the same multi-payer negotiation, as for inpatient care. (Hawaii also negotiates some rates.) Utah pays a percentage of charges, rather than costs, while Arkansas uses Blue Cross customary charge screens. Finally, Delaware pays blended rates based on a mix of hospital-specific and statewide experience.

Table 10. Principal Outpatient Hospital Reimbursement Approach

State	Hospital-specific rate based on		Fee schedule	Case payment	Other	Notes
	Cost	Percent of cost				
Alaska	x					Rate-of-increase limit
Alabama			x			
Arkansas					x	Percent of Blue Cross customary charges
Arizona	x					Only for non-AHCCCS patients
California			x			
Colorado		72%				
Connecticut			x			
District of Columbia	x					Rate-of-increase limit
Delaware					x	Visit rates blend of hospital-specific, state average; other services cost-based
Florida	x					Cost up to ceiling set at 80th percentile for county
Georgia		90%				
Hawaii		75%				Some rates negotiated
Iowa				x		Blended hospital/statewide rate
Idaho	x					Radiology/surgery based on schedule for comparable non-hospital service
Illinois			x			
Indiana			x			
Kansas			x			Based on schedule for comparable non-hospital service
Kentucky	x					
Louisiana		83%				
Massachusetts				x		State-developed prices
Maryland					x	State rate-setting commission sets hospital-specific rates
Maine	x					
Michigan			x			
Minnesota				x		Uses Medicare prices

State	Hospital-specific rate based on		Fee schedule	Case payment	Other	Notes
	Cost	Percent of cost				
Missouri		90%				
Mississippi	x					
Montana			x			93% of cost for services not on schedule
North Carolina		80%				
North Dakota	x					
Nebraska		85%				
New Hampshire	x					
New Jersey		94.2%				
New Mexico		97%				
Nevada			x			
New York			x			
Ohio			x			
Oklahoma			x			
Oregon		59%				
Pennsylvania			x			
Rhode Island					x	State and Blue Cross negotiate rates with hospital association
South Carolina			x			
South Dakota	x					
Tennessee	x					Only for services outside TennCare
Texas		80.3%				84.48% of cost for high-volume providers
Utah					x	Percent of charges: 77% urban, 93% rural
Virginia	x					Emergency room paid at all-inclusive rate
Vermont	x					Services available in physicians' offices paid at physician rate
Washington				x		State-developed prices
Wisconsin	x					Per visit rates based on past hospital-specific costs, rate of increase limit
West Virginia			x			
Wyoming			x			

State	Hospital-specific rate based on		Fee schedule	Case payment	Other	Notes
	Cost	Percent of cost				
Number of states using method	15	11	16	4	5	

Source: Medicaid state plans and amendments approved as of Nov. 7, 2002, except as follows: Maine: MaineCare Benefits Manual, Chapter III, Section 45, 01-015 CMR (Code of Maine Rules) Chapter 101, at [http://www.state.me.us/sos/cec/rcn/apa/10/ch101.htm], as of July 31, 2003. Maryland: Maryland Health Services Cost Review Commission, *Report to the Governor Fiscal Year 2001*, at [http://www.hscrc.state.md.us/hscrc_publications/pdfs/gov_report_2001_1.pdf], as of July 31, 2003. Nevada: *Nevada Medicaid Rates and Cost Containment Unit Rate Matrix*, [http://dhcfp.state.nv.us/pdf%20forms/RateSummary_03-17-03.pdf], as of July 31, 2003. Rhode Island: *Rhode Island Medicaid Program, Annual Report, Fiscal Year 2002*, at [http://www.dhs.state.ri.us/dhs/reports/MA_AnnualReport_2002.pdf], as of Aug. 20, 2003. Washington, at [http://fortress.wa.gov/dshs/maa/hrates/opps/Policy_Summary.htm], as of Aug. 6, 2003.

DSH Payments[15]

Current DSH Requirements. Federal Medicaid law requires that states make additional payments to hospitals that serve a disproportionate share of Medicaid and other low-income patients. The statute defines which hospitals must receive DSH payments and which hospitals may never receive DSH payments. States can decide on their own whether to make payments to hospitals that are in neither category. Similarly, the law sets minimum payment amounts that must be made for certain hospitals and maximum payment amounts for individual hospitals and for all hospitals in the state. Again, states are free to set their payments at any level between the minimum required and the maximum permitted.

Individual state plan specifications for DSH payments are often extremely complex, defining numerous classes of facilities and varying payment amounts; some states amend this section of their plan every year. Accordingly, this section will not offer a comparison of the way different states have designed their DSH programs, but will merely summarize the current requirements.

Hospitals That Must Receive DSH Payments. A hospital must be deemed a DSH hospital if either of the following is true:

- Its Medicaid utilization rate is more than one standard deviation above the average Medicaid utilization rate for all Medicaid-participating hospitals in the state.[16] The Medicaid

[15] For additional information on DSH payments, see CRS Report 97-483, *Medicaid Disproportionate Share Payments*, by Jean Hearne.

[16] The "standard deviation" used in the first criterion is a statistical measure of the dispersion of hospitals' utilization rates around the average; the use of this measure (continued...)

utilization rate is defined as the number of days of care furnished to Medicaid beneficiaries during a given period divided by the total number of days of care provided during the period.

- Its low-income utilization rate is at least 25%. The low-income utilization rate is the sum of two fractions: Medicaid payments plus state and local subsidies divided by total patient care revenues, and inpatient charges attributable to charity care (other than charity care subsidized by state or local government) divided by total inpatient charges.

In computing either of these measures, states are now required to include Medicaid patients whose stays were paid for by an MCO, rather than directly by the state.

Hospitals That May Not Receive DSH Payments. A state may not make DSH payments to a hospital whose Medicaid utilization rate is less than 1%. In addition, a hospital may not be deemed a DSH hospital unless it has on staff at least two obstetricians who are prepared to accept Medicaid patients. This requirement does not apply to children's hospitals or to those that do not furnish non-emergency obstetrical care; rural hospitals may use other attending physicians for obstetrical care.

Minimum DSH Payment. In computing the amount of the supplementary payment, the state must use one of three methods. It may (a) use the formula for comparable payments under Medicare, with special adjustments for children's hospitals; (b) provide for a fixed payment increase or percentage increase for DSHs plus an additional increase for hospitals whose Medicaid utilization is more than one standard deviation above the statewide mean; or (c) develop its own methodology which may vary payments to different types of hospitals, so long as all hospitals of each type are treated equally and payments are reasonably related to hospitals' Medicaid or low-income volume. The payments are required even if they result in Medicaid payments to a hospital in excess of the hospital's usual charges to the public for similar services.

Maximum Payment to an Individual Hospital. The DSH payment cannot exceed the sum of (a) the hospital's costs for Medicaid patients that are not already met through non-DSH Medicaid hospital payments and (b) the hospital's costs for patients without health insurance or other third-party coverage.[17] (Third-party payment does not include state and local subsidies for indigent care.) California has a permanent waiver to pay certain "high disproportionate share" public hospitals up to 175% of this limit. BIPA granted a similar exemption to all states, but only for the two state fiscal years beginning on or after September 30, 2002.

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[16] (...continued)
identifies hospitals whose Medicaid utilization is unusually high.

[17] Note that non-DSH Medicaid payments include enhanced payments under UPL arrangements. Centers for Medicare and Medicaid Services, *State Medicaid Director Letter*, no. 02-013, Aug. 16, 2003.

Maximum DSH Payments to Mental Hospitals. The BBA limited total DSH payments to mental hospitals during a year to the lesser of the dollar amount of such payments in FY1995 or a percentage of the state's DSH allotment (see below) for the year. This percentage was initially based on the percentage of the state's FY1995 payments that went to mental hospitals, then was phased down to 50% for FY2001, 40% for FY2002, and 33% for FY2003 and later years.

DSH Allotments. The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) limited national aggregate spending for DSH payments to 12% of total Medicaid program spending, roughly the level projected for FY1992. "High" DSH states — those with DSH payments already exceeding 12% of their Medicaid spending — could not increase the percentage of spending devoted to DSH payments. That is, those payments could not increase faster than the rate of growth in the state's overall Medicaid spending. Other states were allowed to raise their DSH payments, subject to an allocation system that would keep aggregate national payments within the cap.

The BBA of 1997 replaced this formulaic allocation with a table of specified allotments for each of the years FY1998 through FY2002. These allotments effectively froze states with very low DSH payments at their 1995 payment levels and required higher-spending states to gradually reduce their payments. After 2002, each state's annual allotment would increase at the rate of the medical care component of the CPI-U. BIPA froze the allotments for FY2001 and FY2002 at the FY2000 levels, meaning high-DSH states would not have to reduce their spending so rapidly. For FY2003, however, the DSH allotment returned to the level prescribed by the BBA — that is the original published FY2002 allotment plus inflation. **Table 11** shows the allotments for FY1998 through FY2003. The reversion to the BBA rules for FY2003 meant that total allotments dropped about 11% in a single year, and some states' allotments dropped by as much as 25%.

Table 11. Federal DSH Allotments for 1998-2003

(millions of dollars)

	1998	1999	2000	2001	2002	2003
Alabama	293	269	248	257	263	250
Alaska	10	10	10	10	11	9
Arizona	81	81	81	84	86	82
Arkansas	2	2	2	19	19	19
California	1,085	1,068	986	1,021	1,047	890
Colorado	93	85	79	82	84	75
Connecticut	200	194	164	170	174	162
Delaware	4	4	4	4	4	4
District of Columbia	23	23	32	33	34	32
Florida	207	203	197	204	209	162
Georgia	253	248	241	249	256	218
Hawaii[a]	0	0	0	0	0	0
Idaho	1	1	1	7	7	7

	1998	1999	2000	2001	2002	2003
Illinois	203	199	193	200	205	175
Indiana	201	197	191	198	203	174
Iowa	8	8	8	17	17	18
Kansas	51	49	42	43	45	33
Kentucky	137	134	130	135	138	118
Louisiana	880	795	713	713	713	631
Maine	103	99	84	87	89	85
Maryland	72	70	68	70	72	62
Massachusetts	288	282	273	283	290	248
Michigan	249	244	237	245	252	215
Minnesota	33	33	33	34	35	33
Mississippi	143	141	136	141	144	124
Missouri	436	423	379	392	402	385
Montana	.2	.2	.2	5	5	5
Nebraska	5	5	5	12	13	13
Nevada	37	37	37	38	39	38
New Hampshire	140	136	130	130	132	132
New Jersey	600	582	515	533	547	523
New Mexico	5	9	9	9	10	9
New York	1,512	1,482	1,436	1,486	1,525	1,304
North Carolina	278	272	264	273	280	240
North Dakota	1	1	1	4	4	4
Ohio	382	374	363	376	385	330
Oklahoma	16	16	16	17	17	16
Oregon	20	20	20	21	21	20
Pennsylvania	529	518	502	520	533	456
Rhode Island	62	60	58	60	62	53
South Carolina	313	303	262	271	278	266
South Dakota	1	1	1	5	5	5
Tennessee[a]	0	0	0	0	0	0
Texas	979	950	806	834	856	776
Utah	3	3	3	8	9	9
Vermont	18	18	18	19	19	18
Virginia	70	68	66	68	70	71
Washington	174	171	166	172	176	150
West Virginia	64	63	61	63	65	55
Wisconsin	7	7	7	41	42	42
Wyoming	[b]	[b]	[b]	[b]	[b]	[b]
Total	**10,272**	**9,958**	**9,278**	**9,662**	**9,893**	**8,748**

Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Medicaid Program; Disproportionate Share Hospital Payments," 69 *Federal Registar* 15850 — 15884, Mar. 26, 2004.

a. Does not make DSH payments
b. Allotments round to less than $1 million.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) provides a one-time 16% increase in the FY2004 allotment for each state. A state's allotment will be frozen at this 2004 level until the year for which the Secretary estimates that the allotment that would have been available under the previous rules (that is, the FY2003 allotment plus cumulative inflation) equals or exceeds the 2004 amount. For that year, the state would receive the allotment determined under the previous rules; for subsequent years, allotments would again increase at the rate of the medical care component of the CPI-U. There is an exception for a "low DSH" state, one whose FY2000 DSH spending was greater than zero but less than 3% of the state's total Medicaid spending. A low DSH state will receive the 16% increase in its allotment for FY2004 and an additional 16% increase for each fiscal year through FY2008. For FY2009 and later years, the allotment would increase with the medical care component of the CPI-U.

Amount of DSH Payments. **Table 12** shows DSH payments as a percentage of total spending for general and mental hospital services, and as a percentage of all Medicaid spending, in FY2001. Overall, DSH payments account for about a third of payments for general hospitals and nearly half of payments for mental hospitals. About 21% of total DSH payments went to mental hospitals.[18]

[18] Some states show payments to inpatient mental hospitals that exceed the 50% of total DSH ceiling as imposed under the BBA. This may be because CMS-64 reports for a given year can reflect spending related to a prior year.

Table 12. Disproportionate Share Hospital Payments, as a Share of Total Hospital Payments and Total Net Medicaid Spending, 2001

State	General hospital			Inpatient mental hospital			IMH as percent of total DSH	DSH as percent of total Medicaid spending[a]
	Regular	DSH	Percent DSH	Regular	DSH	Percent DSH		
Alaska	161	5	3%	14	9	39%	65%	2%
Alabama	316	363	53%	36	3	9%	1%	13%
Arkansas	364	22	6%	68	1	1%	4%	1%
Arizona	141	74	35%	0	28	99%	28%	4%
California	4,356	1,926	31%	1,021	—	0%	0%	8%
Colorado	303	186	38%	2	0	1%	0%	9%
Connecticut	224	203	48%	9	88	90%	30%	9%
District of Columbia	246	79	24%	29	4	12%	5%	8%
Delaware	26	—	0%	11	4	28%	100%	1%
Florida	1,661	189	10%	9	150	94%	44%	4%
Georgia	1,874	425	18%	28	—	0%	0%	8%
Hawaii	82	—	0%	—	—	0%		
Iowa	242	14	6%	21	—	0%	0%	1%
Idaho	126	10	7%	7	—	0%	0%	1%
Illinois	2,757	264	9%	40	115	74%	30%	5%
Indiana	737	514	41%	182	142	44%	22%	16%
Kansas	171	11	6%	31	36	54%	77%	3%
Kentucky	613	155	20%	44	36	46%	19%	6%
Louisiana	687	795	54%	7	77	92%	9%	21%

State	General hospital			Inpatient mental hospital			IMH as percent of total DSH	DSH as percent of total Medicaid spending[a]
	Regular	DSH	Percent DSH	Regular	DSH	Percent DSH		
Massachusetts	1,098	382	26%	44	103	70%	21%	7%
Maryland	447	31	7%	146	31	18%	50%	2%
Maine	200	—	0%	19	49	73%	100%	4%
Michigan	1,079	217	17%	37	215	85%	50%	6%
Minnesota	272	62	18%	31	3	8%	4%	2%
Missouri	897	279	24%	11	176	94%	39%	10%
Mississippi	659	179	21%	40	—	0%	0%	7%
Montana	93	0	0%	—	—	0%	0%	0%
North Carolina	1,484	240	14%	26	175	87%	42%	7%
North Dakota	55	0	1%	3	1	18%	57%	0%
Nebraska	155	0	0%	3	—	0%	0%	0%
New Hampshire	72	131	64%	3	28	90%	17%	18%
New Jersey	891	705	44%	102	413	80%	37%	16%
New Mexico	229	15	6%	2	0	13%	2%	1%
Nevada	140	76	35%	15	—	0%	0%	11%
New York	6,402	1,881	23%	500	574	53%	23%	8%
Ohio	1,486	544	27%	279	93	25%	15%	8%
Oklahoma	138	21	13%	25	1	5%	6%	1%
Oregon	188	13	7%	40	17	30%	57%	1%
Pennsylvania	570	361	39%	152	400	72%	53%	7%
Rhode Island	181	79	30%	19	2	8%	2%	7%

State	General hospital			Inpatient mental hospital			IMH as percent of total DSH	DSH as percent of total Medicaid spending[a]
	Regular	DSH	Percent DSH	Regular	DSH	Percent DSH		
South Carolina	604	321	35%	34	51	60%	14%	12%
South Dakota	85	0	0%	3	1	19%	70%	0%
Tennessee	471	—	0%	2	—	0%	—	—
Texas	—	1,111	NA	52	235	82%	17%	12%
Utah	124	1	0%	11	0	2%	25%	0%
Virginia	520	235	31%	163	2	1%	1%	8%
Vermont	75	27	26%	0	—	0%	0%	4%
Washington	564	213	27%	60	115	66%	35%	8%
West Virginia	236	79	25%	22	23	52%	23%	7%
Wyoming	44	0	1%	15	—	0%	0%	0%
U.S. total (excluding territories)	34,848	12,448	26%	3,456	3,406	50%	21%	7%

Source: Medicaid Financial Management Report (CMS-64), FY 2001. General hospital includes inpatient and outpatient spending.

a. Total does not include administrative spending.

Note that the non-DSH figures include any enhanced payments under UPL programs. In addition, the figures on the DSH share of general hospital spending should be viewed with caution, because states with large numbers of enrollees in MCOs may make DSH payments, but not regular payments, on behalf of those enrollees.

Tables 13 and 14 provide some further perspective on how states are allocating their DSH funds. These tables are based on the most recent annual DSH report filed by each state and posted on the CMS website.[19] While submission of annual reports is required by the statute, one state with DSH spending, Georgia, has never filed a report, while others have not done so for some years. (Some states have filed reports that do not fully categorize all hospitals by type or ownership. These omissions have been corrected when there were only a few instances in a state and the information was readily available from other sources.)

States vary widely in the degree to which they have targeted payments at public hospitals and mental hospitals. In some states, nearly all the payments went to private general hospitals; in others, nearly all payments went to public mental hospitals. (These are states for which only older reports are available, so that the figures do not reflect the BBA-required phase-down of the share of payments going to mental hospitals.) In addition, some states are distributing the funds among a large number of hospitals, while other make DSH payments only to a handful of facilities.

[19] [http://www.cms.hhs.gov/dsh/default.asp].

Table 13. Disproportionate Share Hospital Payments by Type of Hospital and Hospital Ownership, Most Recent Reporting Year

State	Year	DSH payments (millions)	General hospital			Inpatient mental health facility		
			Public	Private	Unknown ownership	Public	Private	Unknown ownership
Alabama	1998	$ 14	0.1%	0.0%	0.0%	99.9%	0.0%	0.0%
Alaska	2000	395	10.8%	0.0%	87.8%	1.4%	0.0%	0.0%
Arizona	1998	2	9.7%	68.8%	9.6%	0.0%	11.9%	0.0%
Arkansas	1999	122	86.8%	13.2%	0.0%	0.0%	0.0%	0.0%
California	2000	1,908	75.4%	24.4%	0.2%	0.0%	0.0%	0.0%
Colorado	1999	175	90.3%	9.7%	0.0%	0.0%	0.0%	0.0%
Connecticut	2001	291	0.0%	69.9%	0.0%	30.1%	0.0%	0.0%
Delaware	1999	33	14.9%	76.7%	0.0%	8.4%	0.0%	0.0%
District of Columbia	1999	35	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%
Florida	1998	371	11.6%	88.4%	0.0%	0.0%	0.0%	0.0%
Georgia[a]								
Hawaii[b]								
Idaho	2000	14	92.8%	7.2%	0.0%	0.0%	0.0%	0.0%
Illinois	2000	1	41.3%	58.7%	0.0%	0.0%	0.0%	0.0%
Indiana	1998	433	0.0%	0.0%	62.8%	0.0%	0.0%	37.2%
Iowa	2001	116	29.5%	6.0%	0.0%	64.5%	0.0%	0.0%
Kansas	1999	44	5.9%	6.0%	0.0%	88.0%	0.0%	0.0%
Kentucky	2000	184	0.0%	0.0%	80.9%	17.7%	1.4%	0.0%
Louisiana	1998	734	98.9%	0.4%	0.7%	0.0%	0.0%	0.1%

State	Year	DSH payments (millions)	General hospital			Inpatient mental health facility		
			Public	Private	Unknown ownership	Public	Private	Unknown ownership
Maine	2001	553	26.7%	55.3%	0.0%	17.8%	0.3%	0.0%
Maryland	2001	81	0.2%	49.8%	0.0%	50.0%	0.0%	0.0%
Massachusetts	2000	50	0.0%	0.0%	0.0%	76.6%	23.4%	0.0%
Michigan	1998	215	0.8%	1.1%	0.0%	98.1%	0.0%	0.0%
Minnesota	1997	56						
Mississippi	1998	455	0.0%	0.0%	60.8%	0.0%	0.0%	39.2%
Missouri	2001	183	98.7%	1.1%	0.0%	0.0%	0.2%	0.0%
Montana	2000	0[c]	0.0%	0.0%	97.8%	0.0%	0.0%	2.2%
Nebraska	1999	339	44.3%	6.6%	0.0%	49.1%	0.0%	0.0%
Nevada	1998	1	0.0%	43.3%	0.0%	56.7%	0.0%	0.0%
New Hampshire	2001	4	45.6%	1.2%	0.0%	0.0%	53.2%	0.0%
New Jersey	1999	175	74.9%	10.3%	0.0%	14.8%	0.0%	0.0%
New Mexico	2000	983	0.0%	0.0%	51.9%	0.0%	0.0%	48.1%
New York	2001	12	80.0%	19.5%	0.0%	0.0%	0.4%	0.0%
North Carolina	1998	74	90.6%	9.4%	0.0%	0.0%	0.0%	0.0%
North Dakota	2001	1,191	44.3%	31.2%	0.0%	24.0%	0.5%	0.0%
Ohio	2001	636	0.0%	0.0%	85.3%	0.0%	0.0%	14.7%
Oklahoma	1999	23	1.8%	83.7%	0.0%	12.4%	2.1%	0.0%
Oregon	2000	25	19.6%	1.6%	0.0%	78.8%	0.0%	0.0%
Pennsylvania	1999	52	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Rhode Island	2001	81	10.3%	87.8%	0.0%	0.0%	1.9%	0.0%

State	Year	DSH payments (millions)	General hospital			Inpatient mental health facility		
			Public	Private	Unknown ownership	Public	Private	Unknown ownership
South Carolina	1999	434	56.5%	35.0%	0.0%	8.3%	0.2%	0.0%
South Dakota	2001	1	4.1%	26.1%	0.0%	69.9%	0.0%	0.0%
Tennessee[b]								
Texas	2001	1,183	56.8%	23.3%	0.0%	19.8%	0.1%	0.0%
Utah	2001	4	43.7%	36.5%	0.0%	19.8%	0.0%	0.0%
Vermont	2001	164	81.1%	13.6%	0.0%	0.0%	5.3%	0.0%
Virginia	1999	26	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Washington	2000	277	54.7%	5.4%	0.0%	39.6%	0.4%	0.0%
West Virginia	2000	11	0.2%	75.0%	0.0%	24.0%	0.8%	0.0%
Wisconsin	1998	80	14.2%	71.5%	0.0%	14.4%	0.0%	0.0%
Wyoming	1999	$ 0[b]	0.9%	99.1%	0.0%	0.0%	0.0%	0.0%

Source: State DSH reports, latest available year.

a. No DSH report filed.
b. Does not make DSH payments.

Table 14. Hospitals Receiving Disproportionate Share Hospital Payments by Type of Hospital and Hospital Ownership, Most Recent Reporting Year

State	Year	Hospitals receiving DSH payments	General hospital			Inpatient mental health facility		
			Public	Private	Unknown ownership	Public	Private	Unknown ownership
Alabama	1998	12	25%	0%	67%	8%	0%	0%
Alaska	2000	2	50%	0%	0%	50%	0%	0%
Arkansas	1999	11	18%	45%	27%	0%	9%	0%
Arizona	1998	30	7%	93%	0%	0%	0%	0%
California	2000	131	29%	62%	8%	1%	0%	0%
Colorado	1999	65	35%	58%	0%	3%	3%	0%
Connecticut	2001	33	0%	94%	0%	6%	0%	0%
District of Columbia	1999	9	11%	78%	0%	11%	0%	0%
Delaware	1999	1	0%	0%	0%	100%	0%	0%
Florida	1998	78	18%	82%	0%	0%	0%	0%
Georgia[a]								
Hawaii[b]								
Iowa	2001	27	59%	41%	0%	0%	0%	0%
Idaho	2000	36	67%	33%	0%	0%	0%	0%
Illinois	2000	88	0%	0%	82%	0%	0%	18%
Indiana	1998	10	30%	20%	0%	50%	0%	0%
Kansas	1999	31	61%	29%	0%	10%	0%	0%
Kentucky	2000	117	0%	0%	90%	3%	8%	0%
Louisiana	1998	85	61%	11%	16%	0%	0%	12%

State	Year	Hospitals receiving DSH payments	General hospital			Inpatient mental health facility		
			Public	Private	Unknown ownership	Public	Private	Unknown ownership
Massachusetts	2000	83	8%	81%	0%	10%	1%	0%
Maryland	2001	20	10%	55%	0%	35%	0%	0%
Maine	2001	4	0%	0%	0%	50%	50%	0%
Michigan	1998	22	9%	64%	0%	27%	0%	0%
Minnesota	1997	1	0%	0%	100%	0%	0%	0%
Missouri	2001	141	0%	0%	89%	0%	0%	11%
Mississippi	1998	55	45%	45%	0%	0%	9%	0%
Montana	2000	8	0%	0%	75%	0%	0%	25%
North Carolina	1998	133	53%	32%	6%	6%	4%	0%
North Dakota	2001	7	0%	86%	0%	14%	0%	0%
Nebraska	1999	12	25%	25%	0%	0%	50%	0%
New Hampshire	2001	29	83%	14%	0%	3%	0%	0%
New Jersey	1999	77	0%	0%	82%	0%	0%	18%
New Mexico	2000	25	24%	68%	0%	0%	8%	0%
Nevada	1998	11	73%	27%	0%	0%	0%	0%
New York	2001	265	10%	80%	0%	9%	0%	0%
Ohio	2001	173	0%	0%	97%	0%	0%	3%
Oklahoma	1999	14	7%	21%	0%	36%	36%	0%
Oregon	2000	11	18%	64%	0%	18%	0%	0%
Pennsylvania	1999	1	0%	0%	100%	0%	0%	0%
Rhode Island	2001	14	7%	79%	0%	0%	14%	0%
South Carolina	1999	52	50%	42%	0%	6%	2%	0%

State	Year	Hospitals receiving DSH payments	General hospital			Inpatient mental health facility		
			Public	Private	Unknown ownership	Public	Private	Unknown ownership
South Dakota	2001	12	8%	83%	0%	8%	0%	0%
Tennessee[b]								
Texas	2001	171	53%	39%	0%	6%	2%	0%
Utah	2001	29	3%	93%	0%	3%	0%	0%
Virginia	1999	42	5%	76%	0%	0%	19%	0%
Vermont	2001	14	0%	100%	0%	0%	0%	0%
Washington	2000	61	70%	25%	0%	2%	3%	0%
Wisconsin	1998	25	4%	68%	0%	16%	12%	0%
West Virginia	2000	59	3%	95%	0%	2%	0%	0%
Wyoming	1999	3	33%	67%	0%	0%	0%	0%

Source: State DSH reports, latest available year.

a. No DSH report filed.
b. Does not make DSH payments.

These data alone cannot indicate which states are using DSH payments for the intended purpose of helping hospitals with low-income and uninsured patients, and which are probably recovering the funds through transfers or using them to pay for non-Medicaid residents of psychiatric facilities. States vary, for example, in the share of general hospitals operated by government units, and those with few public general hospitals (such as Maryland) are likely to make more payments to private providers than states where public hospitals are more common.

Adequacy of Hospital Reimbursement

Since the shift away from cost-based reimbursement that began in the 1980s, aggregate Medicaid payments to hospitals (including regular inpatient and outpatient payments and DSH payments) have consistently been less than the total costs hospitals incur in treating Medicaid beneficiaries. However, the gap narrowed dramatically during the 1990s.

The only comprehensive source of data on Medicaid hospital costs and payments is an annual survey of community hospitals conducted by the American Hospital Association (AHA). The survey includes questions about gross Medicaid charges and actual Medicaid payments received by each hospital. Hospitals' charges are generally in excess of their actual costs. AHA estimates actual costs for Medicaid patients at each hospital by using that hospital's overall cost-to-charge ratio; the estimate may be inaccurate if the ratio is actually different for Medicaid and non-Medicaid patients. It should also be noted that 35% of hospitals — especially public and for-profit hospitals — did not participate in the most recent survey; values for these hospitals have been imputed.

Table 15 shows payments by Medicaid and other major payers as a percentage of costs in 1991 through 2001. Nationally, aggregate Medicaid payments were 81.6% of estimated costs for Medicaid beneficiaries in 1991. The ratio rose steadily through the decade; by 2001, aggregate Medicaid payments — including regular and DSH payments — equaled 98% of costs.[20] While this is a significant improvement, hospitals overall are still losing money on Medicaid patients. AHA estimates that 73% of hospitals had negative inpatient margins in 2000.[21]

One likely factor in Medicaid losses is that states have been granting annual increases lower than the rate of inflation. A study for Oregon's hospital association by Lewin Associates contends that, over a 10-year period, Medicaid payment rates increased 13%, while inflation was 33%. In addition, the study notes that rates for each hospital continued to be based on data from 1987. This means that rates do not account for changes in case mix or other factors that might cause one hospital's costs to rise faster than another's. Examination of state plan documents indicates that a number of other states allow long intervals to pass without "rebasing" their hospital cost data.

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[20] The Medicaid payment figures are net revenues; that is, they do not include any amounts that might have been returned to the state through intergovernmental transfers or other mechanisms.

[21] AHA, *Cracks in the Foundation: Averting a Crisis in America's Hospitals*, Aug. 2000.

Table 15. Hospital Payment-to-Cost Ratios, by Source of Revenue, 1991-2001

(in percentages)

Year	Medicare	Medicaid	Uncompensated care	Private payers
1991	88.4	81.6	19.6	129.7
1992	88.8	90.9	18.9	131.3
1993	89.4	93.1	19.5	129.3
1994	96.9	93.7	19.3	124.4
1995	99.3	93.8	18.0	123.9
1996	102.4	94.8	17.3	121.5
1997	103.6	95.9	14.1	117.6
1998	102.6	97.9	13.2	113.6
1999	101.1	96.7	13.2	112.3
2000	100.2	96.1	12.1	112.5
2001	99.4	98.0	12.2	113.2

Source: Medicare Payment Advisory Commission (MedPAC), Report to the Congress, *Medicare Payment Policy*, Mar. 2003, based on data from the American Hospital Association annual survey of hospitals.

Note: Payment-to-cost ratios indicate the relative degree to which payments from each payer cover the costs of treating its patients. Operating subsidies from state and local governments are considered payments for uncompensated care, up to the level of each hospital's uncompensated care costs. Data are for community hospitals and reflect all types of patient care services. Imputed values are used for missing data (about 35% of observations),which corrects for underrepresentation of proprietary and public hospitals relative to voluntary institutions. Most Medicare and Medicaid managed care patients are included in the private payers category. The costs allocated to Medicare and Medicaid include CMS's allowed and nonallowed costs. [This note by MedPAC means that its method for estimating hospitals' costs for Medicare and Medicaid patients does not take account of federal rules for determining whether specific costs are reimbursable.]

Hospital losses are not due solely to reimbursement methods. Coverage limitations also play a role. For example, under Maryland's all-payer system, Medicaid pays the same daily rates as Medicare and private insurers. However, the state has imposed a limit on the number of covered inpatient days. The result is a loss for uncovered days that is passed on to all payers in the form of higher rates.[22]

Hospitals and private insurers have always contended that Medicaid losses must be made up through higher charges to other payers, a phenomenon known as cost-shifting. Private insurers pay more than the costs of treatment for their enrollees, while both Medicaid and Medicare pay less than cost. What is striking is how much cost-shifting has diminished. As **Table 15** shows, charges to private payers were nearly 30% above costs in 1991, largely to compensate for Medicare and Medicaid losses. By 2001, private payers paid 13% above costs. Some of the change is probably attributable to pressure for lower prices from major managed care plans

[22] "Maryland Health Cuts to Mean Higher Insurance Rates," *Baltimore Sun*, Aug. 3, 2003, p. 1D.

and other insurers. But hospitals might have been more willing to accept lower prices from private payers because their losses from the public programs had dropped so much.

One final point to be made about the figures in **Table 15** is that the proportion of uncompensated care costs made up through state or local subsidies has gone from 19.6% in 1991 to 12.2% in 2001, a drop of more than one-third. Yet losses from uncompensated care have not risen proportionately; as a percent of total hospital costs, the losses were 4.8% in 1991 and 5.3% in 2000. One possible explanation is that non-Medicaid subsidies were partially replaced by DSH payments to safety net hospitals.

The possible role of Medicaid in offsetting some hospitals' losses from bad debts or charity care appears to vary by state. **Table 16** is based on the 2000 annual member survey of the National Association of Public Hospitals and Health Systems (NAPH). This organization chiefly represents large state and local hospitals; a few members are operated by private, non-profit corporations but function as "safety net" providers, treating substantial numbers of Medicaid and uninsured patients. The table thus illustrates the experience of a few major safety net providers in each state listed, and may not be representative of all hospitals, or even comparable safety net hospitals, in each state.[23]

The table first compares estimated costs for Medicaid patients and Medicaid revenues, including DSH payments. Of the 20 states listed, 10 were paying the reporting hospitals less than their Medicaid costs. In the other 10 states, Medicaid revenues exceeded costs, sometimes substantially. The table then compares costs and revenues for patients classed as "self pay/other." This group is made up of all patients without private insurance, Medicaid, or Medicare, including the uninsured and people with coverage through CHAMPUS, workers compensation, and other sources. Offsetting revenues for this group include various forms of non-Medicaid public funding, such as local subsidies or state indigent care pools), and other funding sources for the self-pay/other population. In nearly all the states, the reporting hospitals incurred sizeable losses for this population. (Exceptions may be artifacts of the method of estimating costs from gross charges.)

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[23] The survey, like the AHA survey, ascertains Medicaid and self-pay/other gross charges but not costs. As in the AHA data, the estimates in the table assume that the Medicaid and self-pay/other cost/charge ratios are the same as the overall cost/charge ratio reported by the hospital.

Table 16. Estimated Costs and Revenues, Medicaid and Self-Pay/Other Patients, NAPH Member Hospitals, 2000

(millions of dollars)

		Medicaid			Self-pay and other			Combined Medicaid/ self-pay/other gain/loss
State	Count of entities	Estimated cost	Revenue	Percent gain/ loss	Estimated cost	Revenue	Percent gain/ loss	
California	15	$1,812	$1,797	-1%	$1,323	$947	-28%	-12%
Colorado	2	$112	$165	48%	$198	$45	-77%	-32%
Florida	9	$387	$301	-22%	$374	$416	11%	-6%
Georgia	1	$153	$194	27%	$214	$101	-53%	-20%
Hawaii	3	$30	$24	-21%	$14	$15	10%	-11%
Iowa	1	$13	$6	-52%	$45	$38	-15%	-23%
Illinois	1	$40	$41	3%	$37	$23	-39%	-17%
Indiana	1	$81	$105	29%	$100	$66	-34%	-6%
Louisiana	9	$184	$624	238%	$456	$4	-99%	-2%
Massachusetts	2	$185	$120	-35%	$210	$208	-1%	-17%
Minnesota	1	$140	$128	-9%	$24	$41	71%	3%
Missouri	1	$84	$77	-9%	$65	$64	-2%	-6%
New Mexico	1	$64	$87	37%	$91	$55	-39%	-8%
Nevada	1	$65	$66	1%	$78	$67	-14%	-7%
New York	12	$1,772	$1,788	1%	$731	$496	-32%	-9%
Ohio	2	$136	$154	13%	$102	$56	-45%	-12%
Tennessee	3	$184	$112	-39%	$86	$65	-25%	-34%
Texas	5	$513	$495	-4%	$1,022	$ 958	-6%	-5%
Virginia	1	$64	$79	24%	$128	$109	-15%	-2%
Washington	1	$116	$98	-16%	$46	$33	-28%	-19%

Source: Author's calculations from National Association of Public Hospitals and Health Systems, America's Safety Net Hospitals and Health Systems, 2000.

Note: Assumes Medicaid and self-pay/other cost/charge ratio equal to overall cost/charge ratio. The table omits five hospitals, one in Alabama, two in Illinois, and two in New York, that reported total costs greater than total charges.

In some states it appears clear that Medicaid reimbursement is reducing the burden of uncompensated care. Louisiana is paying the responding hospitals, all operated by Louisiana State University, more than twice their Medicaid costs. (The nine hospitals received about one-third of Louisiana's DSH funding in 1998.) The excess nearly exactly offsets the hospitals' bad debt and charity care costs. Hospitals in several other states, such as Colorado, Indiana, and New Mexico, received considerably more in Medicaid payments than their Medicaid costs. In these states, however, the Medicaid payments and other public subsidies were insufficient to offset costs for uncompensated care.

The two states with the most responding hospitals, California and New York, paid these hospitals amounts roughly equal to their estimated Medicaid costs. The 15 California hospitals received $1.2 billion in DSH funds in 2000, or 64% of the state's total DSH spending of $1.9 billion. In New York, the 12 hospitals received $407 million in 2001, or 34% of the state's $1.2 billion in DSH spending. But these payments were just sufficient to bring Medicaid payments close to Medicaid costs, with no excess available to subsidize other patients.

Physician and Dental Care

Medicaid payment levels for physician and dental care, and their effects on provider participation and beneficiary access, have been issues since the earliest years of the program. States have commonly paid independent practitioners using fixed fee schedules, often at rates well below those paid by Medicare or private insurers. Many physicians refused to accept Medicaid patients or limited their Medicaid caseloads, leaving beneficiaries to rely on more costly hospital outpatient departments and emergency rooms as a primary source of care.

Medicaid payments to physicians and other providers are subject to the general requirement 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. OBRA 89 codified this requirement (previously established only by regulation) and established specific reporting requirements with respect to payment rates for obstetric and pediatric services, to allow the Secretary to determine the adequacy of state payments for these services. These special reporting requirements were repealed by the BBA, but the requirement that payments be sufficient to assure access remains in the statute. It has been the basis for numerous lawsuits by groups of physicians, dentists and other providers.[24]

This section provides data on payment levels for physician and dental services and summarizes some recent literature on how these payment levels affect access to care.

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[24] For reviews of recent litigation, see National Health Law Program, *Docket of Medicaid Cases to Improve Provider Participation*, Feb. 23, 2003, at [http://www.nls.org/conf2003/provider-docket.htm] and summaries by the American Dental Association, at [http://www.ada.org/prof/govt/dentistryworks/med-litigate.html], as of Sept. 2003.

Physician Payment. Every state except Hawaii now pays physicians the lesser of actual charges or a fixed fee schedule amount for each visit or procedure, whether performed in offices, hospitals, or other settings.[25] States set these fee schedules in various ways. Some were originally based on physicians' actual charges for services, while others are set arbitrarily by the state or negotiated with provider groups. Others use systems comparable to Medicare's, under which each procedure is assigned a weight on a resource-based relative value scale (RBRVS); the weightings reflect relative physician work, practice expenses, and malpractice costs associated with different procedures. A brief physician office visit might have a value of three, an appendectomy a value of 150. The state then multiplies the different values by a single standard dollar amount. If a unit is valued at $5, the state will pay $15 for the brief office visit and $450 for the appendectomy. Some states have adopted Medicare's scales, while others use different weighting systems. The effect is the same as under a fee schedule, except that the Medicaid agency has an external reference for its pricing decisions.

However the schedule is established, basic rates and/or inflation increases are fixed by the state and may bear no relation to what physicians ordinarily charge or what they are paid by Medicare or private insurers. **Table 17** compares each state's Medicaid rates in 2001 for selected procedures. The rates are those reported by state Medicaid directors in an annual survey conducted by the American Academy of Pediatrics (AAP). The AAP collects data on a large number of different procedures; the five shown here were selected arbitrarily as representative of broad classes of services: primary care, mental health, and so on. (Unfortunately, because AAP focuses on pediatric care, its procedure list does not include obstetric services, payment for which has been a long-standing issue in Medicaid programs.)

As the table shows, states' payment rates vary enormously. Leaving aside Alaska, an outlier because of its high cost of living, rates for an initial pediatric preventive office visit range from $20 in Pennsylvania to $114.87 in New Mexico, almost six times as much. Payment for a complex procedure like a cardiac catheterization ranges from $80 in New York to $1,688 in Arizona, a twenty-fold difference.[26]

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[25] Hawaii continues to use the "reasonable charge" method used by Medicare before Medicare adopted its own fee schedule: the reasonable charge for a specific service is the lowest of (a) the provider's actual charge for that service; (b) the provider's customary charge for comparable services; or (c) the "prevailing" charge in the area, fixed at the 75th percentile of charges for comparable services.

[26] This rate applies to individuals not enrolled in the Arizona Health Care Cost Containment System (AHCCCS), the managed care program that serves most Medicaid beneficiaries in Arizona.

Table 17. Medicaid Payment Rates for Selected Physician Procedures, 2001

	Preventive visit, new patient, age 1-4 (99382)[a]	Psychotherapy, office, 45-50 minutes (90806, nonfacility)[a]	Initial hospital care, moderate complexity (99222)[a]	Upper GI endoscopy, biopsy (43239, nonfacility)[a]	Appendectomy (44950)[a]	Left heart catheterization (93510)[a]
Alabama	$70.00	$63.00	$76.00	$169.00	$405.00	$894.00
Alaska	$160.07	$142.29	$174.65	$378.70	$823.44	$2,761.37
Arizona	$101.18	$94.11	$114.86	$240.85	$534.28	$1,687.99
Arkansas	$51.28	$88.13	$84.00	$373.00	$488.00	$356.00
California	$47.13	$46.44	$73.20	$234.18	$400.59	$1,038.99
Colorado	$55.05	NA	$88.37	$20.06	$334.30	$441.55
Connecticut	$50.00	$50.00	$51.40	$161.36	$374.70	$172.11
Delaware	$97.52	NA	$107.73	$227.94	$496.04	$1,596.11
District of Columbia*	$45.00*	NP	$36.00*	$123.00*	$267.00*	$108.00*
Florida	NA	$50.34	$61.42	$129.63	$527.99	$145.57
Georgia	$55.38*	NP	$104.28	$219.02	$463.03	$1,526.14
Hawaii	$31.50	$84.71	$73.90	$233.73	$429.07	$267.77
Idaho	$59.20	$57.54	$117.35	$327.29	$557.96	$1,644.41
Illinois	$44.30	$50.25	$54.43	$264.35	$396.45	$770.05
Indiana	$34.52	$63.67	$80.67	$181.60	$314.84	$1,167.49
Iowa	$44.36	$60.28	$60.31	$394.19	$688.77	$526.22
Kansas	$35.00	$60.00	$69.54	$220.00	$268.00	$1,431.45
Kentucky	$79.91	$65.73	$84.07	$179.22	$333.52	$1,223.29
Louisiana	$36.90	$76.70	$41.40	$177.66	$343.81	$232.65
Maine	$50.20*	$73.60	$63.05	$166.95	$297.19	$423.91

	Preventive visit, new patient, age 1-4 (99382)[a]	Psychotherapy, office, 45-50 minutes (90806, nonfacility)[a]	Initial hospital care, moderate complexity (99222)[a]	Upper GI endoscopy, biopsy (43239, nonfacility)[a]	Appendectomy (44950)[a]	Left heart catheterization (93510)[a]
Maryland	$37.00	$40.50	$24.50	$234.00	$206.00	$80.00
Massachusetts	$90.86	$66.22	$81.05	$192.99	$397.28	$220.84
Michigan	$62.13	$59.89	$66.39	$85.01	$322.09	$1,013.16
Minnesota	$34.82	$67.77	$100.42	$325.99	$610.27	$463.50
Mississippi	$37.63	$78.80	$60.59*	$175.64*	$304.20*	$1,310.01
Missouri	$23.00	NC	$25.00	$110.00	$251.00	$165.00
Montana	$58.47	$82.03	$99.65	$205.69	$455.63	$923.99
Nebraska	$72.80	$79.49	$71.28	$201.20	$467.90	$194.40
Nevada	$59.07	$81.62	$99.66	$17.72	$799.87	$1,541.19
New Hampshire	$40.00	$65.00	$86.00	$126.00	$284.00	$900.00
New Jersey	$22.00	$37.00	$22.00	$163.00	$211.00	$1,045.00
New Mexico	$114.87	$85.72	$104.17	$228.71	$476.03	$1,473.62
New York	$30.00	NP	$10.00	$100.00	$160.00	$80.00
North Carolina	$77.75	$89.97	$109.26	OM	$495.82	$1,550.72
North Dakota	$84.59	$78.38	$95.04	$196.29	$433.40	$1,332.53
Ohio	$57.61	$57.10	$55.71	$172.53	$353.21	$1,175.83
Oklahoma	$67.97	$63.03	$76.40	$157.11	$345.25	$1,054.26
Oregon	$71.88	NC	$76.81	$118.59	$372.64	$1,172.16
Pennsylvania	$20.00	NA	$29.50	$211.50	$301.50	$187.50
Rhode Island	$37.00*	NP	$44.00	$184.80	$248.30*	$235.20
South Carolina	$38.00	$55.94	$38.00	$152.44	$321.72	$1,027.53

	Preventive visit, new patient, age 1-4 (99382)[a]	Psychotherapy, office, 45-50 minutes (90806, nonfacility)[a]	Initial hospital care, moderate complexity (99222)[a]	Upper GI endoscopy, biopsy (43239, nonfacility)[a]	Appendectomy (44950)[a]	Left heart catheterization (93510)[a]
South Dakota	$28.30	NP	$86.30	$317.50	$529.20	$1,293.81*
Tennessee	No fee-for-service program					
Texas	$49.01	$64.10	$82.65	$207.84	$343.68	$1,307.07
Utah	$61.94	$55.23	$71.26	$148.80	$316.88	$867.91
Vermont	$62.46	NP	$77.05	$116.10*	$270.60*	$147.60*
Virginia	$74.21	$67.44	$82.29	$173.68	$380.70	$1,218.66
Washington	$67.58	$57.27	$70.02	$156.14	$321.01	$1,040.21
West Virginia	$76.64	$74.01	$81.91	$186.75	$398.26	$1,252.20
Wisconsin	$31.39	NA	$64.72	$471.66	$522.39	$402.25
Wyoming	$45.00	$60.00	$92.34	$270.90	$630.00	$260.00

Source: *American Academy of Pediatrics, Medicaid Reimbursement Survey*, 2001.

Note: NA=Not applicable. NC=Not covered. OM=Other method. NP=Information not provided by state.

*Data provided by state in 1998/1999 survey.

a. The codes are from Current Procedural Terminology (CPT), Fourth Edition, developed by the American Medical Association and used by CMS in determining physician payment amounts.

Table 18 shows the reported Medicaid rates as a percentage of the 2001 Medicare rate for the same state. Rates under the Medicare fee schedule are partially adjusted using Geographic Practice Cost Indices (GPCIs), which reflect differences in the costs of practicing medicine in different areas. Sometimes there is one GPCI for a whole state, in which case the Medicare rate used for comparison is the statewide rate. Sometimes there are different GPCIs for different parts of a state, in which case the Medicare comparator is for the specific area noted in the table.[27]

[27] AAP's own published comparison uses the national rate before application of the GPCIs. As local Medicare rates for the five listed procedures varied by as much as 44% in 2001, use of local rates seemed preferable.

Table 18. Medicaid Payment Rate as a Percentage of Medicare Physician Fee Schedule, 2001

	Preventive visit, new patient, age 1-4 (99382)[a]	Psychotherapy, office, 45-50 minutes (90806, nonfacility)[a]	Initial hospital care, moderate complexity (99222)[a]	Upper GI endoscopy, biopsy (43239, nonfacility)[a]	Appendectomy (44950)[a]	Left heart catheterization (93510)[a]
Alabama	56%	57%	59%	52%	65%	44%
Alaska	156%	149%	157%	146%	158%	182%
Arizona	102%	102%	108%	96%	108%	117%
Arkansas	47%	88%	72%	132%	88%	21%
California (Los Angeles)	38%	43%	58%	73%	66%	53%
Colorado	50%	NA	77%	7%	61%	26%
Connecticut	41%	46%	41%	50%	62%	9%
Delaware	79%	NA	85%	71%	82%	81%
District of Columbia	40%*	NA	30%*	42%*	47%*	6%*
Florida (Miami)	NA	48%	49%	42%	85%	8%
Georgia (Atlanta)	48%*	NA	87%	74%	82%	85%
Hawaii	26%	81%	61%	75%	73%	14%
Idaho	58%	61%	108%	127%	110%	109%
Illinois (Chicago)	43%	54%	50%	102%	78%	51%
Indiana	29%	60%	65%	59%	52%	61%
Iowa	42%	63%	54%	148%	133%	34%
Kansas	34%	63%	63%	84%	51%	92%
Kentucky	78%	69%	76%	69%	64%	81%
Louisiana (New Orleans)	34%	77%	36%	64%	62%	14%
Maine (southern)	40%*	67%	50%	51%	49%	21%

	Preventive visit, new patient, age 1-4 (99382)[a]	Psychotherapy, office, 45-50 minutes (90806, nonfacility)[a]	Initial hospital care, moderate complexity (99222)[a]	Upper GI endoscopy, biopsy (43239, nonfacility)[a]	Appendectomy (44950)[a]	Left heart catheterization (93510)[a]
Maryland (Baltimore)	32%	39%	20%	79%	36%	4%
Massachusetts (Boston)	82%	67%	70%	68%	73%	13%
Michigan (Detroit)	53%	56%	52%	28%	50%	53%
Minnesota	32%	69%	88%	118%	115%	28%
Mississippi	35%	80%	53%*	64%*	56%*	80%
Missouri (St. Louis)	23%	NA	23%	44%	50%	11%
Montana	58%	88%	92%	80%	89%	61%
Nebraska	69%	83%	64%	75%	90%	12%
Nevada	58%	88%	92%	7%	158%	102%
New Hampshire	40%	70%	80%	49%	57%	61%
New Jersey (northern)	20%	37%	19%	56%	38%	59%
New Mexico	92%	78%	81%	70%	78%	74%
New York (Manhattan)	29%	NA	9%	38%	30%	5%
North Carolina	68%	88%	92%	NA	87%	87%
North Dakota	62%	66%	69%	54%	64%	58%
Ohio	54%	58%	49%	63%	65%	72%
Oklahoma	67%	67%	70%	61%	68%	71%
Oregon (Portland)	64%	NA	66%	41%	68%	68%
Pennsylvania (Philadelphia)	17%	NA	24%	69%	51%	10%
Rhode Island	32%*	NA	36%	62%	43%*	13%
South Carolina	37%	59%	35%	58%	63%	68%

	Preventive visit, new patient, age 1-4 (99382)[a]	Psychotherapy, office, 45-50 minutes (90806, nonfacility)[a]	Initial hospital care, moderate complexity (99222)[a]	Upper GI endoscopy, biopsy (43239, nonfacility)[a]	Appendectomy (44950)[a]	Left heart catheterization (93510)[a]
South Dakota	28%	NA	81%	125%	107%	87%
Tennessee	NA	NA	NA	NA	NA	NA
Texas (Houston)	43%	62%	69%	71%	59%	74%
Utah	59%	57%	64%	55%	60%	55%
Vermont	59%	NA	68%	43%	51%	9%
Virginia	68%	69%	73%	62%*	72%*	74%*
Washington (Seattle)	58%	56%	58%	52%	56%	57%
West Virginia	72%	76%	72%	69%	74%	78%
Wisconsin	31%	NA	59%	183%	99%	27%
Wyoming	44%	63%	83%	103%	120%	17%

Source: *American Academy of Pediatrics, Medicaid Reimbursement Survey, 2001*, and *2001 Medicare Physician Fee Schedule*, available at [http://www.cms.hhs.gov/physicians/mpfsapp/step0.asp].

Note: NA = Not available.

*Data provided by state in 1998/1999 survey.

a. The codes are from Current Procedural Terminology (CPT), Fourth Edition, developed by the American Medical Association and used by CMS in determining physician payment amounts.

Although states generally pay less than Medicare for the listed services, the gap varies considerably by procedure. In states that have systems similar to Medicare's RBRVS, but use a different dollar multiplier to establish Medicaid rates, the ratio of Medicaid to Medicare rates will be roughly constant. In other states that have assigned their own values to different procedures, rates may be far below Medicare's for some services and higher for others. The payment gap tends to be larger for preventive office visits and for cardiac catheterization than for the other listed services.

The gap between Medicaid physician payment rates and rates paid by private insurers is likely to be even greater. Studies done for the Medicare Payment Advisory Commission (MedPAC) estimate that Medicare physician rates were about 83% of average private rates in 2001.[28]

The relationship between Medicaid fee-for-service payment rates and physicians' willingness to accept Medicaid patients was extensively studied in the 1970s and 1980s, but has received less attention recently — perhaps because policy focus has shifted to access by enrollees in managed care arrangements. While these earlier studies did show a positive relationship between payment levels and participation, changes in the health care marketplace and other factors might mean that the results would be different now.

A recent study by the Center for Studying Health System Change found that the proportion of physicians accepting Medicaid patients dropped from 87.1% in 1997 to 85.4% in 2001. The share accepting no new Medicaid patients increased slightly, from 19.4% to 20.9%. However, there was no consistent relationship between these measures and relative physician payment levels. The author suggests that capacity constraints, the prevalence of Medicaid managed care, administrative rules, and other market factors might play a role.[29] Similarly, a multi-variate analysis of factors affecting access and use by adult beneficiaries in 13 states in 1996 found that those in states with above-average Medicaid physician payments were no more likely than others to have a usual source of care or to have had a doctor's visit in the last year.[30]

One recent survey of pediatricians, summarized in **Table 19**, found that, while nearly 90% had some Medicaid patients, only 61% accepted all Medicaid patients seeking care. Part of the difference may be related to capacity; nearly a quarter of the respondents were not accepting all privately insured patients, either. While physicians clearly felt that payments were inadequate — over half reported that Medicaid payments were insufficient even to cover their overhead, leaving aside any

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[28] The difference is much smaller than in 1994, when Medicare paid 66% of average private rates. MedPAC attributes the change to shifts from indemnity plans to lower-paying HMOs and PPS. MedPAC, *Report to the Congress: Medicare Payment Policy*, 2003.

[29] P. Cunningham, *Mounting Pressures: Physicians Serving Medicaid Patients and the Uninsured, 1997-2001*, Center for Studying Health System Change, Tracking Report no. 6, Dec. 2002.

[30] T. Coughlin, and S. Long, "Adult Health Care Access and Use Under Medicaid: Does it Vary by State?" *Journal of Health Care for the Poor and Underserved*, vol. 14, no. 2 (2003), pp. 208-228.

compensation for the physician's time — fewer than one-third said that they would see more Medicaid patients if payments were raised. On average, pediatricians said that Medicaid rates would have to exceed 82% of their customary charge before they would accept additional Medicaid patients. (As **Table 18** showed, the Medicaid rate for a well child visit was at or above 82% of the Medicare rate in only four states in 2001.)

Table 19. Survey of Pediatricians on Medicaid Participation, 2000

Currently accept any patients covered by —	
Medicaid	89.5%
SCHIP	87.1%
Currently accept all patients covered by-	
Medicaid	61.2%
SCHIP	63.7%
Private insurance	74.3%
Medicaid payments cover overhead	
Yes	13.2%
No	54.4%
Don't know	32.4%
Would see more Medicaid patients with increased reimbursement	31.0%
Percent of customary fee for well-child visit needed to —	
Accept more, or any, Medicaid patients	82.0%
Accept all Medicaid patients	86.5%

Source: American Academy of Pediatrics, Division of Health Policy Research, *Pediatrician Participation in Medicaid/SCHIP: Survey of Fellows of the American Academy of Pediatrics, 2000*.

It should be noted that, while low reimbursement was the most commonly cited reason for limited Medicaid participation, there were other issues, including paperwork, unpredictable and delayed payments, and a perception that Medicaid patients miss appointments.

Dental Payment

Adequacy of payment for dental care, as for physician care, has been a constant issue in Medicaid programs. States have always used fixed fee schedules for dental services, and payments are commonly below dentists' usual fees. While no national estimates are available, **Table 20** compares Medicaid fees to median private fees for selected services in 12 states. The private fees are drawn from the 2002 annual survey of dentists by Dental Economics; the Medicaid fees are from the states' most recent fee schedule. The states are those (a) for which Dental Economics' sample

was sufficient to allow reporting of state-level medians and (b) whose fee schedules were readily accessible through the state's web site.[31]

[31] The General Accounting Office (GAO) has done its own comparison of state fee schedules and provider charges, using 1999 fees and American Dental Association survey data. The results are somewhat different, perhaps because GAO uses different procedures and compares Medicaid fees to mean (rather than median) private fees for entire regions (rather than individual states). Generally, GAO found higher Medicaid/private fee ratios, but the relative ranking of states was fairly similar. U.S. General Accounting Office, *Oral Health: Factors Contributing to Low Use of Dental Services by Low-Income Populations* (GAO/HEHS-00-149), Sept. 2000.

Table 20. Medicaid Fees, 2003, and Median Private Fees, 2002, for Selected Dental Procedures

	Comprehensive oral evaluation (D0150)[a]		Complete x-ray series (D0210)[a]		Cleaning, child (D1120)[a]		Filling (amalgam), two surfaces (D2150)[a]		Root canal, molar (D3330)[a]	
	Medicaid fee	Percent of median fee	Medicaid fee	Percent of median fee	Medicaid fee	Percent of median fee	Medicaid fee	Percent of median fee	Medicaid fee	Percent of median fee
Connecticut[b]	$13.00	20%	$24.75	25%	NA	NA	$22.00	19%	$192.50	23%
Florida	$16.00	32%	$32.00	40%	$14.00	29%	$41.00	43%	$235.00	34%
Illinois	$21.05	41%	$30.10	35%	$25.40	56%	$48.15	48%	$202.30	29%
Indiana	$35.50	93%	$72.25	99%	$34.50	93%	$72.25	84%	$524.00	84%
Massachussetts[c]	$36.00	56%	$63.00	66%	$33.00	66%	$80.00	80%	$613.00	77%
Michigan	$14.89	31%	$40.95	48%	$19.53	47%	$31.21	39%	$378.00	62%
Missouri	$38.50	101%	$33.50	45%	$18.50	51%	$37.00	49%	$241.00	44%
New Jersey[d]	NA	NA	$26.00	31%	$13.00	26%	$38.00	36%	$247.00	34%
New York	NA	NA	$58.00	75%	$43.00	86%	$84.00	84%	$ 406.00	58%
North Carolina[e]	$45.00	102%	$75.19	94%	$21.62	51%	$79.41	84%	NA	NA
Pennsylvania	$20.00	40%	$45.00	58%	$22.00	49%	$50.00	53%	$270.00	41%
Texas	$18.02	46%	$36.04	47%	$18.75	48%	$43.73	52%	$312.13	50%

Source: R. Willeford, "2002 Practice, Salary, and Fee Surveys," *Dental Economics*, vol. 92, no.2 (Dec. 2002), pp.28-44, and state Medicaid dental fee schedules as of Aug. 2003.

Note: NA = Medicaid fee schedule used does not include procedure.

a. The codes are from Current Procedural Terminology (CPT), Fourth Edition, developed by the American Medical Association and used by CMS in determining physician payment amounts.
b. Fee schedule for adults; children's services covered under HuskyCare plans.
c. Fees for early and periodic screening, diagnosis and treatment-related services (EPSDT), when higher.
d. Fees for specialist services, when higher.
e. Fees reported in proposed settlement of *McCree v. Odom*, a beneficiary lawsuit on dental access (U.S. District Court — Eastern District of North Carolina Case No.: 4:00-CV-173-H(4)); at [http://www.dhhs.state.nc.us/dma/mccreesettlement/dentalsettlementagree.pdf].

As with physician payment, there is wide variation among states. However, there appears to be somewhat more consistency across different procedures within a single state — that is, some of the states are low payers and others high payers across the board. It should be emphasized that the comparison here is not between what Medicaid pays and what some insurer or third-party payer pays for the same service, but between Medicaid rates and providers' charges. Private dental insurance plans also commonly use fixed fee schedules, and these, too, may often be well below providers' charges. The difference is that, while patients with private insurance may have to pay the balance, dentists who treat Medicaid patients must accept the Medicaid rate as payment in full.

Low fees probably play a role in limited use of dental services by Medicaid beneficiaries, especially children. (Some state plans offer little or no dental coverage for adults.) One recent study found that fewer than one in five children with Medicaid received a dental visit over the course of a year.[32] Whether increasing fees would improve access is not certain. Responding to a GAO survey of 40 states that increased rates between 1997 and 2000, 14 reported increases in participation or utilization, 15 reported no increase, and 11 indicated that not enough time had elapsed or the state did not have reliable data. In states reporting changes, the improvement was often marginal. GAO concluded that the size of rate increases was less important in explaining access improvements than the absolute amount of the fees after the increase.

A 2002 study by the National Conference of State Legislatures identified a number of factors in dentist participation unrelated to Medicaid reimbursement, including stigmatization of Medicaid beneficiaries and a perception that they fail to keep appointments. In addition, the study noted that many practices are already at capacity with private-pay patients and have no need to accept Medicaid beneficiaries.[33]

Federally Qualified Health Centers and Rural Health Clinics

Under OBRA 89, states were required to cover services in federally qualified health centers (FQHCs) and to pay full reasonable cost for these services. FQHCs include community health centers, migrant health centers, and health care for the homeless programs receiving funding from the Health Resources and Services Administration, as well as centers that meet the standards for a grant but are not actually receiving federal funding. States were also required, under a 1977 amendment, to pay reasonable costs for services of rural health clinics (RHC), which provide services of nurse practitioners and physician assistants in medically underserved rural areas.

The BBA provided for a gradual phase-out of mandatory cost reimbursement for FQHCs and RHCs, with required reimbursement dropping to 70% of cost by

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[32] U.S. Surgeon General, *Surgeon General's Report on Oral Health*, May 2000.

[33] S. Gehshan, and T. Straw, *Access to Oral Health Services for Low-Income People: Policy Barriers and Opportunities for Intervention*, National Conference of State Legislatures, Oct. 2002.

FY2003 and with no minimum beginning in FY2004. During the transition, states were required to make supplemental payments to FQHCs and RHCs that had contracts with Medicaid MCOs under which the MCO paid less than the required percentage of costs. In 1999, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA, included by reference in the Consolidated Appropriations Act for FY2000, P.L. 106-113) slowed the phase-out and delayed repeal of minimum payment rules until FY2005.

BIPA established a new prospective payment system for FQHCs and RHCs. Each center or clinic received a per visit rate for 2001 based on its own average reasonable costs for 1999 and 2000. For later years, this rate is updated by the "Medicare economic index" (MEI) used to update Medicare physician payments for primary care; the rate may be modified to reflect a change in the scope of services provided by the facility. The state and the center may agree to an alternative payment methodology, but only if aggregate payments under the alternative method are at least equal to those that would have been made under the standard method. BIPA continued the requirement that states make supplemental payments to FQHCs and RHCs who are paid less than the minimum by a Medicaid MCO. Finally, GAO was required to report on whether rates should be periodically rebased or refined and on how to do so.

The GAO report is not due until the end of 2004, but GAO has already concluded that the new system is likely to pay many facilities less than their costs, for several reasons. First, the initial 2001 rates were based on costs for the two preceding years, with no allowance for inflation.[34] Second, the MEI index used to update the rates rises less rapidly than other measures of inflation, and centers may have difficulty holding increases to these limits, especially if they began with a low per-visit rate. GAO suggests that it will be difficult to develop a system that assures the continued viability of FQHCs and RHCs while maintaining incentives for efficiency.[35]

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[34] In addition, some states were already paying less than full actual costs, because some costs were disallowed as not "reasonable under various tests."

[35] U.S. General Accounting Office, *Health Centers and Rural Clinics: Payments Likely to be Constrained Under Medicaid's New System*, (GAO-01-577), June 2001.

Long-Term Care

Nursing Facilities

Payments to nursing facilities (NFs) are the single largest component of Medicaid expenditures, accounting for 19% of spending in 2002. At the same time Medicaid is the key funding source for NFs; in 2002, 67% of NF residents relied on Medicaid as their principal payer.[36] Thus ability to control growth in NF spending has an important effect on state budgets, while the adequacy of Medicaid reimbursement can determine whether a facility can offer high-quality care. The tension between the competing goals of cost containment and quality assurance has been present almost since the beginning of the Medicaid program.

Payment Methods. Since the 1980 Boren amendment allowed states to move away from Medicare's retrospective cost-based reimbursement rules, states have evolved very complex NF payment systems. These systems commonly distinguish among direct patient care costs; costs for various operating, support, and administrative functions; and capital costs, such as interest, rent, and depreciation. A state may treat each component differently: for example, payment to a particular facility might be the sum of a case-mix adjusted fixed amount for direct care, a facility-specific cost-based payment subject to a peer group ceiling for other operating costs, and a "fair rental value" payment for capital costs.

The following discussion of payment methods cannot capture the full complexity of states' systems. Instead, it focuses chiefly on how states pay for the direct care component, the actual delivery of services to individual residents by nursing staff. Obviously the totality of the state payment, relative to costs, can affect quality or access. Still, a payment system that has incentives to hold down administrative costs or that limits the rate of return on capital investment has different implications from a system that squeezes direct care spending.

Payment for Direct or Nursing Care. **Table 21** shows each state's basic payment method for the direct care component or, in states classifying costs differently, its nearest equivalent.[37] The table classes states according to whether NFs receive facility-specific rates subject to a peer group ceiling, receive rates set for a whole group of facilities, or are paid under some other method. The table also notes which states offer incentive payments to facilities with costs below the ceiling or rate. For states using some form of case mix adjustment, the table indicates the method. Finally, where applicable, it identifies the facility characteristics states use in establishing peer groups of nursing facilities.

Over two-thirds of the states pay the lesser of the facility's actual costs for Medicaid residents or a fixed ceiling based on the cost experience of comparable

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[36] American Health Care Association analysis of CMS OSCAR data for 2002 at [http://www.ahca.org/research/oscar/rpt_payer1_dec02.pdf] as of Sept. 2003.

[37] States have different definitions of this component and of the types of personnel and other costs it may include.

NFs. States may set statewide ceilings or define peer groups on a number of dimensions, including size, location, ownership, and whether a facility is hospital-based or freestanding. A handful of states continue, for payment purposes, the distinction between intermediate care facilities (ICFs) and skilled nursing facilities (SNFs) that was eliminated by the nursing home reform provisions of OBRA 87. Two states treat facilities granted a waiver of OBRA 87 minimum staffing requirements as a separate group.

Of the states paying the lesser of cost or fixed ceilings for direct care, 11 have incentive arrangements, under which facilities whose costs are below the ceiling share in the savings. Many more states use these arrangements for other cost components, such as administration, where rewards for cost-cutting may arguably be less likely to affect patient care.

Table 21. Payment Methodologies for Nursing Facility Direct Care Component, 2002

	Basic method						
State	NF-specific rate subject to peer group ceiling	Fixed rate for peer group	Other	Incentives for facilities with costs below ceiling/rate	Method of case mix adjustment (if any)	Facility characteristics used to define peer groups	Notes
Alabama	110% of median			x		Bed size	
Alaska			NF-specific, rate of increase limits				
Arizona			Capitation		3 levels		ALTCS; levels are NF, HCBS, ventilator-dependent
Arkansas	105% of median					Statewide	Statewide fixed rate for other components; direct has 90% floor
California		Median			7 levels	Location, size	
Colorado	125% of average					Statewide	
Connecticut	135% of median					Location, size	
Delaware		Median			4 levels	Public, private by county	
District of Columbia	Median					Hospital-based/ freestanding	
Florida	Median plus 1.75 SD					Location, size	
Georgia	90th percentile			x		Size, skilled/ intermediate mix	
Hawaii	115% of average				3 levels		Full cost for highest acuity level
Idaho	Median				RUGs	Location, Hospital-based/ freestanding	

	Basic method						
State	**NF-specific rate subject to peer group ceiling**	**Fixed rate for peer group**	**Other**	**Incentives for facilities with costs below ceiling/rate**	**Method of case mix adjustment (if any)**	**Facility characteristics used to define peer groups**	**Notes**
Illinois		Unspecified basis			See note	Location	Fixed hourly rate times estimated nursing hours, based on resident assessment
Indiana		Median			RUGs	Statewide	Profit-sharing if cost below rate
Iowa	60th to 70th percentile, depending on class					Hospital-based/ freestanding, SNF/ICF	SNFs get add-on for high case mix, high Medicaid share
Kansas	115% of median				RUGs	Statewide	
Kentucky		Unspecified basis			RUGs	Urban/rural	
Louisiana		62nd percentile			6 levels	Statewide	
Maine	110%-150% of median, depending on class				45 state-developed groups	Hospital-based/ freestanding, size	
Maryland	See note at right			x	6 levels	Location, size	Fixed nursing cost ceiling for care level based on survey data
Massachusetts			Blend		6 levels		Blend of facility-specific, statewide
Michigan	80th percentile			x		Hospital-based/ freestanding, ownership, specialty, size	

	Basic method						
State	**NF-specific rate subject to peer group ceiling**	**Fixed rate for peer group**	**Other**	**Incentives for facilities with costs below ceiling/rate**	**Method of case mix adjustment (if any)**	**Facility characteristics used to define peer groups**	**Notes**
Minnesota			NF-specific, rate of increase limits		11 classes	Hospital-based/ freestanding, location	Facility with costs above median gets lower increase
Mississippi	120% of median				RUGs	Size	
Missouri	120% of median					Statewide	
Montana		Unspecified basis			RUGs	Statewide	
Nebraska	125% of median				19 levels	Urban/rural, waiver	
Nevada		60th percentile			6 levels	Statewide	Method for SNF; ICF method not available
New Hampshire	Median				RUGs	Statewide	Statewide fixed rate for other components
New Jersey	115%-120% of average, depending on class					Ownership, specialty	
New Mexico	110% of median			x		State, non-state	
New York	105% of mean				RUGs	Size, location, high or low case mix	Direct care floor at 95% of mean. Medicare maximization incentive
North Carolina	80th percentile				SNF/ICF	Statewide	Statewide fixed rate for other components
North Dakota	Unspecified basis			x	RUGs	Statewide	Fixed statewide ceiling; basis not specified
Ohio	85th percentile				RUGs	Size, location	

	Basic method						
State	**NF-specific rate subject to peer group ceiling**	**Fixed rate for peer group**	**Other**	**Incentives for facilities with costs below ceiling/rate**	**Method of case mix adjustment (if any)**	**Facility characteristics used to define peer groups**	**Notes**
Oklahoma		Average				Statewide	
Oregon		Average				Statewide	Fixed 40% add-on for residents with complex needs
Pennsylvania	117% of median				RUGs	Location, size, Hospital-based/ freestanding, specialty	Add-on for high-Medicaid NF
Rhode Island	80th percentile			x		Statewide	
South Carolina	105% of mean					Statewide	
South Dakota	115% of median				RUGs	Waiver	Risk corridor: pays full direct care cost to 115% of median, 80% of excess up to 125% of median
Tennessee	65th percentile			x		SNF/ICF (equivalents)	Incentive reduced for occupancy below 80%
Texas	107% of mean				11 levels	Statewide	
Utah	120% of median			x		Statewide	
Vermont	115% of median				RUGs	Statewide	
Virginia	112% of median				3 levels	Location, size	
Washington	105% of median				RUGs	Location	95% floor; scheduled shift to fixed price at median for peer group

	Basic method						
State	**NF-specific rate subject to peer group ceiling**	**Fixed rate for peer group**	**Other**	**Incentives for facilities with costs below ceiling/rate**	**Method of case mix adjustment (if any)**	**Facility characteristics used to define peer groups**	**Notes**
West Virginia	Average			x	See note	Size	Unspecified case mix scoring based on minimum data set (MDS)
Wisconsin		Unspecified basis			5 levels	Location, size	CMI adjusted upward for small NF
Wyoming	125% of median			x		Statewide	
Number of states using method	36	11	4	11	31 (14 RUG)		

Source: Medicaid state plans and amendments approved as of Nov. 7, 2002, except as follows: Nevada Medicaid Rates and Cost Containment Unit Rate Matrix, [http://dhcfp.state.nv.us/pdf%20forms/RateSummary_03-17-03.pdf], as of July 2003. Ohio Administrative Code 5101-3-3.

Note: ALTCS = Arizona Long Term Care System; CMI = case mix index; HCBS = home and community-based services; ICF = intermediate care facility; SNF = skilled nursing facility; RUG = resource utilization groups.

Eleven states pay fixed per diem amounts for direct care. In some states the per diem rates are based, as in states using cost ceilings, on the experience of comparable facilities. In other states, the per diems are fixed by law or regulation. (While the rates may be derived through some form of cost analysis, a specific formula is not described in the state plan.)

Of the remaining states, two use facility-specific ceilings based on the NF's historical costs and fixed updates, while one, Massachusetts, pays a rate based on a blend of facility-specific and statewide experience. Finally, Arizona provides NF and other long-term care services through the Arizona Long Term Care System (ALTCS), under which contracting plans receive fixed capitation payments for care of each enrollee. Payment amounts vary for two classes of nursing home residents and for enrollees receiving home care.

Case Mix. More than half the states now use some form of case mix adjustment in paying NFs. Of these, 14 use the resource utilization groups (RUGs) developed by CMS for Medicare SNF payment. The Medicare system assigns each resident to one of 44 groups based on a resident assessment that measures physical function, rehabilitation needs, cognitive impairment, and other factors. Medicaid programs commonly use a set of 34 RUGs; these have fewer distinct categories of rehabilitative care, because fewer Medicaid residents are receiving such care. The remaining states have developed their own classification systems, usually grouping residents into a much smaller number of care categories.

Case mix is often used differently in Medicaid NF payment than in Medicare SNF payment. Under Medicare's PPS for SNF services, there is a fixed daily rate for each resident; part of this rate, the nursing and therapy case-mix components, varies by the resident's RUG class.[38] In Medicaid programs case mix is often used, not to establish payment for a particular resident, but to adjust the per diem cost ceiling for the entire facility. A facility that has served residents with more intensive needs during some base period will be allowed a higher ceiling than other facilities in its peer group.

Case mix adjustment is intended both to treat NFs fairly and to reduce incentives to refuse heavy care patients. At least some observers contend that the adjustments may create perverse incentives of its own. For example, an NF might be penalized for promoting resident independence, because payment is greater for residents requiring more assistance.[39]

Labor Cost Adjustments. There are concerns that the supply of nurses' aides and other direct care workers in nursing homes, as well as in-home and personal care programs, is not keeping pace with demand. Providers have difficulty retaining these workers because of low wages and benefits and physically demanding

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[38] There are separate urban and rural rates. Payment is further adjusted to reflect local wage levels.

[39] C. Harrington, et al., *1998 State Data Book on Long Term Care Program and Market Characteristics*, at [http://www.cms.hhs.gov/medicaid/services/98sdbltc.pdf].

work; some studies have found turnover rates approaching 100%.[40] State constraints on growth in the direct care component of NF payment have limited providers' ability to improve compensation or benefits; an individual facility that does so on its own may risk exceeding a class-based cost ceiling. Some states have sought to address this problem through "wage pass-through programs," which directly compensate providers that increase wages for direct-care workers. (Some other states have periodically made general rate adjustments to reflect increases in federal or state minimum wage requirements.)

Table 22 summarizes the pass-through programs in 28 states. Most programs target NFs, though some also reach home care and/or personal care programs. Some are voluntary — the provider receives enhanced reimbursement if it shows that it has raised wages — while others require participation by all providers in the targeted group. Information on the effectiveness of the programs is limited. Some states have reported modest improvements in turnover rates, while others have found no change or have not measured the effects.[41]

Table 22. Summary of State Wage Pass-Through Programs

State	Target provider type			Participation		
	Nursing facility	Home care	Personal care	Voluntary	Mandatory	Not available
Arizona	x	x	x			x
California	x				x	
Colorado		x		x		
Illinois		x			x	
Kansas	x	x		x		
Louisiana	x					x
Massachusetts	x	x			x	
Maine	x	x	x		x	
Michigan	x				x	
Minnesota	x				x	
Missouri	x				x	
Montana	x		x	x		
North Dakota	x			x		
Oklahoma	x				x	
Rhode Island	x	x	x			x

[40] U.S. General Accounting Office, *Nursing Workforce: Recruitment and Retention of Nurses and Nurse Aides is a Growing Concern*, statement of Williams J. Scanlon in U.S. Congress, Senate Committee on Health, Education, Labor and Pensions, (GAO-01-750T), May 17, 2001.

[41] Paraprofessional Healthcare Institute, *State Wage Pass-Through Legislation: An Analysis*, Workforce Strategies, no. 1, Apr. 2003.

State	Target provider type			Participation		
	Nursing facility	Home care	Personal care	Voluntary	Mandatory	Not available
South Carolina	x	x	x			x
Texas		x			x	
Virginia	x		x	x		
Washington		x			x	
Wisconsin	x					x
Wyoming	x			x		
Total	17	10	6	6	10	5

Source: Paraprofessional Healthcare Institute, State Wage Pass-Through Legislation: An Analysis (Workforce Strategies n. 1), Apr. 2003.

Payment Levels and Adequacy. Analyses performed for the nursing home industry indicate that state Medicaid programs are, in the aggregate, paying less than the full costs of caring for Medicaid residents. However, it is difficult to know whether payments are insufficient across the board or just for the most costly facilities. **Table 23** presents the results of studies by BDO Seidman, LLP for the American Health Care Association, the organization of proprietary nursing homes. The studies, based on data collected from state affiliates, show the difference between average daily rates and daily costs (excluding capital costs) in 36 states in 1999 and 37 states in 2000. Averages are weighted by Medicaid days in each facility. In 2000, Medicaid payments as a percent of cost ranged from a low of 83% in South Dakota to 100% in Alabama. The average for the 37 states was 92%.

Table 23. Average Medicaid Shortfall Per Day, Medicaid Nursing Facility Payments in Responding States 1999 and 2000

State	1999				2000			
	Rate	Cost	Difference	Rate as percentage of cost	Rate	Cost	Difference	Rate as percentage of cost
Alabama	102.78	100.30	2.48	102%	107.13	106.99	0.14	100%
Arkansas	64.52	70.48	-5.96	92%	69.40	75.34	-5.94	92%
California	88.47	95.58	-7.11	93%	97.54	104.74	-7.20	93%
Colorado	111.39	119.12	-7.73	94%	113.57	120.87	-7.30	94%
Connecticut	156.06	165.00	-8.94	95%	No response			
Delaware	No response				118.89	138.56	-19.67	86%
Florida	106.99	119.15	-12.16	90%	112.82	123.99	-11.17	91%
Georgia	No response				90.11	92.80	-2.69	97%
Illinois	No response				87.44	95.56	-8.12	92%
Indiana	92.80	103.64	-10.84	90%	105.14	112.56	-7.42	93%
Iowa	84.83	89.99	-5.16	94%	83.21	89.08	-5.87	93%
Kansas	85.28	93.91	-8.63	91%	91.34	97.01	-5.67	94%
Maine	113.04	122.87	-9.83	92%	119.12	130.68	-11.56	91%
Maryland	123.46	133.16	-9.70	93%	127.96	138.22	-10.26	93%
Massachusetts	120.76	135.47	-14.71	89%	128.59	145.02	-16.43	89%
Michigan	103.94	111.81	-7.87	93%	109.24	119.64	-10.40	91%
Missouri	93.06	101.03	-7.97	92%	97.26	109.91	-12.65	88%
Montana	92.26	103.04	-10.78	90%	No response			
Nebraska	99.13	106.03	-6.90	93%	105.01	111.07	-6.06	95%
Nevada	102.15	116.02	-13.87	88%	No response			
New Hampshire	117.43	127.50	-10.07	92%	119.25	139.87	-20.62	85%
New Jersey	124.95	146.06	-21.11	86%	131.78	154.11	-22.33	86%
New Mexico	99.72	105.32	-5.60	95%	101.23	105.89	-4.66	96%
New York[a]	154.09	164.47	-10.38	94%	161.18	173.74	-12.56	93%

State	1999				2000			
	Rate	Cost	Difference	Rate as percentage of cost	Rate	Cost	Difference	Rate as percentage of cost
North Carolina	94.31	97.00	-2.69	97%	97.72	101.36	-3.64	96%
North Dakota	95.91	99.70	-3.79	96%	102.74	105.33	-2.59	98%
Ohio	115.81	125.31	-9.50	92%	122.64	131.33	-8.69	93%
Oklahoma	No response				66.57	74.17	-7.60	90%
Oregon	91.10	104.24	-13.14	87%	94.97	110.03	-15.06	86%
Pennsylvania	125.14	135.03	-9.89	93%	131.13	143.85	-12.72	91%
Rhode Island	111.79	121.83	-10.04	92%	117.46	129.59	-12.13	91%
South Dakota	79.99	93.80	-13.81	85%	83.21	99.75	-16.54	83%
Tennessee	81.48	86.63	-5.15	94%	88.39	94.13	-5.74	94%
Texas	78.47	82.07	-3.60	96%	83.06	88.25	-5.19	94%
Utah	88.55	101.01	-12.46	88%	90.24	106.74	-16.50	85%
Vermont	103.02	122.97	-19.95	84%	108.24	127.03	-18.79	85%
Virginia	82.12	92.68	-10.56	89%	87.51	99.93	-12.42	88%
Washington[b]	106.96	118.92	-11.96	90%	109.68	126.23	-16.55	87%
West Virginia	109.10	117.26	-8.16	93%	110.97	117.74	-6.77	94%
Wisconsin	99.57	109.85	-10.28	91%	104.05	118.48	-14.43	88%
Weighted average			-9.05	92%			-9.78	92%

Source: BDO Seidman LLP, *A Briefing Chartbook on Shortfalls in Medicaid Funding for Nursing Home Care*, 1999 and 2000 eds., American Health Care Association, 2001 and 2002. Note that data are based on reports from state affiliate associations; not all states reported in one or both years.

a. The data represent single level nursing facilities only. Multilevel facilities providing non-nursing home services such as housing, adult day care and home health were excluded since the reported costs did not reflect allocations between nursing home and non-nursing home services.
b. Rates and costs are exclusive of property costs and property rates which were not included in the available database.

As in the case of hospital payments, Medicaid payments to nursing facilities are usually based on historical cost data with periodic updates. Annual increases in rates or ceilings may or may not keep pace with inflation, and some states may go for long intervals without "rebasing" — updating cost data to reflect changes in facility case mix, occupancy levels, or other factors that may affect costs. As a result, even facilities whose costs were at one time fully covered by Medicaid reimbursement may gradually see shortfalls. **Table 24** shows the change between 1999 and 2000 in average payment rates and average costs in the 33 states for which BDO Seidman has survey responses in both years. Costs rose more rapidly than rates in 21 of the 33 states.

Table 24. Change in Daily Medicaid Nursing Facility Payment Rates and Daily Costs, 1999-2000

State	Percent change in	
	Average daily rate	Average daily cost
Alabama	4.2%	6.7%
Arkansas	7.6%	6.9%
California	10.3%	9.6%
Colorado	2.0%	1.5%
Florida	5.4%	4.1%
Indiana	13.3%	8.6%
Iowa	-1.9%	-1.0%
Kansas	7.1%	3.3%
Maine	5.4%	6.4%
Maryland	3.6%	3.8%
Massachusetts	6.5%	7.0%
Michigan	5.1%	7.0%
Missouri	4.5%	8.8%
Nebraska	5.9%	4.8%
New Hampshire	1.5%	9.7%
New Jersey	5.5%	5.5%
New Mexico	1.5%	0.5%
New York	4.6%	5.6%
North Carolina	3.6%	4.5%
North Dakota	7.1%	5.6%
Ohio	5.9%	4.8%
Oregon	4.2%	5.6%
Pennsylvania	4.8%	6.5%
Rhode Island	5.1%	6.4%
South Dakota	4.0%	6.3%

State	Percent change in	
	Average daily rate	Average daily cost
Texas	5.8%	7.5%
Utah	1.9%	5.7%
Vermont	5.1%	3.3%
Virginia	6.6%	7.8%
Washington	2.5%	6.1%
West Virginia	1.7%	0.4%
Wisconsin	4.5%	7.9%

Source: BDO Seidman LLP, *A Briefing Chartbook on Shortfalls in Medicaid Funding for Nursing Home Care*, 1999 and 2000 eds., Washington, 2001 and 2002.

Still, even in states whose payments keep pace with inflation and other changes affecting costs, some facilities may still lose money. Nearly all state systems pay the lesser of actual costs or a fixed ceiling, in order to create pressure for greater efficiency in the most costly providers. If a state pays nearly all facilities their full costs and underpays a small number of facilities, the average payment to cost ratio will inevitably be less than 100%.

Table 25, based on the 1999 National Nursing Home Survey, suggests that cost ceilings may have affected overall Medicaid payment/cost ratios. The table shows daily charges reported for residents whose current principal source of payment was Medicaid. (Charges would ordinarily be at or above actual costs, although some facilities might have reported what they actually expected Medicaid to pay.) It then shows the actual Medicaid payment rates reported by facilities.[42] Median rates are about 95% of median charges, but the gap widens at the upper end of the distribution.

Table 25. Medicaid Daily Nursing Facility Charges and Payment Rates, 1999

	Average Medicaid daily charge per current resident	Medicaid daily payment rate for the average facility
Mean	$112	$105
Median	$102	$97
75th percentile	$128	$116
90th percentile	$167	$139

Source: Author's calculations from the *1999 National Nursing Home Survey*.

[42] The average charge is weighted according the number of residents for which each charge level was reported, while average Medicaid payment rates are weighted by the number of facilities reporting a given rate. While it would have been preferable to use the same method for both numbers, the design of the NNHS precludes this. In practice, some states that calculate medians to set ceilings use the median facility, while others use the median resident.

In some states, peer group or statewide ceilings, or flat rates based on group experience, may be at least as important as limited annual increases in explaining current payment shortfalls. Whether these ceilings are set at appropriate levels is a difficult policy question, the answer to which depends in part on how sensitive the states' system is to differences in facility and resident characteristics. If a state uses a single statewide ceiling with no case mix adjustment, then a very efficient facility might be penalized because it is in a high-cost urban area or has residents with complex needs.

Some observers have suggested that state use of complex ceiling systems for NF cost containment, in preference to simple rate cuts or freezes, was driven in part by concerns about litigation during the period when the Boren amendment was still in effect. It was easier for states to show that their payments were adequate to meet the costs of "efficiently and economically operated" facilities if only a minority of NFs were affected by payment constraints.[43] With the repeal of the Boren requirements, across-the-board limitations may have greater appeal for states. As **Table 24** showed, many states limited general 1999-2000 rate increases to levels below average cost growth; more may do so in response to current budgetary problems.

Intermediate Care Facilities for the Mentally Retarded

Until the 1980s, most Medicaid services for people with mental retardation or developmental disabilities were provided in large state-operated Intermediate Care Facilities for the Mentally Retarded (ICFs-MR). As a result of the availability of the home and community-based services waivers, court decisions requiring treatment in less restrictive settings, and other factors, over three-fourths of people receiving Medicaid-funded MR/DD services were in the community in 2002.[44] However, the absolute number of ICF-MR residents actually grew slightly between 1977 and 2002, and ICF-MR spending still accounts for nearly 5% of Medicaid spending.

As **Table 26** shows, the major change in the use of facilities to provide care for this population is that many residents are now in smaller facilities or in facilities operated by local government or private organizations. The share of ICF-MR residents in non-state facilities went from 12.5% in 1977 to 59.7% in 2002. Only 1.6% of residents were in facilities with 15 or fewer beds in 1977, compared to 37.8% in 2002.

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[43] CMS *Report to Congress: Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes* (known as the "Phase I" report) ch. 2, at [http://cms.hhs.gov/medicaid/reports/rp700-2.pdf], as of Sept. 2003.

[44] Of 489,138 service recipients, 378,566 were served under HCBS waivers as of June 2002. Research and Training Center on Community Living, *Residential Services for Persons with Developmental Disabilities, Status and Trends Through 2002*, University of Minnesota, Minneapolis, 2003.

Table 26. ICF-MR Residents at End of Year by Facility Size and Ownership, 1977 and 2002

Facility type/size	1977		2002	
State	**Residents**	**Percent**	**Residents**	**Percent**
1-15 residents	356	0.3%	1,013	0.9%
16 or more residents	92,498	87.1%	43,530	39.4%
All state	92,854	87.5%	44,543	40.3%
Non-state				
1-15 residents	1,354	1.3%	40,748	36.9%
16 or more residents	11,958	11.3%	25,281	22.9%
All non-state	13,312	12.5%	66,029	59.7%
All facilities				
1-15 residents	1,710	1.6%	41,761	37.8%
16 or more residents	104,456	98.4%	68,811	62.3%
Total	106,166	100.00%	110,572	100.00%

Source: Research and Training Center on Community Living, Institute on Community Integration/UCEED, *Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2002*, University of Minnesota, 2003.

Most states that use both state-operated and non-state ICF-MRs have different payment rules for the two classes of facilities. States generally pay state-operated ICF-MRs their full operating costs, for the obvious reason that paying less would mean forgoing federal matching funds without reducing state expenditures. While some states also reimburse the full costs of non-state facilities, many have developed alternate systems.

Table 27 shows the payment methods used by the 44 states that make payments to non-state facilities, whether public or private. (Note that two states made no ICF-MR payments in FY 2001, while five others used only state facilities.) The table classes states according to whether non-state facilities receive full costs or costs subject to a peer group ceiling, or are paid under some other method. For states using some form of case mix adjustment, the table indicates the method. Finally, where applicable, it identifies the facility characteristics states use in establishing peer groups of ICF-MRs.

Table 27. Basic Medicaid Payment Method, Direct Care Component, Non-State Intermediate Care Facilities for the Mentally Retarded, 2002

	Basic method			Facility characteristics used to define peer groups	Method of case mix adjustment (if any)	Notes
	Full reasonable cost	Cost with direct care component subject to peer group ceiling	Other method			
Alabama		90th percentile		Bed sizes 4-15, 16+		
Alaska						No ICF-MR payments in FY2001
Arizona						No ICF-MR payments in FY2001
Arkansas			Under 16 beds: fixed statewide rate 16+ beds: cost with ceiling for nonpatient care			
California		65th percentile		Bed sizes 1-59, 60+		Separate groups for small rehabilitative or nursing
Colorado		125% of average		All	Three care levels	
Connecticut		135% of median		All		
Delaware		75th percentile		All private		
District of Columbia		Median		All	Adjustment for high acuity	
Florida			Base cost plus fixed inflation	All	Four levels	
Georgia		90th percentile		All		
Hawaii		115% of average		All		
Idaho		See note				Fixed cap to assure aggregate payments below UPL

	Basic method			Facility characteristics used to define peer groups	Method of case mix adjustment (if any)	Notes
	Full reasonable cost	Cost with direct care component subject to peer group ceiling	Other method			
Illinois			Fixed hourly rate times estimated nursing hours, based on resident assessment	Bed sizes 4-16, 17+, location		
Indiana		See note		ICF-MR, community residential (CRF)	Seven care levels	Percent of median for community residential facility ceiling varies by level of care; ceiling for ICF-MR at 125% of median
Iowa		80th percentile		All private		Penalty for occupancy < 80%
Kansas			Fixed dollar limits	Bed sizes 4-8, 9-16, 17+	Five levels	
Kentucky	x					
Louisiana			Fixed rates based on average per diem	Bed sizes 1-8, 9-32, 33		
Maine	x					
Maryland						No non-state ICF-MR in FY2001
Massachusetts						No non-state ICF-MR in FY2001
Michigan						No non-state ICF-MR in FY2001
Minnesota			Base cost plus fixed inflation			
Mississippi		110% of median		All		
Missouri		135% of mean		All private		
Montana	x					
Nebraska		See note			Levels not described in state plan	Personnel ceilings based on "model" staffing hours for facility size/level of care

	Basic method			Facility characteristics used to define peer groups	Method of case mix adjustment (if any)	Notes
	Full reasonable cost	Cost with direct care component subject to peer group ceiling	Other method			
Nevada			1-6 beds: ceiling at 60th percentile; 6+ beds, full cost			
New Hampshire			Under 16 beds: full cost; 16+ beds: ceiling based on median			
New Jersey	x					
New Mexico			Base cost plus fixed inflation		Three levels	Non-care components subject to ceilings
New York			Fixed dollar or staffing screens	Bed sizes 1-30/30+, location		Staffing screens include disability measures
North Carolina		Median		Bed sizes 1-32, 33+	Five levels	
North Dakota	x					Up to approved budget
Ohio		~82nd percentile		Bed sizes 1-8/9+	Four levels	
Oklahoma			Fixed rate based on mean costs	Standard/ specialized <17		
Oregon						No non-state ICF-MR in FY 2001
Pennsylvania	x					Up to approved budget
Rhode Island	x					
South Carolina	x					
South Dakota	x					
Tennessee		65th percentile		All		
Texas			Fixed rate for level of care	Bed sizes <9, 9-13, 14+	Five levels	
Utah			Negotiated rate			

	Basic method			Facility characteristics used to define peer groups	Method of case mix adjustment (if any)	Notes
	Full reasonable cost	Cost with direct care component subject to peer group ceiling	Other method			
Vermont	x					Up to approved budget
Virginia	x					Rate cannot exceed highest rate for state facility
Washington			Cost with ceiling for noncare components			
West Virginia		Mean		Bed sizes 1-8, 8, 9+	Four levels	
Wisconsin		Fixed dollar ceiling		Location	Four levels	
Wyoming						No non-state ICF-MR in FY 2001
Number of states using method	11	19	14		12	

Source: Medicaid state plans and amendments approved as of Nov. 7, 2002, except as follows: 114.1 Code of Massachusetts Regulations 29; MaineCare Benefits Manual 50.07; Nevada Medicaid Rates and Cost Containment Unit Rate Matrix, at [http://dhcfp.state.nv.us/pdf%20forms/RateSummary_03-17-03.pdf], as of July 2003; Ohio Administrative Code 5101-3-3; Rules of the Tennessee Dept. of Health (1200-13-6)

Eleven of the states pay non-state ICFs-MR their full costs; a few of these require that operating budgets be approved in advance. Another 19 use cost ceilings, comparable to those used in NF payment, for the direct care component of costs or for the entire per diem rate. Some of these use peer groups, based on bed size or other characteristics. Others group all facilities together (partly because some states have few or no residents in larger facilities). Of the remaining states, three use different methods for smaller and larger facilities. Most of the rest use some form of fixed rate, often based on peer group means.

Twelve states use some form of case mix adjustment, classifying residents in a small number of level of care groups. Illinois estimates needed hours of nursing home care as part of the resident assessment and uses this estimate to set the direct care component for each patient.

Home and Community-Based Services

In FY2002, Medicaid spent nearly $25 billion for community long-term care services for the aged, the disabled, the mentally retarded/developmentally disabled, and other defined groups. As **Table 28** shows, two-thirds of the spending was made through section 1915(c) home and community-based services (HCBS) waivers. The rest went for non-waiver personal care and home health services; these are optional services defined in the state plan and must be furnished to all Medicaid beneficiaries who require them. Waiver services, on the other hand, are available to a limited number of individuals approved for waiver participation.

Table 28. Medicaid Spending for Home and Community Care, FY2002

	Spending (millions)	Percentage
Home and community-based services waivers	$16,408	66%
Non-waiver personal care	$5,547	22%
Non-waiver home health care	$2,765	11%
Total	$24,720	100%

Source: Brian Burwell, Kate Sredl, and Steve Eiken, *Medicaid Long Term Care Expenditures in FY2002*, The Medstat Group, May 2003, available at [http://www.hcbs.org/hcbs_data.htm], as of Nov. 2003.

In addition, each approved waiver is subject to a "budget neutrality" test; total spending on waiver services cannot exceed what would have been spent to provide institutional services to the same population. Some waiver programs apply this test on an aggregate basis; that is, they allow some participants to incur costs greater than the cost of institutional care, so long as overall costs meet the cap. Other programs establish individual budget limits. In either case, states can keep spending within the established budgets by limiting the scope of services provided, the number of units of service any individual can receive, and/or the payment for each service.

Non-Waiver Home and Personal Care. Payment methodologies for non-waiver services are specified in state plans. Because these services account for a comparatively small share of overall Medicaid spending, information from state plan documents was not collected for this report. **Table 29** provides information compiled by Health Management Associates from state plans and other sources, reflecting methods in effect as of January 2003.

Table 29. Payment Methods for Non-Waiver Home Health Care and Personal Care Services, January 2003

State	Home health care	Personal care
Alabama	Cost based payment for government providers, fee for service using time units for private providers, medical equipment and supplies paid fee for service	Not covered
Alaska	Percentage of charge	Fee for service using hourly rates
Arizona	Fee for service	Not covered
Arkansas	Fee for service	Fee for service using hourly rates, transportation paid rate per mile
California	Fee for service	Fee for service using hourly rates, or negotiated rates
Colorado	Fee for service, using maximum daily rate	Not covered
Connecticut	Fee for service	Not covered
Delaware	Fee for service	Not covered
District of Columbia	Fee for service using Medicare cost ceilings	Fee for service using hourly rates, adjusted for multiple beneficiaries same address
Florida	Fee for service	Not covered
Georgia	Prospective cost based rate per visit	Not covered
Hawaii	Fee for service using Medicare cost ceilings	Not covered
Idaho	Fee for service using Medicare cost ceilings, medical equipment rental paid at one-twelfth purchase price for 12 months	Hourly rates based on nursing facility wages, rates vary for independent providers and agencies
Illinois	Fee for service	Not covered
Indiana	Prospective cost based rates	Not covered
Iowa	Cost based payment for most services with some paid on fee for service basis	Not covered
Kansas	Fee for service	Fee for service using hourly rates
Kentucky	Fee for service	Not covered

State	Home health care	Personal care
Louisiana	Prospective rates based on historical cost	Not covered
Maine	Fee for service using Medicare cost ceilings	Fee for service using hourly rates with annual payment ceiling
Maryland	Fee for service with rates set geographically	Per diem varied by level of care
Massachusetts	Fee for service using peer groups to set maximum payments	Fee for service
Michigan	Fee for service	Fee for service using hourly rates adjusted for level of care
Minnesota	Fee for service	Fee for service
Mississippi	Fee for service with nursing facility rate as upper limit, medical equipment rented if cost over $150	Not covered
Missouri	Fee for service	Fee for service with monthly payment ceiling at 60% to 100% of average nursing facility rate depending on services provided
Montana	Percentage of charge using a percentage of Medicare allowable cost as ceiling	Negotiated hourly rates
Nebraska	Fee for service	Federal minimum hourly wage, increased following training or licensure
Nevada	Fee for service	Negotiated hourly rates
New Hampshire	Fee for service	Fee for service
New Jersey	Cost based payment per time unit, medical supplies paid fee for service	Fee for service using hourly rates
New Mexico	Cost based payment using Medicare upper limits	Fee for service
New York	Prospective cost based rates, services provided on long term basis paid 75% nursing facility rate	Fee for service
North Carolina	Prospective cost based rates for nursing, home health aide and therapies, other services paid on reasonable charge basis using Medicare limits	Negotiated hourly rates up to reasonable cost
North Dakota	Prospective cost based rate per visit	Not covered
Ohio	Fee for service for nursing, home health aide and therapies, medical supplies paid 75% list price if no payment limit available	Fee for service
Oklahoma	Prospective cost based hourly rate adjusted for cost of travel and medical supplies	Per diem

State	Home health care	Personal care
Oregon	Fee for service	Established hourly rate for individual providers and negotiated rate for agencies
Pennsylvania	Fee for service	Not covered
Rhode Island	Fee for service	Fee for service using hourly rates
South Carolina	Cost based payment using Medicare upper limits for visits, medical equipment paid at 50th percentile of Medicare allowable charge	Not covered
South Dakota	Fee for service, medical equipment paid at 75% of charge	Cost based payment
Tennessee	Visits paid fee for service using Medicare cost ceilings, medical equipment and supplies paid percentage of charge	Not covered
Texas	Cost based payment for visits, medical equipment and supplies paid fee for service	Not covered
Utah	Fee for service, payment for medical equipment and supplies may be negotiated	Fee for service
Vermont	Fee for service	Not covered
Virginia	Fee for service using geographic adjustments	Not covered
Washington	Fee for service using prevailing charge as limit	Hourly rate up to 54.5% of nursing facility rate
West Virginia	Visits paid at Medicare rates, medical equipment and supplies paid 90% of Medicare rates	Monthly rate based on hours of care
Wisconsin	Fee for service using Medicare cost ceilings	Fee for service using hourly rate for care and visit rate for supervision
Wyoming	Visits paid fee for service, medical supplies paid reasonable charge	Not covered

Source: Kaiser Commission on Medicaid and the Uninsured and National Conference of State Legislatures, *Medicaid Benefits: Services Covered, Limits, Copayments and Reimbursement Methodologies*, at [http://www.kff.org/content/2003/20031027/], as of Nov. 2003.

Note: Payment methods indicated in this table are defined by the authors as follows: "Fee for service" means the state has established a maximum payment amount for a particular service, or uses the maximum applicable to the Medicare program for the service, and pays the lesser of the provider's charge or this amount. Often the payment is capped by an estimate of cost. "Cost based payment" means there is a year-end settlement process or some documentation of actual cost is required to justify payment, while "prospective payment" means there is not such a process although the payment rates are generally based on historical cost. Some states make payment using a "percentage of charge" to reflect cost, typically using some documentation of a provider's historical cost to charge ratio. Some states negotiate payment rates.

Home and Community-Based Services Waivers. The HCBS waiver programs offer a wide variety of services. One study found that services offered in at least some states included: adult day care, adult day habilitation, adult day health services, assistive technology, adaptive equipment, case management, personal care attendants, habilitation services, homemaker services, home health aide, nursing care service, personal care services, respite care, training for the family, day treatment or other partial hospitalization, and vocational services.[45]

There has been little study of how states pay for particular home and community services. While reimbursement methodologies for regular Medicaid services are described in state plans, methodologies for waiver services are not. Instead, they are described in individual waiver applications and waiver amendments, which are maintained by CMS regional offices and are not readily accessible. Occasional surveys of state waiver programs have not addressed reimbursement, in part because service coverage and service definitions vary so widely that cross-state comparisons are impossible.[46] Even within a state, there may be multiple waiver programs, each with its own service definitions and payment rules. Finally agencies, providers, and researchers in this field often tend to think of Medicaid as a "funding stream," merged with other sources of funding for clients, and do not focus on individual Medicaid payment transactions.

Given the complexity of waiver programs and the limits of available information on reimbursement, a full review of payment rules is beyond the scope of this report. Instead, the following discussion provides illustrations of how different states pay for two key services: personal care and case management. These may serve to highlight some of the policy considerations states must address in paying for waiver services. The section concludes with a brief review of state systems that use bundled payments for overall care of an HCBS waiver participant.

Most of the information has been drawn from a set of case studies performed for CMS by the Lewin Group, the Urban Institute, and the University of Minnesota Research and Training Center on Community Living. The studies, completed in 2001, reviewed programs for the aged and disabled (AD) in seven states (Alabama, Indiana, Kentucky, Maryland, Michigan, Washington, and Wisconsin) and programs for the mentally retarded and developmentally disabled (MRDD) in six states (Indiana, Kansas, Louisiana, New Jersey, Vermont, and Wyoming).[47]

Personal Care. Personal care services (both waiver and non-waiver) are furnished by home health agencies, personal care agencies, and local government agencies (such as area agencies on aging, AAAs). In addition, many states directly pay individual personal care attendants. A 1998-1999 survey found that states paid an average of $13 an hour for agency services, compared to $8-$9 an hour for

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[45] S. Lutzky, et al., *Review of the Medicaid 1915(c) Home and Community Based Services Waiver Program Literature and Program Data*, report prepared for the Health Care Financing Administration, Reston, VA, June 2000.

[46] Personal communication with Brian Burwell.

[47] The complete set of studies is available at [http://www.hcbs.org/resources/five.htm].

independent workers. While agency rates were 27% to 39% higher than those for independent providers, the attendants employed by the agencies earned only a little more than the minimum wage.[48]

Some states vary payment, not according to whether services are performed by an agency or an individual provider, but according to some measure of intensity. For example, Louisiana pays a slightly higher rate per hour of care for "high need" participants, $11.36 versus $10.05 per hour of regular care. Maryland's non-waiver personal care program uses three daily rates for personal care based on the complexity of the beneficiary's needs and informal support system: $10 per day for minimal assistance furnished in one visit; $20 for extensive help provided in one or two daily visits; and $50 for constant supervision and assistance throughout the day. There are concerns that daily, as opposed to hourly, rates give providers incentives to minimize the hours of care they provide.

However rates are set, case studies found that states often failed to increase them over time, even to account for inflation. One conclusion was that, given the choice between increasing enrollment and raising rates, states preferred to cover more beneficiaries. As is the case for direct care workers in nursing homes, low payment or wage rates for personal care workers have led to problems in recruiting and high turnover. The problems are made worse if waiver limits on covered hours per individual mean that the workers cannot even work full-time.[49] In the 1998-1999 survey, 61% of states reported recruiting problems. The authors suggest that supply problems may in turn lead to poor quality, lack of access, and ultimately premature institutional placement for participants. High turnover may also mean limited training and lack of skills needed to provide necessary support services, as well as difficulty in establishing worker-client relationships.

A few states have made additional payments to agencies that agree to pay higher wages. However, as **Table 23** showed, of 28 states with wage pass-through programs, only six had extended these programs to personal care services. Some states, such as Washington, have also acted to improve direct payment to independent workers (but only by $1 per hour, leaving rates well below those paid to agencies).

At least one state, New Jersey, considered more sweeping action. A 2003 legislative proposal would have shifted all personal care attendants, now employed by 100 different agencies, to state-administered regional home care councils; minimum wages would be $10 an hour.[50]

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[48] A. LeBlanc, M. Tonner, and C. Harrington, "State Medicaid Programs Offering Personal Care Services," *Health Care Financing Review*, vol. 22, no. 4, summer 2001, pp. 155-173.

[49] Paraprofessional Health Care Institute, *The Personal Assistance Services and Direct-Support Workforce: A Literature Review*, report prepared for CMS, June 2003.

[50] Henry J. Kaiser Family Foundation, "New Jersey Assembly Bill to Establish State-Administered Home Health Care System Leads to 'Fierce Debate'," *Daily Health Policy Report*, June 25, 2003, at [http://www.kaisernetwork.org/daily_report/rep_index.cfm?hint=3&DR_ID=18480].

Case Management. Case management includes "assessing the beneficiary's needs, developing the plan of care, arranging for the delivery of services, monitoring the beneficiary, and conducting periodic reassessments of the beneficiary's needs and modifying the plan of care as needed."[51] While most waiver programs provide case management, states differ in how it is structured and paid for. Some states use their own employees, whether in the Medicaid unit or in another unit such as the agency responsible for MRDD services. Some contract with agencies or individuals specifically to provide case management, while others pay public or nonprofit agencies a bundled rate that includes case management and service provision.

However case management is paid for, a recurring issue is whether the funding is adequate to hire sufficient qualified personnel. GAO has reported that, in 20 of 51 waiver programs reviewed by CMS regional offices or state audits, case managers were not providing ongoing assessment and monitoring of waiver beneficiaries or follow-up of changes in beneficiaries' care needs was inadequate. This may be due in part to the fact that managers in some states carry a larger caseload than in others; the variation may in turn be a function of reimbursement levels.

The state of Washington pays area agencies on aging (AAAs) to manage participants in both the AD and MRDD waivers. The state treats case management as part of the AAA's administrative budget, rather than as a service, and thus allows a fixed amount set at the start of the year; the amount does not change even if caseloads rise. In addition the annual budgets assume an average caseload per manager. This has gone from 100 in the late 1990s to a proposed 75 in FY2001-FY2003, but some advocates say this is still too high for adequate contact and quality monitoring.

In New Jersey's MRDD program, budgets for county-level community services offices assume three different levels of managers with different caseloads and visit frequency: primary (direct supervision of an individual living alone), with a caseload of 35-45 and monthly visits; program (management of people in residential settings where other workers attend the person), with a caseload of 90-100 and quarterly visits, and resource (for persons living with the family), providing only annual contact with up to 250 cases. Indiana's MRDD program, instead of setting levels of care, has a fixed fee schedule for different management services, from $8.00 per quarter hour of ongoing case management to $355 for an initial diagnostic and evaluation service.

Wyoming allows participants in its MRDD program to choose their own service coordinator from a listing of qualified individuals. The state has reportedly made a substantial investment in case management and has one of the lowest caseloads in the U.S., 25 to 30 participants per manager. The state pays managers a monthly flat fee of $200 per child and $150 per adult — meaning that managers can make an adequate living even with the limited caseload. Indiana's AD program also allows

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[51] U.S. General Accounting Office, *Long-Term Care: Federal Oversight of Growing Medicaid Home and Community-Based Waivers Should be Strengthened*, (GAO-03-576), Washington, June 2003.

participants to choose between a private case manager and one supplied by the local AAA; most choose the AAA.

Budgeted or Bundled Payments. Some states, instead of paying for individual services under their waiver programs, make fixed payments to agencies for complete services to individual clients or to entire populations.

The Kansas MRDD program originally had a system that paid fixed daily rates to providers for in-home support, residential services, or day services; rates varied depending on the client's assignment to one of five tiers reflecting assessed need. In 2000 Kansas shifted to a system that pays bundled rates (again by acuity tier) for family/individual supports to an agency selected by the family. While some choose community service providers, others enroll with a community organization that will receive the payments and pool them for participating families; each family hires its own helpers and is reimbursed by the organization. Some groups of families have formed "participant alliances," which receive the bundled payments and directly hire and oversee helpers.

In Vermont's MRDD program, a single nonprofit agency is designated to serve most waiver participants in each of 10 geographic regions. The agencies receive capped annual budgets, based on the previous year's allocation with inflation or other adjustments, and are expected to provide all services for their current caseload within this budget. The allocation is increased when an agency takes on a new participant; the budgeted amount for new entrants is generally at one of 10 flat rates (from $7,191 to $71,376 per year in 2000) based on the client's assessed service needs. Within the overall budget, the agency develops and manages individual budgets in consultation with families or guardians.

Michigan's AD program makes fixed daily payments to one of 23 regional waiver agents, chiefly AAAs or nonprofit organizations. The payment in 2000 included $32 per day for services and $9 or $10 for administration. The agency is at risk if average service costs for all clients exceed the allowance; there are concerns that some agencies might treat the $32 figure as an individual ceiling rather than an aggregate one. To limit potential losses for clients with complex needs, there is an exceptions process under which an agency can obtain additional funding for clients whose services cost more than $96 per day.

Managed Care

Over 15 million beneficiaries, or 38% of the Medicaid population, were enrolled in managed care organizations (MCOs) or other full-risk capitated arrangements as of June 2002.[52] Contracting organizations agree to provide or accept financial liability for a broad range of Medicaid-covered acute care services in return for a fixed monthly payment for each enrollee. (Capitation for long-term care is used in Arizona's ALTCS program and in a small number of programs of all-inclusive care

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[52] Prepaid plans providing only specific Medicaid services, such as behavioral health, dental care, or non-emergency transportation, had 9.5 million enrollees; some of these were also enrolled in MCOs.

for the elderly or PACE programs — programs under which Medicare and Medicaid make integrated capitation payments for preventive, acute and long-term care services to MCO-like organizations). Many states require some classes of Medicaid beneficiaries — such as families eligible on the basis of meeting old welfare program rules, poverty-related groups of pregnant women and children, or higher-income families enrolled through Medicaid expansion waivers — to enroll in MCOs, either statewide or in selected areas. In other states, enrollment is voluntary; beneficiaries may choose between an MCO and fee-for-service (with or without a primary care case management feature). Some states have mandatory enrollment in some geographic areas and voluntary enrollment in others.

Federal Medicaid law requires simply that "prepaid payments to the entity [be] made on an actuarially sound basis." Until recently, federal regulations provided that state payments for enrollees in MCOs could not exceed the "fee-for-service equivalent" — the estimated amount the state would have spent for a comparable population not enrolled in the MCO and continuing to receive services on a fee-for-service basis. (This limit was similar to the adjusted average per capita cost (AAPCC) formerly used in setting Medicare HMO payments.) The use of the fee-for-service equivalent as an upper limit was dropped in 2001, partly because some states had enrolled so many beneficiaries in MCOs that they no longer had reliable data on fee-for-service experience. Instead the regulations now provide detailed specifications of what would constitute "actuarially sound" payment rates.

Under the new rules, a qualified actuary must certify that the state's capitation rates have been developed in accordance with generally accepted actuarial principles and practices. Rates must be based only on services covered under the state's Medicaid plan; that is, the state may not pay extra for services available under the MCO contract but not provided to other beneficiaries. Finally, the state must provide CMS with documentation of the basis for the rates and with an explanation of any incentive arrangements, or stop-loss, reinsurance, or other risk-sharing methodologies. (These contractual options are explained below.)

Rate-Setting Methods

This section provides information on how states establish payment rates for MCOs. It relies on two national surveys: a 2001 survey by the Urban Institute that collected information from 36 of the 39 states with full-risk MCO contracts,[53] and a 2003 survey of 41 states by the National Academy for State Health Policy. This survey included the 39 states with full-risk contracts and two additional states, Alabama and South Dakota, that have prepaid contracts for limited services.

Basic Approach. Capitation rates can be established in three basic ways: the state can simply set them administratively, it can negotiate with plans, or it can use a process of competitive bidding. **Table 30** shows the basic method in use in states

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[53] Under a full-risk contract, the MCO assumes liability for most or all covered Medicaid services. Contracts may have "carve-outs" or exclusions for specific services, such as mental health care or prescription drugs, which the state buys in some other way; in addition contracts commonly exclude long-term care services.

in 2001. As the Urban Institute Report points out, states may actually use a mix of methods; a state that sets rates may also engage in negotiation, while one that relies on competitive bids might have some limits on what bids will be deemed acceptable. The Urban Institute Report suggests that some states have moved away from competitive bidding, because it is administratively burdensome and the results are often subject to disputes. States with larger numbers of enrollees are somewhat more likely to use administered rate-setting, as are states with a higher proportion of enrollees in commercial MCOs.

Table 30. Principal Approach to MCO Rate-Setting, 2001

	Administered	Negotiated	Competitive bidding	MCO enrollment (thousands)	Percent of MCO enrollees in commercial MCOs
Arizona			x	528	7%
California	x			2,838	84%
Colorado	x			123	49%
Connecticut		x		240	84%
Delaware	x			83	100%
District of Columbia			x	78	0%
Florida	x			526	76%
Hawaii			x	118	77%
Illinois		x		136	38%
Indiana			x	109	0%
Iowa	x			59	100%
Kansas	x			46	100%
Kentucky		x		120	0%
Maryland	x			421	0%
Massachusetts		x		192	59%
Michigan			x	704	63%
Minnesota	x			326	99%
Missouri			x	379	37%
Nevada	x			48	100%
New Hampshire			x	6	100%
New Jersey	x			459	28%
New Mexico			x	212	100%
New York		x		696	57%
North Carolina	x			44	100%

	Administered	Negotiated	Competitive bidding	MCO enrollment (thousands)	Percent of MCO enrollees in commercial MCOs
North Dakota		x		0	100%
Ohio	x			278	61%
Oklahoma			x	162	87%
Pennsylvania	x			860	24%
Rhode Island		x		112	100%
South Carolina	x			28	0%
Texas	x			428	68%
Utah	x			83	84%
Virginia	x			157	83%
Washington			x	415	78%
West Virginia	x			43	100%
Wisconsin	x			266	100%
Total	**19**	**7**	**10**	**11,324**	**62%**

Source: John Holahan and Shinobu Suzuki, *Medicaid Managed Care Payment Methods and Capitation Rates in 2001: Results of a New National Survey*, Urban Institute, 2002, and CMS enrollment data as of June 2001.

Note: Enrollment is total in commercial MCOs, Medicaid MCOs, and (in California only), health insuring organizations (HIOs).

However rates are established, states commonly pay different amounts for different enrollees, depending on enrollee characteristics. Most states use age, sex, and eligibility category to set rates. Somewhat fewer use geography, possibly because some states have contracts that only cover one geographic area. Only a few states consider whether an enrollee is in an institution or is dually eligible for Medicare and Medicaid. This is presumably because many states do not enroll beneficiaries who are aged or disabled in MCOs. Finally 18 states consider health status in plan payment. Of these, 11 states adjust rates for a few specific conditions (e.g., HIV) and nine have a comprehensive system of risk adjustment (New Jersey and Utah use both types of adjustment). Risk adjustment systems are considered further below.

Table 31. Factors in Capitation Payment, 2002

Factor	Number of states using factor	Percent of states with risk contracts
Age	37	90%
Eligibility category	35	85%
Sex	33	80%
Geography	28	68%
Health status	18	44%
Institutional/Medicare status	12	29%
States with risk programs	41	100%

Source: Unpublished data collected by the National Academy for State Health Policy for the Congressional Research Service in 2003.

In addition to using more or fewer factors, states vary widely in the number of different "rate cells" they establish — that is, how many categories within each grouping they use. The Urban Institute Report found that states had as few as two rate cells (for example, under age 19 and 19 or over) or as many as 126. In a state with only a few rate cells, plans may have an incentive to seek out lower-cost populations within each cell. In a state with very many cells, data used to set rates for each cell might be statistically unreliable, and values could fluctuate widely from year to year.[54] Federal regulations currently require that states make adjustments for eligibility category, age, sex, and geography, but allow a state to explain why an element is not applicable; inadequate sample size would be one acceptable explanation. States are encouraged but not required to use adjustments based on health status or diagnosis.

Reinsurance, Risk Sharing, and Incentive Payments. While MCOs agree to accept financial liability for the services required by their enrollees, there are a number of reasons why it may be necessary to limit their potential losses on individual cases or in the aggregate. First, some plans have very small numbers of enrollees and could be overwhelmed by a few high-cost cases. In 2002, 52 full-risk contractors had fewer than 5,000 Medicaid enrollees. Second, Medicaid-only MCOs, especially recently established ones, may have little capital and a limited ability to sustain losses. Third, a large proportion of spending for MCO enrollees — who are disproportionately women and children — is related to pregnancy and to problems of newborns. These unpredictable events cannot be corrected for in prospective rate-setting, and a plan that gets fewer or more than its share of pregnancies in a particular year might be considerably over- or underpaid. **Table 32** summarizes the ways in which states limit losses for risk contractors.

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[54] This was the case under Medicare's former HMO payment system, which recalculated rates annually for every county in the U.S.

Table 32. Reinsurance and Risk-Sharing Arrangements, 2002

Method	Number of states using method	Percent of states with risk contracts
Reinsurance: commercial	19	46%
Mandatory	*6*	*15%*
Voluntary	*13*	*32%*
Reinsurance: state[a]	13	32%
Mandatory	*7*	*17%*
Voluntary	*7*	*17%*
Condition specific limits	7	17%
Risk corridors	5	12%
Risk pools	4	10%
Recalculate upper payment limit	4	10%
States reporting any arrangement	29	71%

Source: Unpublished data collected by the National Academy for State Health Policy for the Congressional Research Service in 2003.

a. New York reported both voluntary and mandatory state reinsurance programs.

One way in which MCOs — whether or not contracting with Medicaid — commonly limit losses is by purchasing reinsurance (sometimes known as stop-loss coverage) from a commercial reinsurer. The reinsurer assumes some or all of the liability when costs for an individual enrollee exceed a deductible amount, such as $100,000 or $250,000. Less commonly, the entity might obtain aggregate reinsurance, which limits its overall losses for the year; for example, the reinsurer might begin paying claims when the entity's costs exceed 110% of revenues.

In 2002, 19 states reported that their risk contractors obtained commercial reinsurance; six of these states required contractors to do so. Other states act as reinsurers themselves. For example, an MCO contract might provide that the contractor will be liable for the first $25,000 in costs for a Medicaid enrollee, after which the state would assume liability. Of 13 states with these arrangements, reinsurance was voluntary in six and mandatory in six; one state reported both voluntary and mandatory coverage. Seven states provide what amounts to reinsurance by limiting contractors' liability for enrollees with specific conditions, such as HIV.

Five states had contracts with "risk corridors." These work somewhat like aggregate reinsurance: the contractor is liable for all costs up to some fixed percentage of its capitation revenue. Costs above the limit are shared by the contractor and the state or may be assumed entirely by the state.[55] Four states had

[55] Federal regulations provide that total payments to the MCO under a risk corridor arrangement may not exceed what would have been paid under Medicaid fee-for-service for the services received by enrollees, plus an administrative allowance. Note that this rule (continued...)

risk pools, in which multiple contractors make payments (usually a per capita assessment) into a combined fund that is used to help pay for high-cost cases. Finally, there are four states that base their prospective capitation rates for a year on projected fee-for-service expenditures for a comparable population and recalculate those rates retrospectively if fee-for-service costs are greater than expected. (NASHP treats this as a risk-sharing arrangement; however, it is different from the others in that it does not relate to the contractors' actual spending.)

Finally, a state may provide supplemental incentive payments to an MCO for meeting specified performance targets — for example, providing more child health screenings under the early and periodic screening, diagnostic, and treatment program (EPSDT). Or the state may share savings with the MCO; that is, it may split the difference between the MCO's capitation rates and the estimated amount that would have been spent for the enrollees in the fee-for-service program. Federal rules require that these arrangements cannot provide payments greater than 105% of approved capitation rates, must be offered equally to public and private contractors, and may not be linked to intergovernmental transfers.

Risk Adjustment. Rate cells based only on age, sex, eligibility category, or location can capture differences in average spending for entire population groups but cannot predict the level of risk represented by individual enrollees. Within each population defined by a rate cell, there can be significant variation in health status and likely costs. This has two consequences. First, in states in which MCO enrollment is voluntary, the group choosing to enroll may have better or worse health status than the group choosing to remain in the fee-for-service system. If capitation rates are based on fee-for-service experience, overall payments to MCOs might not reflect the level of risk they are assuming. Second, when multiple MCOs are competing, any one entity might be over- or underpaid, depending on the health status of the beneficiaries it enrolled. This creates incentives to market to healthier beneficiaries and/or promote disenrollment by sicker ones.[56]

As mentioned earlier, NASHP reports that nine states have attempted to deal with this problem by adding risk adjustment to their rate-setting methods.[57] Risk adjustment systems assign enrollees to some form of health status or diagnostic category; capitation rates are increased or decreased to reflect higher or lower expected costs for enrollees in each category. NASHP does not provide further details on what systems states are using or what groups of enrollees the system applies to. **Table 33** has been pieced together from the 2001 Urban Institute survey and from information reported by Kronick et al., in 2000.

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[55] (...continued)
relates to services actually furnished to enrollees, while the repealed fee-for-service equivalent rule compared capitation rates to average expenditures for a comparable non-enrolled population.

[56] While there are rules prohibiting these practices, they may be difficult to detect, and there is a long history of such abuses under both Medicaid and Medicare.

[57] See page 93.

Table 33. Risk Adjustment Systems

State	Population covered	Classification system
Colorado	SSI + 1931	DPS
Delaware	SSI + 1931	CDPS
Maryland	SSI + 1931	ACGs
Michigan	SSI	CDPS
Minnesota	1931	ACGs
New Jersey	SSI	DPS
Oregon	SSI	DPS
Utah	SSI	CDPS
Washington	1931	CDPS

Source: Holahan and Suzuki, 2002, and Richard Kronick et al., "Improving Health-Based Payment for Medicaid Beneficiaries: CDPS," *Health Care Financing Review*, vol. 21, no. 3, spring 2000, p. 29-64.

Note: SSI = Supplemental Security Income. 1931= Families eligible under Section 1931 of Title XIX of SSA. These are families eligible on the basis of meeting welfare program rules in place in 1996. ACGs = Adjusted Clinical Groups. DPS = Disability Payment System. CDPS = Chronic Illness and Disability Payment System.

Four of the states adjust payments for aged and disabled SSI recipients; two adjust payments for recipients who are members of families with dependent children qualifying under old welfare program rules; and three adjust for both groups. Maryland and Minnesota use adjusted clinical groups (ACGs). This system, originally developed for use in the Medicare+Choice program, uses diagnostic information from past inpatient and ambulatory claims (or encounter reports), along with age and sex, to assign each enrollee to a risk category. (There are several ACG models, using different numbers of groupings.) The remaining states use the Disability Payment System (DPS) or the more recent refinement, the Chronic Illness and Disability Payment System (CDPS). These systems, developed by researchers at the University of California, San Diego, also use data from past claims to classify enrollees by diagnoses and complications.

Kronick et al., report that the CDPS method performs better than ACGs in predicting costs for the disabled. Neither system was very good at predicting costs for families eligible on the basis of meeting former welfare program rules (Section 1931 eligibles). One key problem in risk adjustment for Medicaid is that many beneficiaries are enrolled only for a limited period. This means that it may not be possible to collect sufficient data to classify short-term enrollees under a given system, and the data are likely to be less reliable than data collected for longer-term enrollees.[58]

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[58] E. Adams, J. Bronstein, and C. Raskiind-Hood, "Adjusted Clincal Groups: Predictive Accuracy for Medicaid Enrollees in Three States," *Health Care Financing Review*, vol. 24, no. 1, fall 2002, pp. 43-61.

Most states that have not adopted broader risk adjustment have made special provisions for costs related to pregnancies and newborns. Of the 36 states responding to the Urban Institute survey, 28 had some provision. Of these, 21 made lump-sum payments to MCOs for each pregnancy. Twelve had established separate rates for women qualifying for Medicaid on the basis of pregnancy; one of these also paid a higher rate for a Section 1931-eligible pregnant woman. Finally, eight states paid higher rates for newborns or infants under one year old.

Payment Levels

Table 34 shows 1998 and 2001 Medicaid managed care rates for Section 1931 and poverty-related populations in selected states; the rates are adjusted for some differences in population and in services covered under contracts. In both years, the highest-paying state (North Dakota) paid nearly twice as much as the lowest-paying state (Oklahoma). Rates increased an average of 18% over three years, but some states were cutting rates while others were increasing substantially.

Differences were not found to correlate with differences in Medicare AAPCCs for the areas served, suggesting that general geographic variation in health spending does not explain the wide variation in rates. The authors note that there is considerable variation in states' Medicaid fee-for-service spending as well, depending in part on state cost containment efforts. This variation carries over into MCO rates in states that base rates on fee-for-service experience or consider that experience in negotiating or evaluating bids. Rates may also be affected by biased selection (differences in health risk of MCO and non-MCO beneficiaries not corrected for through risk adjustment) and by whether a state enrolls beneficiaries statewide or only in high-cost urban areas.

Table 34. Change in Medicaid Managed Care Payment Rates, Section 1931 and Poverty-Related Groups, Selected States, 1998-2001

State	1998	2001	Percentage change
Arizona	$126.29	$131.54	4.0
California	94.68	137.79	45.5
Colorado	137.57	134.36	-2.3
Connecticut	161.57	169.37	4.8
District of Columbia	143.39	186.4	30.0
Florida	117.29	135.82	15.8
Georgia	94.29	NA	NA
Hawaii	150.25	147.64	-1.7
Illinois	112.22	146.36	30.4
Indiana	94.98	164.84	73.5
Iowa	142.6	181.43	27.2
Kansas	115.07	134.84	17.2

State	1998	2001	Percentage change
Kentucky	156.42	191.95	22.7
Maine	102.74	NA	NA
Maryland	145.75	180.05	23.5
Massachusetts	169.32	170.96	1.0
Minnesota	151.78	202.36	33.3
Mississippi	126.92	NA	NA
Michigan	140.32	151.79	8.2
Nevada	96.74	128.06	32.4
New Hampshire	148.9	175.95	18.2
New Jersey	152.16	143.04	-6.0
New Mexico	138.04	186.94	35.4
New York	108.24	149.41	38.0
North Dakota	221.83	209.34	-5.6
Ohio	147.91	162.3	9.7
Oklahoma	92.18	118.32	28.4
Rhode Island	133.49	159.29	19.3
South Carolina	132.45	141.38	6.7
Tennessee	101.2	NA	NA
Texas	133.2	127.63	-4.2
Utah	137.22	140.21	2.2
Virginia	146.33	190.35	30.1
Washington	130.47	154.67	18.6
West Virginia	132.87	143.81	8.2
Wisconsin	116.13	132.44	14.1
Average	132.02	157.21	18.1

Source: John Holahan and Shinobu Suzuki, "Medicaid Managed Care Payment Methods and Capitation Rates In 2001," *Health Affairs*, vol. 22, no. 1 (Jan.-Feb. 2003), pp. 204-218. Rates are adjusted for some differences in population and in services covered under contracts.

Whether Medicaid managed care rates are "adequate" is difficult to assess. As Table 35 shows, the number of MCOs participating in Medicaid has dropped, with the number of commercial plans dropping especially sharply. (Some of this change may reflect plan mergers, rather than withdrawal from Medicaid.) At the same time, Medicaid MCO enrollment has been growing, so that more enrollees are served by fewer plans. This suggests that small plans, or plans with a small number of Medicaid enrollees, might have been more likely to drop out. One reason might be that Medicaid imposes special administrative requirements; plans with few Medicaid

enrollees cannot justify the costs. Or they may fail to develop the care systems needed to effectively manage Medicaid beneficiaries.[59]

The commercial MCO share of enrollment peaked in 1999 and has since been dropping. This trend is not necessarily related to payment rates; this was a period when many MCOs were losing money and reevaluating their overall business strategies. At one time, it would have been assumed that declining commercial participation raised concerns about access and quality. Until passage of the BBA, most MCO plans participating in Medicaid were required to have commercial enrollees as well, on the theory that employers and private enrollees were in a better position to press for high-quality care than Medicaid beneficiaries. If this was ever true, since the passage of the BBA, states have arguably been at least as active in monitoring quality as private purchasers.

However, even if increasing reliance on Medicaid-only plans does not necessarily mean quality problems, it is not clear how these plans will be affected by the current financial pressures on states. As was shown in **Table 8**, above, about half of states with MCO programs plan to freeze or reduce their capitation rates for FY2004. Medicaid-only plans cannot shift losses to other purchasers and would need to reduce their provider payments or limit access to care.[60]

Table 35. Commercial and Medicaid-only MCO Plans and Enrollment, 1998-2002

	Plans		Enrollees (thousands)		
	Commercial	Medicaid only	Commercial	Medicaid only	Percent of enrollees in commercial MCOs
1998	283	136	7,248	4,645	60.9%
1999	237	136	8,488	3,524	70.7%
2000	210	127	8,396	4,016	67.6%
2001	202	122	8,846	4,617	65.7%
2002	188	120	9,734	5,723	63.0%

Source: CMS annual summaries, *Managed Care Enrollment by Program Type*, [http://www.cms.hhs.gov/medicaid/mcaidsad.asp], as of Sept. 2003.

[59] For a discussion of these issues, see M. McCue, et al., "Financial Performance and Participation in Medicaid and Medi-Cal Managed Care." *Health Care Financing Review*, vol. 23, no. 2, winter 2001, pp. 69-81.

[60] R. Hurley and D. Draper, "Medicaid Confronts a Changing Managed Care Marketplace," *Health Care Financing Review*, vol. 24, no. 1, fall, winter 2002, pp. 11-25.

Prescription Drugs

Medicaid payment for a prescription drug furnished to a beneficiary on an outpatient basis has two components: an amount to cover the cost of the ingredients (the acquisition or ingredient cost) and an amount to cover the pharmacy's costs to fill the prescription (the dispensing fee). Medicaid regulations establish upper limits on payment for acquisition costs, but do not limit dispensing fees; these must merely be "reasonable." Two separate limits on acquisition costs are used, one for certain multiple source drugs — those for which therapeutic equivalents or "generic" versions are available from three or more suppliers — and one for all other drugs. The limits are designed to encourage the substitution of lower cost generic equivalents for more costly brand name drugs.[61]

Since 1991, pharmaceutical manufacturers have been required to give rebates to states for drugs paid for by Medicaid. The rebate formulas are designed to assure that states pay the lowest price offered by the manufacturer to any other high-volume purchaser. In return, the state must generally cover all the drugs marketed by the manufacturer.

This section reviews the regulatory limits on reimbursement and summarizes state policies on acquisition costs and dispensing fees. It then provides an overview of recent state initiatives in prescription drug purchasing.

Pharmacy Reimbursement Methods

Upper Payment Limits

Multiple Source Drugs. For purposes of the upper payment limits, a "multiple source drug" is one that meets the following two requirements: (a) the drug is made available by at least three different suppliers, and (b) the Food and Drug Administration (FDA) has determined that at least three approved formulations of the drug are "therapeutically equivalent" — that is, contain identical doses of the active ingredient and have the same biological effects. For each multiple source drug, CMS establishes a price limit (known as the maximum allowable cost, or MAC) equal to 150% of the estimated wholesale cost of the least expensive therapeutic equivalent. A state's payments for such drugs during a given period may not exceed what would have been spent if the state had paid the price limit plus a reasonable dispensing fee. (Note that the federal MAC limits apply to aggregate spending for the listed drugs. Many states have established their own MAC systems, which may have higher price limits for some drugs and lower limits for others.)

The effect of the MAC limits is that, when a lower-cost "generic" equivalent exists for a brand-name drug, a pharmacy will be paid the generic price even if the

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[61] For additional information on Medicaid's payment for and coverage of prescription drugs see CRS Report RL30726, *Prescription Drug Coverage Under Medicaid*, by Jean Hearne.

brand-name drug is actually furnished. The pharmacy therefore has a financial incentive to substitute the generic equivalent for the brand-name drug. If the prescribing physician specifies that generic substitution is unacceptable (for example, by writing "dispense as written" or "no substitution" on the prescription), the CMS price limits do not apply. The pharmacy must supply the brand-name drug and may be paid the full brand-name cost.

Other Drugs. For all other drugs (including multiple source drugs for which the prescribing physician has requested no substitution), statewide payments may not exceed the lesser of (a) the pharmacies' usual and customary charge to the general public and (b) the estimated acquisition cost (EAC) plus a dispensing fee. The EAC or ingredient cost is the state's best estimate of what pharmacies are generally paying for a drug.

Dispensing Fees and Ingredient Costs

Table 36 shows the dispensing fee established by each state as well as the state's method of computing the ingredient cost or EAC.

Dispensing Fees. Most states pay fixed dispensing fees ranging from about $3 to $6 per prescription. Some states pay different fees for brand-name and generic drugs; for drugs dispensed in nursing facilities (or for drugs provided in the unit dose systems often used in NFs), or for drugs compounded by the pharmacist from multiple ingredients. A few states pay different fees to different pharmacies, depending on area, the pharmacy's historic costs, or volume of Medicaid or other state-paid prescriptions. New Jersey pays extra for pharmacies providing 24-hour emergency service.

Wisconsin pays higher fees to pharmacists providing "pharmaceutical care," added services such as patient assessment, counseling, or contact with a physician. New Jersey has a much smaller add-on for patient counseling, and three other states pay pharmacists for services related to specific treatments or conditions: Alabama (counseling on Clozaril, a medication for schizophrenia), Missouri (diabetes education), and Washington (emergency contraceptive counseling).

It is possible that many states' dispensing fees are less than the actual overhead cost to pharmacies. GAO has cited studies done for the California and Texas Medicaid programs finding median 2002 costs of $6.95 and $5.95 per prescription, respectively, and a study by the National Association of Chain Drug Stores finding average 2001 costs of $7.26.[62]

Ingredient Cost. Most states base the EAC for a particular drug on the average wholesale price (AWP). This measure is not, as its name would suggest, the average price charged by wholesalers to retail pharmacies. The AWP is a figure reported by the drug's manufacturer to several firms that maintain pricing databases

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[62] U.S. General Accounting Office (GAO), *Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies,* (GAO-03-196), Jan. 2003.

used by states and other purchasers. It resembles a list price or sticker price, and does not reflect what pharmacies are actually paying wholesalers after discounts or rebates. To correct for this, states commonly arrive at an EAC by applying a fixed percentage reduction to the AWP.

Some states also consider the wholesaler's acquisition cost (WAC), what the wholesaler paid for the drug, and then add a fixed percentage amount to reflect the wholesaler's markup. A few states ascertain the actual acquisition cost (AAC), what a specific retailer actually paid for a drug, or the "direct price" charged to the retailer. Several states use different methods to establish the EAC for different classes of drugs. Two, Louisiana and Michigan, pay lower prices to chain pharmacies, on the assumption that high-volume pharmacies pay lower wholesale prices.

Table 36. Pharmacy Dispensing Fees and Ingredient Reimbursement Basis, 2002

State	Dispensing fee	Ingredient reimbursement basis
Alabama	$5.40	AWP- 10%; WAC+9.2%
Alaska	$3.45 minimum[a]	AWP-5%
Arizona	Most drugs paid through AHCCCS plans	
Arkansas	$5.51	AWP-10.5%
California	$4.05	AWP-10%
Colorado	$4.00; $1.89 for institutions	AWP-13.5% or WAC+18%, whichever is lowest; AWP-35% (for generics)
Connecticut	$3.85	AWP-12%
Delaware	$3.65	AWP-12.9%
District of Columbia	$3.75	AWP-10%
Florida	$4.23-$4.73 (LTC)	AWP-13.25%; WAC+7%
Georgia	$4.63 + $0.50 (for generics)	AWP-10%
Hawaii	$4.67	AWP-10.5%
Idaho	$4.94 ($5.54 for unit dose)	AWP-12%
Illinois	G: $5.10, B: $4.00	B: AWP-11%, G: AWP-20%
Indiana	$4.90	B: AWP-13.5%, G: AWP-20%
Iowa	$5.17	AWP-10%
Kansas	$3.40	B: AWP-15%, G: AWP-27% IV AWP-50%, blood AWP-30%
Kentucky	$4.51	AWP-12%
Louisiana	$5.77	AWP-13.5% (AWP-15% for chains)
Maine	$3.35 (+extra fees for compounding)	AWP-13%
Maryland	$4.21	Lowest of : WAC+10%, direct+10%, AWP-10%
Massachusetts	B: $3.50 G: $5.00	WAC+5%
Michigan	$3.72	AWP-13.5% (1-4 stores), AWP-15.1% (5+stores)
Minnesota	$3.65	AWP-9%
Mississippi	$3.91	AWP-12 %

State	Dispensing fee	Ingredient reimbursement basis
Missouri	$4.09	AWP-10.43%, WAC+10%
Montana	$2.00 - $4.70[b]	AWP-15%, direct price for some labelers
Nebraska	$3.27 - $5.00[c]	AWP-11%
Nevada	$4.76	AWP-15%
New Hampshire	$2.50	AWP-12%
New Jersey	$3.73 - $4.07[d]	AWP-10%, WAC+30%, AAC for injectables
New Mexico	$3.65	AWP-12.5%
New York	B: $3.50 G: $4.50	AWP-10%
North Carolina	B: $4.00 G: $5.60	AWP-10%
North Dakota	$5.10	AWP-10%
Ohio	$3.70	WAC + 9%
Oklahoma	$4.15	AWP-12.0%
Oregon	Retail: $3.50 Inst./NF: $3.80	AWP-13%
Pennsylvania	$4.00 ($5.00 for compounds)	AWP-10%
Rhode Island	OP: $3.40, LTC: $2.85	WAC+5%
South Carolina	$4.05	AWP-10%
South Dakota	$4.75 ($5.55 for unit dose)	AWP-10.5%
Tennessee	Most drugs paid through TennCare plans	
Texas	Formula[e]	AWP-15% or WAC+12%, whichever is lowest
Utah	$3.90-$4.40 (based on area)	AWP-15%
Vermont	$4.25	AWP-11.9%
Virginia	$4.25	AWP-10.25%
Washington	$4.20-$5.20 (based on annual # of Rx)	AWP-14%
West Virginia	$3.90 (+ extra $1.00 for compounding)	AWP-12%
Wisconsin	$4.88 (to a maximum $40.11)	AWP-11.25%
Wyoming	$5.00	AWP-11%

Source: National Pharmaceutical Council, *Pharmaceutical Benefits Under State Medical Assistance Programs 2002, 2003*.

Note: B = Brand; G = Generic; AWP = Average Wholesale Price; WAC = Wholesalers Acquisition Cost.

a. Pharmacy-specific, using formula that considers prescription volume and square footage.
b. Based on pharmacy's reported costs, with ceiling and floor.
c. Peer group comparison.
d. Highest rate includes add-ons for emergency service, consultation, and high Medicaid/other state program volume.
e. Average dispensing expense (ADE) formula for payment: (Estimated acquisition cost + 5.27) divided by 0.980 = amount paid + $0.15 delivery service.

In recent years the DHHS Office of the Inspector General (OIG), the Department of Justice, and some states have expressed concerns about the use of the AWP in prescription drug payment. Because it is an arbitrary number that does not reflect what pharmacies actually pay wholesalers, all states that use AWP take a fixed percentage reduction. But there have been allegations that some manufacturers report highly inflated AWPs. As a result, even though the state pays less than the full AWP, it may pay the pharmacy much more than the pharmacy actually paid for the drug. The OIG has recomputed AWPs for some commonly prescribed drugs, using actual wholesale transaction data; 30 states had used some of these revised AWPs as of 2001.[63] The OIG has also suggested that states take larger fixed percentage discounts. On the basis of sample pharmacy pricing information, it found that actual 1999 acquisition costs were 21.84% less than AWP for brand name drugs and 65.93% less than AWP for generics.[64]

Drug Rebate Requirements

OBRA 90 required that drug manufacturers, as a condition of Medicaid coverage of their prescription drug products, enter into agreements with the Secretary of HHS, under which they pay state Medicaid programs rebates for Medicaid-reimbursed drugs.[65] In return, states are required to cover under Medicaid all of the drugs marketed by that manufacturer, with certain exceptions. States may require prior authorization to dispense certain drugs or can establish a formulary, a listing of preferred drugs, and require authorization for all drugs not on the list. There are also certain categories of drugs which can be excluded from coverage entirely.[66]

Rebate requirements do not apply to products dispensed as a part of a service provided in a hospital, physician's or dentist's office, or similar setting, or to drugs provided by MCOs when payment is included in the capitation rate. However, they do apply to drugs dispensed in nursing facilities if the cost of the drugs is not included in the NF's Medicaid per diem payment and is instead reimbursed by Medicaid to the dispensing pharmacy. (For this reason, as of 1998, only three states still included prescription drugs in NF payments.) Rebate requirements may also apply to a nonprescription item such as aspirin, if it is covered in a state's Medicaid plan.

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[63] U.S. Department of Health and Human Services (DHHS), Office of the Inspector General, *Medicaid's Use of Revised Average Wholesale Prices*, (OEI-03-01-00010), Sept. 2001.

[64] Ibid., *Medicaid Pharmacy — Actual Acquisition Cost of Brand Name Prescription Drug Products*, (A-06-00-00023), Aug. 2001, and *Medicaid Pharmacy — Actual Acquisition Cost of Generic Prescription Drug Products*, (A-06-01-00053), Mar. 2002.

[65] Manufacturers are also required (again as a condition of Medicaid reimbursement) to provide similar rebates to FQHCs and other PHS-funded entities, public disproportionate share hospitals, and various other specified purchasers.

[66] There are 10 categories of drugs that a state is permitted to exclude. Examples include medications for weight loss, fertility drugs, drugs for hair loss, and barbiturates.

Rebates are computed and paid to states each quarter on the basis of price information supplied by manufacturers to CMS and utilization information furnished to the manufacturers by state Medicaid agencies. (The federal share is recovered through an adjustment in federal matching payments to states.)

In setting the amount of required rebates, the law distinguishes between two classes of drugs. The first includes single source drugs (generally, those still under patent) and "innovator" multiple source drugs (drugs originally marketed under a patent but for which generic competition now exists). The second class includes all other, "non-innovator" multiple source drugs (generics).

Single Source and Innovator Multiple Source Drugs. For these drugs, manufacturers are required to pay state Medicaid programs a basic rebate for each covered drug, along with an additional rebate if drug product prices increase faster than inflation, as measured by the Consumer Price Index for all urban consumers (CPI-U).

Basic rebate amounts are determined by comparing the average manufacturer price (AMP) for a drug — the average price paid by wholesalers — to the "best price," the lowest price offered by the manufacturer in the same period to any wholesaler, retailer, provider, HMO, nonprofit entity, or governmental entity in the U.S. Prices offered to federal agencies, state pharmaceutical assistance programs, and certain other entities are not considered in determining the best price. Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, prices negotiated from manufacturers for discount card drugs and prices negotiated by private plans providing the new Medicare prescription drug benefit will also be excluded from the calculation.

The basic rebate is the greater of 15.1% of the AMP or the difference between the AMP and the best price. The additional rebates are required for any drug whose price increases faster than the CPI-U. In determining the rebate, prices in effect on October 1, 1990 — or the date of introduction, if later — are used as a base; these are then compared with prices as of the month before the start of the period for which the rebate is to be issued.

Non-innovator Multiple Source Drugs. For multiple source drugs, basic rebates are a fixed 11% of the AMP. Prices offered to other payers are not considered, nor is there any additional rebate for excess price increases.

Table 37 shows prescription drug spending in FY2001 before and after rebates (including supplemental rebates in some states; see below). Nationally, rebates reduced spending by about 20%.

Table 37. Effect of Rebates on Medicaid Drug Spending, FY2001

State	Prescription drug spending ($ thousands)		Percent reduction
	Before rebate	After rebate	
Alabama	387	310	19.8%
Alaska	56	44	20.3%
Arizona[a]	3	3	0.0%
Arkansas	242	196	18.9%
California[b]	2,984	2,198	26.3%
Colorado	166	132	20.6%
Connecticut	305	243	20.3%
Delaware	81	64	21.0%
District of Columbia	64	53	16.5%
Florida[b]	1,476	1,178	20.1%
Georgia	736	626	15.0%
Hawaii	75	61	19.2%
Idaho	103	84	18.3%
Illinois	884	713	19.3%
Indiana	562	458	18.4%
Iowa	235	192	18.2%
Kansas	185	145	21.5%
Kentucky	592	487	17.7%
Louisiana	585	470	19.7%
Maine	192	150	21.8%
Maryland[b]	244	210	14.0%
Massachusetts	798	617	22.6%
Michigan	585	473	19.1%
Minnesota	266	211	20.5%
Mississippi	493	405	17.9%
Missouri	676	542	19.8%
Montana	73	59	18.4%
Nebraska	171	141	17.7%
Nevada	62	45	26.6%
New Hampshire	92	78	15.2%
New Jersey	651	527	19.1%
New Mexico	58	46	20.9%
New York	2,986	2,442	18.2%
North Carolina	985	777	21.1%
North Dakota	44	35	19.9%
Ohio	1,100	882	19.8%

State	Prescription drug spending ($ thousands)		Percent reduction
	Before rebate	After rebate	
Oklahoma	171	131	23.5%
Oregon	229	194	15.3%
Pennsylvania	693	563	18.7%
Rhode Island	103	81	20.9%
South Carolina	439	343	21.7%
South Dakota	52	42	18.2%
Tennessee	681	579	15.1%
Texas	1,326	1,057	20.3%
Utah	117	95	18.7%
Vermont	104	82	21.1%
Virginia	418	338	19.0%
Washington	458	367	19.9%
West Virginia	260	207	20.2%
Wisconsin[b]	382	303	20.8%
Wyoming	31	26	18.5%
U.S. total	24,657	19,709	20.1%

Source: Medicaid Financial Management Reports (CMS 64).

a. Arizona did not report rebates on its negligible drug spending for non-MCO services.
b. Includes rebates under state supplemental agreements.

The rebate formula has been criticized on several grounds. First, there may be inconsistencies in the way different manufacturers compute the AMP or the best price. Second, because the rebates are based on AMP while most states use the AWP to determine pharmacy reimbursement, there is no relationship between the rebate amount and the amount the state actually spent on the drug.[67]

The President's FY2003 budget proposal would have changed the formula for computing rebates for single source and innovator multiple source drugs. Instead of comparing the manufacturer's best price to the AMP, it would compare the best price to the AWP. The Bush Administration estimated five-year savings of $5.5 billion. The FY2004 budget proposal did not repeat this specific proposal but included unspecified reforms of the rebate system intended to produce $13.2 billion in savings over10 years.[68]

Recent State Initiatives

Supplemental Rebates. Some states have negotiated supplemental rebates from manufacturers, in return for which the state might agree to include all the

[67] DHHS, Office of the Inspector General, *2002 Red Book (The Cost-Saver Handbook)*.

[68] DHHS, *Budget in Brief, FY2003* and *Budget in Brief, FY2004*.

manufacturer's products on its formulary or waive prior authorization. As of FY2001, only California showed significant savings from these agreements, with supplemental rebates equal to 7% of gross drug spending.

At least three states, Florida, Michigan, and Maine, automatically require prior authorization unless the manufacturer agrees to pay a supplemental rebate. Florida requires a 10% rebate, while Michigan requires a rebate equal to the difference between the drug's price and the lowest price for any drug in the same "therapeutic class" (a group of drugs with similar formulas, effects, or clinical use).[69] CMS has notified states of its willingness to approve similar systems.[70] Federal courts have rejected suits by manufacturers and patient advocates seeking to block the Florida and Maine programs.

Maine's program, MaineRx, is not intended to produce savings for Medicaid but to help residents without prescription drug coverage. The state plans to negotiate supplemental rebates with manufacturers in return for an exemption from prior authorization requirements. Instead of retaining the rebate, the state would pass it on to pharmacies, which would in turn give discounts to uninsured consumers. The Pharmaceutical Research and Manufacturers Association (PhRMA) obtained an injunction blocking implementation of the program, partly on the ground that Medicaid law prohibited Maine from limiting access to services by Medicaid beneficiaries to benefit other citizens. The Supreme Court lifted the injunction in May 2003, but did not actually rule that the program was legal; it could still be subject to scrutiny by CMS or lower courts.[71]

Pharmacy Plus. CMS is sponsoring a demonstration program under which states may extend pharmacy benefits to Medicare beneficiaries and disabled people with incomes below 200% of poverty who do not already receive Medicaid drug coverage.[72] As of September 2003, programs have been approved in Florida, Illinois, South Carolina, and Wisconsin. The programs must be budget-neutral; that is, the state must achieve some savings elsewhere in the Medicaid program that will offset the costs of the coverage.[73] Because the benefits are treated as Medicaid coverage, the programs will automatically get Medicaid-level rebates without the side agreements planned for the MaineRx program. (At this writing, it is unknown how these demonstrations will be affected by the enactment of the Medicare prescription

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[69] Two drug companies, Pfizer and Bristol-Myers Squibb, were exempted in return for offering special programs to improve care for Medicaid beneficiaries. D. Gencarelli, *Medicaid Prescription Drug Coverage: State Efforts to Control Costs*, National Health Policy Forum, NHPF Issue Brief 790, May 2003.

[70] CMS, *State Medicaid Directors Letter*, no. 02-014, Sept. 2002.

[71] *Pharmaceutical Research and Manufacturers of America v. Walsh*, U.S. Supreme Court, no. 01-188, May 19, 2003.

[72] The program is operated under Section 1115 of the Social Security Act, which authorizes the Secretary to waive provisions of Medicaid law to conduct demonstrations.

[73] Some of the states with approved plans have met this requirement by arguing that the newly covered groups themselves might otherwise have incurred high hospital or nursing home bills that would have led them to spend down to Medicaid.

drug benefit, which provides low-income subsidies to people with incomes below 150% of poverty.)

Purchasing Pools. In February 2003, Michigan and Vermont announced the formation of a joint purchasing pool that would operate in essentially the same way as Michigan's existing supplemental rebate program.[74] Manufacturers would bid for inclusion on a preferred drug list to be used by both states. South Carolina has since joined the initiative, and about 10 other states are reportedly discussing participation.[75] A number of other states have been considering similar coalitions. Georgia and Texas have been exploring a different approach, under which the state Medicaid agency and other agencies within the same state, possibly including the state employees' health benefit plan, would engage in joint purchasing.[76]

Cost Containment. Because growth in prescription drug costs has been a major factor in Medicaid spending increases, most states have taken measures to control spending growth. **Table 38** shows changes implemented in FY2003 or planned for FY2004. Relatively few states have directly reduced AWP-based payments, but more are seeking supplemental rebates. As the preceding discussion would suggest, some of the measures designed to steer beneficiaries toward preferred drugs may also be intended to give manufacturers incentives to negotiate rebates.

States' ability to command larger discounts for Medicaid beneficiaries or leverage their buying power on behalf of other state residents may have been diminished by passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Dual eligibles (beneficiaries eligible for both Medicare and full Medicaid benefits) will receive covered drugs through the new Medicare benefit beginning in 2006. This will significantly reduce the volume of drugs Medicaid programs pay for directly.[77] Spending for beneficiaries aged 65 and older accounted for 32% of Medicaid drug spending in 1999, and this figure does not include spending for nonelderly disabled dual eligibles. The shift of this spending to Medicare may reduce states' bargaining power.

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[74] Michigan Department of Community Health, "Michigan and Vermont Implement Nation's First Multi-State Medicaid Pharmaceutical Pooling Program, press release, Feb. 20, 2003, at [http://www.michigan.gov/mdch/0,1607,7-132-8347-61874—M_2003_2,00.html] as of Sept. 2003.

[75] S. Lueck, "States' Efforts to Cut Drug Prices Get a Boost from Medicaid Chief," *Wall Street Journal*, May 30, 2003.

[76] National Conference of State Legislatures, *Pharmaceutical Bulk Purchasing: Multi-state and Inter-agency Plans*, at [http://www.ncsl.org/programs/health/bulkrx.htm] as of Sept. 2003.

[77] States will contribute to drug costs for dual eligibles indirectly, through required maintenance of effort payments; see below.

Table 38. Number of States Making Medicaid Prescription Drug Policy Changes, FY2003 and FY2004

	FY2003	Planned FY2004
AWP less greater discount	17	8
More prescriptions under prior authorization	32	25
Preferred drug list	14	30
New or higher beneficiary copays	14	17
Seek supplemental rebates	11	21
Require generics	4	5
Limit number of prescriptions per month	5	4

Source: V. Smith, et al., *States Respond to Fiscal Pressure: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2003 and 2004*, Kaiser Commission on Medicaid and the Uninsured, 2003.

Other Payment Requirements

Federal Rules for Specified Services

Although the services already discussed account for the vast majority of Medicaid spending, state programs cover many other mandatory or optional services. The following discussion is limited to services for which special payment rules are established by federal law.

Home and Community-Based Care Option. In addition to the HCBS waiver, Medicaid law permits states to offer home and community-based care for functionally disabled elderly persons as an optional Medicaid service. While waiver programs have limits on the numbers of participants, a state offering the HCBS optional service must cover everyone meeting eligibility standards established by the state. Perhaps for this reason, only Indiana and Texas reported payments for this service in FY2001. Payment rates for the care must be reasonable and adequate to meet the costs of providing the care efficiently, economically, and in conformity with laws and quality and safety requirements. However, the federal statute provides that payments over the course of a quarter for persons receiving the services may not exceed 50% of what would have been paid by Medicare to treat the same average number of patients in a nursing facility in the state.

Hospice Services. If the state elects to cover hospice services, it must follow Medicare reimbursement rules for hospices, with minor differences. Under Medicare rules, payment for each day of care furnished by the hospice is at fixed rates according to the nature of the care received by the patient: a day may be classed as routine home care, continuous home care, inpatient respite care, or general inpatient care. Average payments per patient are subject to an annual "cap amount" updated annually by the Secretary and applied on an aggregate basis. The hospice cap amount for the year ending October 31, 2003 was $18,661.29. The aggregate number of inpatient care days provided by the hospice in any 12 month period may not exceed 20% of the total number of days of hospice care provided.

Medicaid programs may or may not use the annual cap, but must impose the limit on inpatient days; Medicaid inpatient days furnished to patients with AIDS are not counted towards this limit. Under Medicaid, additional payment for room and board may be made for patients who receive hospice services while residing in a nursing facility or ICF/MR (this is not true under Medicare).

Indian Health Service. The Indian Health Service (IHS) within the Department of Health and Human Services (DHHS) provides or purchases health services for certain groups of Native Americans and Alaska Natives. The IHS provides care in two different ways: directly through IHS facilities or tribally owned and operated facilities, and on a "contract care" basis through referral to off-reservation health care providers. The IHS requires that alternative payment resources available to users of IHS services be exhausted before IHS will accept financial responsibility. Native Americans may qualify for Medicaid in the same way as any other population, by meeting categorical and financial standards.

In the case of services provided in IHS facilities to Medicaid beneficiaries, IHS or the facility bills Medicaid directly, at fixed rates established annually by DHHS.[78] Federal matching funds for services in IHS facilities are available at 100%, rather than at the state's usual matching rate. When services are furnished by a contract provider, the provider is expected to collect from any "alternative resource" available to the patient, including Medicaid, Medicare, or other health insurance, before seeking reimbursement from IHS. If Medicaid is the responsible payer, federal funding is available at the state's usual matching rate; the state is liable for the remainder, as with any other Medicaid service.

Laboratory Services. Payment for a laboratory test performed by a physician, independent laboratory, or hospital (except tests for the hospital's own inpatients) may not exceed the amount that would be paid under Medicare rules for the same test. Medicare payment is based on regional fee schedules established by the Secretary for each type of test.

Programs of All-Inclusive Care for the Elderly (PACE). The BBA authorized the PACE program, under which Medicare and state Medicaid programs make integrated capitation payments for preventative, acute, and long-term care to MCO-like organizations that furnish services to frail elderly people. (As of January 2003, 10 states had approved PACE programs.) The Medicaid component of the capitation for PACE enrollees is negotiated by the state and the provider. It is required to be less than would have been spent for comparable individuals in the fee-for-service sector, taking into account the comparative frailty of PACE enrollees and "such other factors as the Secretary determines to be appropriate." (The Secretary has not so far specified any additional factors.)

Volume Purchasing. States may arrange for "volume purchasing" of laboratory services (other than those provided by hospitals or rural health clinics) or

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[78] The Alaska Native and American Indian Direct Reimbursement Act of 2000 (P.L. 106-417) authorized direct Medicaid billing by tribes, tribal organizations, or Alaska Native health organizations that are operating IHS owned or leased facilities.

medical devices, such as durable medical equipment or eyeglasses. One or more providers of the specified service may be selected by the state, through competitive bidding or other means, as the sole source of the items covered in an area or statewide. Some states will permit other providers to furnish the item or service, but only if they are prepared to meet the price of the approved source. The state must ensure that services remain accessible to beneficiaries. If the arrangement is for laboratory services, the laboratory must be state-licensed and/or meet other requirements established by the Secretary, and no more than 75% of the laboratory's charges may be for Medicare and Medicaid beneficiaries.

Coordination with Medicare

While coverage under Medicare Part A (hospital insurance) is automatic for persons meeting eligibility standards, coverage under Part B (supplemental medical insurance) requires payment of a monthly premium by the beneficiary. Some persons not automatically eligible for Part A coverage may also obtain that coverage by paying a premium. In addition, Medicare beneficiaries are liable for cost-sharing: deductible and coinsurance payments imposed for most Medicare-covered services. State Medicaid programs are required to help defined populations of low-income Medicare beneficiaries with Medicare-required premiums and sometimes cost-sharing.

As **Table 39** shows, there are five groups of Medicare beneficiaries eligible for Medicaid assistance. The amount of help they receive generally decreases with rising income. In addition to meeting income tests, beneficiaries must meet resource tests. For dual eligibles, assets are limited to the SSI standard ($2,000 for an individual and $3,000 for a couple.); for the other groups, the limits are twice these amounts.[79]

Table 39. Medicaid Benefits for Low-Income Medicare Beneficiaries

	Family income	Medicaid pays
Full Medicaid beneficiaries (dual eligibles)	Varies by state	All Medicaid-covered services; Medicaid secondary to Medicare
Qualified Medicare beneficiaries (QMBs)	Above state Medicaid eligibility level, no greater than 100% of FPG	All Medicare premiums and cost-sharing
Specified low-income Medicare beneficiaries (SLMBs)	Between 100% and 120% of FPG	Medicare Part B premium
Qualified individuals (QIs) — provision expires November 20, 2004	Between 120% and 135% of FPG, but enrollment limited through fixed dollar funding cap for each state	Medicare Part B premium
Qualified disabled and working individuals	No greater than 200% of FPG	Medicare Part A premium

Source: Title XIX of the Social Security Act.
Note: FPG = Federal poverty guideline.

[79] For the QMB amd SLMB groups, states can also use more liberal methodologies for counting resources, meaning that they could disregard some amount of excess assets.

Dual eligibles are elderly or disabled people who are eligible for Medicare and who also qualify for full Medicaid benefits, such as SSI recipients, the medically needy, and people meeting special eligibility standards for long-term care coverage. States pay Medicare premiums and cost-sharing for these beneficiaries and cover services included in the state plan and not covered by Medicare — most notably, long-term nursing facility care and outpatient prescription drugs.[80] Note that, when the new Medicare prescription drug benefit takes effect in 2006, state Medicaid programs will no longer be permitted to cover drugs that are included in the Medicare benefit. Instead, dual eligibles will receive the low-income subsidies provided for under the Medicare law.[81]

Qualified Medicare beneficiaries (QMBs) do not qualify for full Medicaid coverage, but have incomes no greater than 100% of the federal poverty guideline (FPG): $8,980 for an individual and $12,120 for a couple in 2003. Medicaid programs must pay both Part A and Part B premiums and required Medicare cost-sharing for QMBs. Specified low-income Medicare beneficiaries (SLMBs) have incomes between 100% and 120% of the FPG. Medicaid pays only the Part B premium and does not pay cost-sharing for SLMBs.

Qualifying individuals (QIs) have incomes between 120% and 135% of the FPG. States pay the Part B premium for these individuals with 100% federal funding, subject to a fixed-dollar annual cap for each state; this can mean that not all eligible applicants will receive assistance. The provision for QIs expires November 20, 2004.

Finally, states are required to pay the Part A premium, but not the Part B premium or cost-sharing, for qualified disabled and working individuals. These are certain persons whose social security disability insurance benefits cease after they return to work but who are permitted to continue to receive Medicare by paying the Part A premium.

When states pay Medicare deductibles and coinsurance for dual eligibles and QMBs, they have two options for computing the Medicaid payment amount. They may choose to pay the full cost-sharing amounts determined by Medicare. Or they may pay the difference, if any, between what Medicare paid and what the state would have paid under its usual Medicaid rules for the same service. For example, suppose the Medicare allowed fee for a given physician service is $100 and the state's Medicaid fee schedule allows $75 for the same service. Medicare pays 80%, or $80,

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[80] Technically, a state could choose not to pay premiums ("buy in") for dual eligibles whose incomes exceed 120% of poverty (chiefly persons in institutions who are spending down). However, states are given a financial incentive to obtain Part B coverage for all Medicaid beneficiaries who could qualify for it. If the state fails to buy in for a beneficiary and then makes Medicaid payments for services that could have been covered by Medicare, it may not claim federal matching for the resulting expenditures. (There is an exception for services furnished prior to the date of the beneficiary's Medicaid application and covered as a result of a retroactive grant of Medicaid eligibility.)

[81] States will make maintenance of effort payments to the federal government. These will begin in 2006 at 90% of states' estimated per capita drug spending (less dispensing fees and rebates) for dual eligibles and will phase down to 75% in 2014 and later years.

leaving $20 to be paid as coinsurance. The state may pay the full $20, or it may determine that the practitioner has already been paid in full and pay nothing. (This option for states was clarified by the BBA after a number of court rulings requiring payment of full cost-sharing.)

Table 40 shows which states have chosen to pay full Medicare cost-sharing (MR) and which pay up to the ordinary payment limits under the state plan (SP). As the table indicates, some states pay differently for Part A and Part B cost-sharing, while others have exceptions for specific services. Only major exceptions are noted in the table.

Table 40. Medicaid Payment Policies for Medicare Cost-Sharing

State	Payment method	Notes
Alaska	MR	Hospital inpatient/outpatient SP
Alabama	SP	Part A deductibles MR
Arkansas	MR	
Arizona	MR	Non-AHCCCS services only
California	SP	Skilled nursing facility MR
Colorado	SP	
Connecticut	MR (Part A)/SP (Part B)	
District of Columbia	SP	Part A deductibles MR
Delaware	SP	
Florida	SP	
Georgia	SP	
Hawaii	MR	
Iowa	MR	
Idaho	MR (Part A)/SP (Part B)	
Illinois	SP	Skilled nursing facility MR
Indiana	SP	
Kansas	SP	
Kentucky	MR	
Louisiana	SP	
Massachusetts	SP (Part A), MR (Part B)	
Maryland	MR	
Maine	SP	
Michigan	SP	
Minnesota	MR	
Missouri	MR	Hospital inpatient SP
Mississippi	SP	
Montana	MR (Part A)/SP (Part B)	
North Carolina	SP	
North Dakota	MR	Skilled nursing facility SP
Nebraska	MR	
New Hampshire	SP	
New Jersey	SP	Hospital inpatient/outpatient MR
New Mexico	MR	
Nevada	SP	
New York	MR	
Ohio	MR	

State	Payment method	Notes
Oklahoma	Part A MR, Part B: 94% of deduct and 75% of coins	
Oregon	SP	
Pennsylvania	SP	
Rhode Island	SP	
South Carolina	MR	
South Dakota	MR	
Tennessee	SP	Most dual eligibles in TennCare
Texas	MR	Hospital inpatient SP
Utah	MR	Hospital inpatient/outpatient, other specified services SP
Virginia	SP	
Vermont	MR	
Washington	SP	
Wisconsin	SP	
West Virginia	MR	
Wyoming	MR	

Source: Medicaid state plans and amendments approved as of Nov. 7, 2002, except as follows: Florida Medicaid program, *Summary of Services 2002*, [http://www.fdhc.state.fl.us/Medicaid/sos.pdf], July 25, 2003. *New Jersey Administrative Code*, 10:49. North Carolina Medicaid *Special Bulletin* VI, Sept. 2002, [http://www.dhhs.state.nc.us/dma/bulletin/pdfbulletin/0902specrev111402.pdf], as of July 2003.

Note: MR = pays full Medicare cost-sharing; SP = pays up to state plan limit.