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RESEARCH BRIEF

HSR Health Services Research

New evidence of state variation in Medicaid payment policies for dual Medicare-Medicaid enrollees

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Abstract

Objective: To develop the first longitudinal database of state Medicaid policies for paying the cost sharing in Medicare Part B for services provided to dual Medicare-Medicaid enrollees ("duals") and an index summarizing the impact of these policies on payments for physician office services.

Data sources: Medicaid policy data collected from electronic sources and inquiries with states.

Study design: We constructed a national database of Medicaid payment policies for the period 2004-2018, consolidating information from online Medicaid policy documents, state laws, and policy data reported to us by state Medicaid programs. Using this database and state Medicaid fee schedules, we constructed a Medicaid payment index for duals. This index represented the proportion of the Medicare allowed amount that physicians would expect to be paid from Medicare and Medicaid for a subset of physician office services (evaluation and management services) based on annual state payment policies and Medicaid fee schedules.

Principal findings: In 2018, 42 states had policies to limit Medicaid payments of Medicare cost sharing when Medicaid's fee schedule was lower than Medicare's—an increase from 36 such states in 2004. In the preponderance of states with these policies, combined Medicare and Medicaid payments for evaluation and management services provided to duals averaged 78 percent of the Medicare allowed amount for these services, reflecting relatively low Medicaid fee schedules in these states. In 2013 and 2014, physicians who qualified for the Affordable Care Act's Medicaid "fee bump" were paid 100 percent of the Medicare allowed amount for these services.

Conclusions: Medicaid programs vary across states and over time in their payments of cost sharing for physician office services provided to duals. Our database and index can facilitate monitoring of these policies and research on the consequences of policy changes for duals.

KEYWORDS
dual eligibles, state Medicaid policies

1 | INTRODUCTION

For low-income individuals enrolled in Medicare and Medicaid ("duals"), Medicaid serves as a supplemental insurer to Medicare, covering Medicare's cost sharing obligations, including the deductible and 20 percent coinsurance for physician services covered by Medicare Part B. However, states differ in the extent to which their Medicaid programs pay Medicare's cost sharing for duals, which may affect providers' incentives to serve these patients.[1]

These differences in Medicaid payments arise from two sources of policy variation. First, states differ in their adoption of so-called "lesser-of" policies, which are provisions for Medicaid to pay the lower of (a) Medicare's cost sharing, or (b) the difference between the Medicaid fee schedule and Medicare's payment for a service (net of cost sharing).[1] Second, Medicaid fee schedules, which vary across states and over time,[2-5] affect the amount of cost sharing that Medicaid will pay providers in lesser-of states.

In lesser-of states with low Medicaid fee schedules, providers can be paid substantially less when rendering services to duals vs other Medicare beneficiaries, who either pay Medicare's cost sharing out of pocket or have private supplemental (ie, Medigap) insurance to cover these expenses. Figure 1 illustrates the magnitude of these payment differentials for a hypothetical physician office visit covered by Medicare Part B, which we show separately for a claim occurring in the deductible vs coinsurance phase of the Part B benefit. In the deductible phase, where Medicare pays $0 toward claims, physicians in lesser-of states are paid up to the level of the state's Medicaid fee schedule. In the coinsurance phase, where Medicare pays 80 percent of Part B allowed charges, physicians receive no payment from Medicaid when a state's Medicaid fee schedule is less than 80 percent of Medicare's—as is often the case[2]—effectively capping a provider's total payment from Medicare and Medicaid at 80 percent of the Medicare allowed amount (ie, price). Providers are prohibited from billing duals for unpaid balances. In states with policies to pay the full amount of Medicare's cost sharing, combined payments from Medicare and Medicaid equal 100 percent of the Medicare allowed amount regardless of the state's prevailing Medicaid fee schedule.

Several studies have found that payment differentials attributable to lesser-of policies diminish duals' access to care.[6-9] However, these studies examined policies from more than a decade ago[6-9] and most employed cross-sectional designs using a single year of data,[7,8] precluding more rigorous longitudinal analyses of state policy changes. Research examining the consequences of changes in these payment policies is hindered by a lack of longitudinal state policy data.

What This Study Adds

- State Medicaid programs differ in their policies for paying Medicare's cost sharing obligations on behalf of low-income Medicare beneficiaries dually enrolled in Medicaid ("duals").
- There is some evidence that state policies to limit Medicaid payments of Medicare cost sharing diminish duals' access to care. However, these studies have been limited by a lack of longitudinal state policy data.
- We developed a new longitudinal database of state Medicaid payment policies for duals and an index that summarizes the impact of these policies on expected payments for physician office services.
- Our database and index can facilitate monitoring of state policies and research on the effects of policy changes for duals.

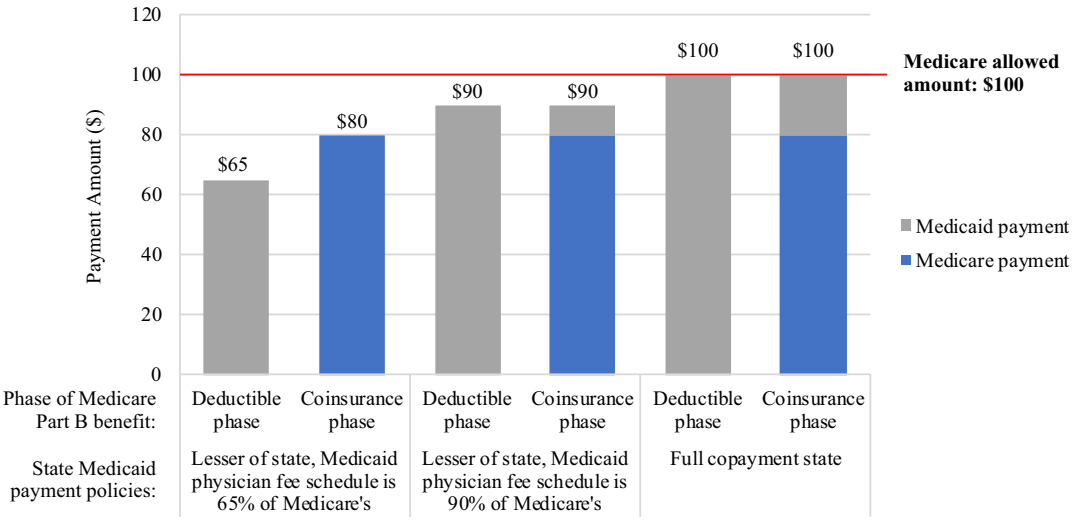

FIGURE 1 Illustration of Medicare and Medicaid payments to physicians under different state Medicaid payment policies [Color figure can be viewed at wileyonlinelibrary.com]

Source: Authors' illustration of Medicare and Medicaid payments to physicians under different state Medicaid payment policies assuming a hypothetical physician office service with a Medicare allowed amount (ie, price) of $100.

Note: The Medicare Part B deductible is $198 in 2020. After a beneficiary reaches the deductible, Medicare pays 80% of allowed Part B charges for the remainder of the benefit period, termed the "coinsurance phase."

In this research brief, we present findings from a new longitudinal database of state Medicaid policies for paying the cost sharing for physician office services covered by Medicare Part B. This database, assembled by our study team and publicly available on an archived Figshare repository (https://doi.org/10.6084/m9.figshare.12827390.v1), builds on prior efforts[1,10,11] to document variation in state Medicaid payment policies for duals. Specifically, prior policy scans assessed state policies at single points in time, while we tracked policies over a 15-year period (2004-2018). We also developed an index summarizing the proportion of the Medicare allowed amount for office services that physicians would expect to receive from Medicare and Medicaid given states' lesser-of policies and Medicaid fee schedules. Our database and index can facilitate monitoring of state policies and research on the effects of policy changes on low-income Medicare beneficiaries' access to and use of care.

2 | METHODS

2.1 | Policy scan

We conducted an electronic scan of state Medicaid programs' policies for paying the cost sharing for services covered by Medicare Part B. Our policy scan relied on three principal sources: (a) state Medicaid plans and amendments to these plans filed with the Centers for Medicare and Medicaid Services (CMS); (b) state laws catalogued by LexisNexis; (c) and Medicaid provider manuals, program bulletins, and related online policy documents. (Search terms for our queries are in the Appendix S1) Our searches were guided in part by sources identified in prior point-in-time policy scans[1,10,11]; we queried these sources for policy changes preceding or following the periods covered by prior scans. In each year from 2004-2018, we ascertained if a state had a lesser-of policy, paid Medicare's cost sharing in full, or had an "intermediate" payment policy. (We considered states to have intermediate payment policies if they lacked lesser-of policies and paid some, but not all, of Medicare's cost sharing—eg, paying a fixed proportion of Medicare's coinsurance.)

We also directly requested information from each state and the District of Columbia to ascertain current and recent changes to Medicaid payment policies. In cases where we did not receive a response, we prioritized subsequent requests among states that had ambiguities in their electronic policy record, had policy changes, or for which we could not locate any electronically archived policy data. We ultimately received responses from 22 states. We coded a state's payment policy as unclear in any year for which we could not confidently ascertain policies from our searches or inquires with states. The state-provided policy data and electronic documents we located allowed us to construct a complete longitudinal policy record from 2014-2018 for all except two states (New Hampshire and South Dakota). The Appendix S1 provides additional details about the different data sources we obtained for each state.

We separately tracked Medicaid policies for paying the cost sharing for Part B services in physician offices and hospital outpatient departments, which differ in some states. However, this article focuses on payments for physician office services, given policy makers' longstanding interest in understanding how lesser-of policies affect duals' receipt of care from physicians[1] and because physicians cannot recoup unpaid balances through Medicare "bad debt" payments available to hospitals, underscoring the salience of lesser-of policies for physicians.[7,12]

2.2 | Payment index

Medicaid payments of Medicare cost sharing depend on two factors: (a) whether a state has a lesser-of or alternative payment policy, and (b) the state's Medicaid fee schedule relative to Medicare's. We constructed a payment index that summarized the net impact of these two factors on expected payments for evaluation and management services in physician offices. Specifically, we drew a national sample of claims for duals from the Medicare carrier files from 2010-2012, limiting the set of claims to evaluation and management services (HCPCS codes 99201-99215) where the place of service was a physician office. Holding this sample of claims fixed, we simulated the amount of Medicare cost sharing that Medicaid programs would be expected to pay, in each state and year, according to states' annual payment policies and Medicaid physician fee schedules. Because we held the set of Medicare claims constant across each state-year simulation, the variation in this index is driven solely by differences in expected Medicaid payments of Medicare cost sharing given states' annual payment policies and Medicaid physician fee schedules (see Appendix S1 for details). The index reflects expected payment rates to providers serving all duals for whom Medicaid covers Medicare's cost sharing obligations—that is, Medicare beneficiaries with full Medicaid and beneficiaries receiving partial Medicaid benefits through the Qualified Medicare Beneficiary program.[1]

We defined our index as the sum of simulated Medicaid payments and actual Medicare payments (pooled across all claims in the sample), which we expressed as a proportion of the sum of Medicare allowed amounts for these claims. An index value of 80 percent, for example, indicates that a physician's expected payment from Medicaid and Medicare equals 80 percent of Medicare's allowed amount, meaning that a physician would be paid 20 percent less for an office service provided to a dual vs other Medicare beneficiaries. We constructed this index annually for each state and the District of Columbia, except for New Hampshire (from 2004 to 2011) and South Dakota (from 2004 to 2010), as we lacked data on Medicaid payment policies in these state-years, and Tennessee (all study years), which does not have any fee-for-service component in its Medicaid program and therefore lacked data on Medicaid fee-for-service payment rates. In supplementary analyses reported in the Appendix S1, we compared our index to previously reported estimates of Medicaid payments of Medicare cost sharing for a subset of states in 2005 and 2009.[7]

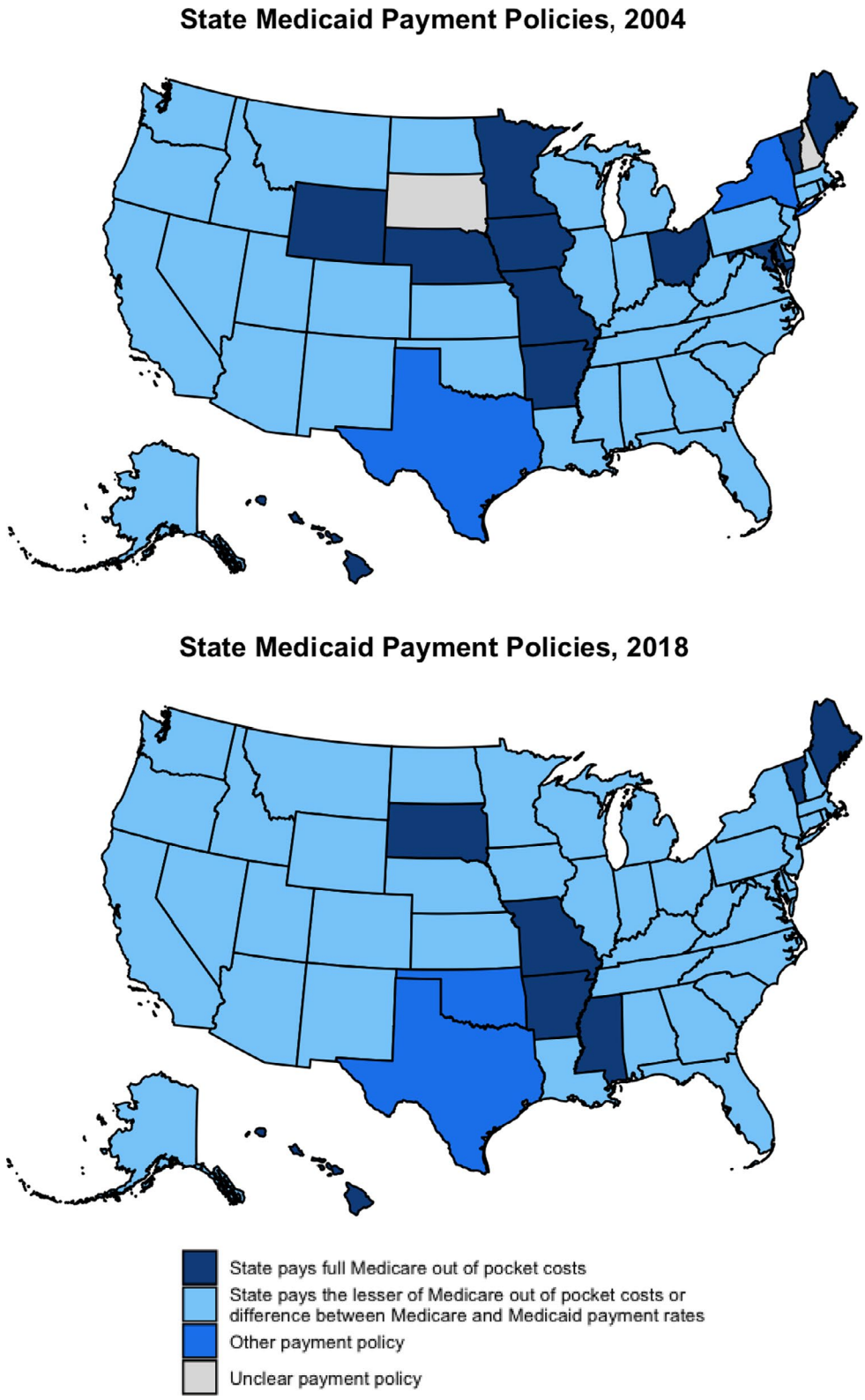

FIGURE 2 State Medicaid policies for paying Part B cost sharing amounts for physician office visits in 2004 and 2018 [Color figure can be viewed at wileyonlinelibrary.com]

Source: Authors' analyses of state Medicaid payment policies. See the notes to Table 1 for a description of other payment policies utilized in specific states. In 2004, we were unable to determine Medicaid payment policies in South Dakota and New Hampshire. The net impact of these policy changes on Medicaid payments to physicians depends on Medicaid's fee schedule for relative to Medicare's. These net impacts are summarized in our payment index for duals, results of which are reported in Table 1

TABLE 1 Payment index based on states' prevailing Medicaid fee schedules

Providers who did not qualify for the Affordable Care Act's Medicaid fee bump															
	2004	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**
Lesser-of states in which the prevailing Medicaid fee schedule for primary care services was < 80% of Medicare's[a]															
Number of states[b]	24	22	19	17	16	17	20	25	27	26	27	29	27	29	29
Mean index across states[c]	77.9%	78.0%	77.9%	77.8%	77.7%	77.8%	78.0%	78.2%	77.9%	77.8%	77.8%	77.7%	77.7%	77.8%	77.8%
Lesser-of states in which the prevailing Medicaid fee schedule for primary care services was ≥ 80% of Medicare's[a]															
Number of states[b]	11	12	15	17	18	17	14	9	9	10	9	8	11	12	12
Mean index across states[c]	91.5%	91.2%	90.4%	91.3%	92.6%	90.7%	89.3%	91.9%	90.3%	89.3%	91.4%	93.0%	92.7%	92.8%	92.8%
States that paid the full amount of Medicare deductibles and coinsurance															
Number of states[b]	11	12	12	12	12	12	12	13	12	12	11	11	10	7	7
Mean index across states[c]	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
States with "intermediate" payment policies[d]															
Number of states[e]	2	2	2	2	2	2	2	2	2	2	3	2	2	2	2
Mean index across states[c]	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%	89.4%	86.4%	86.4%	86.4%	86.4%

[a]We categorized states annually according to their written payment policies and ratio of Medicaid to Medicare fees for primary care services, excluding higher payments provided under the Affordable Care Act's Medicaid fee bump (2013-2014).

[b]Number of states with these payment policies and Medicaid fee schedules by year.

[c]Proportion of Medicare allowed amounts for office-based evaluation and management services (CPT codes 99201-99215) that a physician would expect to be paid from both Medicare and Medicaid according to state Medicaid programs' annual payment policies and the ratio of Medicaid to Medicare fee schedules for primary care physician services. This version of the index represents expected payments to physicians who did not qualify for the Affordable Care Act's Medicaid fee bump and who therefore continued to be paid at prevailing Medicaid fee schedules in states with "lesser-of" policies.

[d]States in these years paid a proportion of Medicare deductibles and coinsurance but neither had a "lesser-of" nor "full copayment" policy. See note (e) for details about these states.

[e]State-years in this category: New York (2004-2014), which paid the full Part B deductible and 20% of the coinsurance; Texas (2004-2018), which paid the full Part B deductible and followed a lesser-of policy for the coinsurance; and Oklahoma, which from 2014-2018 paid 100% of the Part B deductible and 46.25% of the coinsurance.

Source: Authors' analyses of state Medicaid payment policies, the Urban Institute's ratio of Medicaid to Medicare fees for primary care services, and coinsurance and deductible amounts from a sample of Medicare Part B claims for physician office services from Medicare Carrier (physician/supplier) files (see Appendix S1 for details). We could not ascertain payment policies for New Hampshire from 2004-2011 and for South Dakota from 2004-2010; these states are excluded from the table in these years. Tennessee is excluded from this table in all study years because it does not have any fee-for-service component in its Medicaid program and thus lacked data on Medicaid's fee-for-service payments relative to Medicare's.

TABLE 2 Payment index for providers who qualified for the Affordable Care Act's Medicaid fee bump

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Lesser-of states in which the Medicaid fee prevailing schedule for primary care services was < 80% of Medicare's[a]															
Number of states[b]	24	22	19	17	16	17	20	25	27	26	27	29	27	29	29
Mean index across states[c]	77.9%	78.0%	77.9%	77.8%	77.7%	77.8%	78.0%	78.2%	77.9%	100.0%	100.0%	80.4%	80.6%	81.9%	81.9%
Lesser-of states in which the prevailing Medicaid fee schedule for primary care services was ≥ 80% of Medicare's[a]															
Number of states[b]	11	12	15	17	18	17	14	9	9	10	9	8	11	12	12
Mean index across states[c]	91.5%	91.2%	90.4%	91.3%	92.6%	90.7%	89.3%	91.9%	90.3%	100.0%	100.0%	93.0%	92.7%	92.8%	92.8%
States that paid the full amount of Medicare deductibles and coinsurance															
Number of states[b]	11	12	12	12	12	12	12	13	12	12	11	11	10	7	7
Mean index across states[c]	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
States with "intermediate" payment policies[d]															
Number of states	2	2	2	2	2	2	2	2	2	2	3	2	2	2	2
Mean index across states[c]	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%	84.0%	100.0%	100.0%	86.4%	86.4%	86.4%	86.4%

[a]We categorized states annually according to their Medicaid primary care fee index, excluding higher payments provided under the Affordable Care Act's Medicaid fee bump (2013-14). However, the payment index shown in this table reflects the higher levels of Medicaid payments for fee bump-eligible services in this period, and in subsequent years in the limited number of states that continued the fee bump.

[b]Number of states with these payment policies and Medicaid fee schedules by year.

[c]This version of the index represents expected payments to physicians who qualified for the Affordable Care Act's Medicaid fee bump, which was effective nationally in 2013 and 2014 and continued in a limited number of states in subsequent years (see reference 2 for details).

[d]States in these years paid a proportion of Medicare deductibles and coinsurance but neither had a "lesser-of" nor "full copayment" policy. See note (e) in Table 2 for details about these states.

Source: Authors' analyses of state Medicaid payment policies, the Urban Institute's ratio of Medicaid to Medicare fees for primary care services, and coinsurance and deductible amounts from a sample of Medicare Part B claims. See the notes to Table 1 for additional details of our sources and methods.

We developed two versions of this index: one for providers whose Medicaid payments reflected prevailing Medicaid fee schedules in states with lesser-of policies, and a second for providers who qualified for the Affordable Care Act' Medicaid "fee bump." The fee bump increased Medicaid payments to Medicare levels in 2013 and 2014 for certain primary care (principally, evaluation and management) services provided by qualifying physicians. Physicians specializing in internal medicine and family medicine qualified for this fee bump, as did subspecialists who met Medicaid billing volume thresholds for services targeted by the fee bump.[13,14]

3 | RESULTS

In 2004, 36 states had lesser-of policies that limited Medicaid payments to the lesser-of Medicare's cost sharing or the difference between the state's Medicaid fee schedule and Medicare's payment, while 11 states had policies to pay 100 percent of Medicare's cost sharing for physician office visits. In 2018, 42 states had lesser-of policies and seven states had policies to pay 100 percent of Medicare's cost sharing for physician office visits (Figure 2).

Between 2004 and 2018, six states switched from paying Medicare's cost sharing in full to a lesser-of methodology, while New York switched from paying 100 percent of the Part B deductible and 20 percent of the Part B coinsurance to a lesser-of policy (Appendix S1). However, in 2010 Mississippi switched *from* a lesser-of policy *to* a full copayment policy. (Because we could not ascertain payment policies for two states in 2004, we could not determine whether these states switched polices between 2004 and subsequent years).

Table 1 summarizes our index of expected Medicare and Medicaid payments for physician office visits provided to duals based on states' prevailing Medicaid physician fee schedules (not including higher payments provided under the Medicaid fee bump). On average in lesser-of states whose Medicaid physician fee schedules were less than 80 percent of Medicare's, a physician's expected payment from Medicaid and Medicare equaled 77.9 percent of Medicare's allowed amount in 2004—a 22.1 percent payment differential compared to other Medicare beneficiaries. In states with these policies in 2018, expected payments equaled 77.8 percent of Medicare's allowed amount. The index was expectedly higher in years when states had lesser-of policies and Medicaid physician fee schedules equal to at least 80 percent of Medicare's (index: 91.5 percent in 2004 and 92.8 percent in 2018). For years in which states followed "intermediate" payment policies (eg, paying a fixed proportion of Medicare's coinsurance), the index was between the levels reported for lesser-of states with Medicaid physician fee schedules <80 percent vs ≥80 percent of Medicare's.

Table 2 summarizes the index for physicians who qualified for the Affordable Care Act's Medicaid fee bump. This index is identical to the index displayed in Table 1 during the period 2004-2012, but differs during the period of the national fee bump (2013-2014) and to a smaller extent in subsequent years, since some states extended the fee bump beyond 2014.[2] For providers who qualified for the fee bump, the index equaled 100 percent in 2013 and 2014, reflecting the requirement that all Medicaid programs pay qualifying providers the full amount of Medicare's cost sharing for fee bump-eligible services. The implementation of the fee bump led to an approximately 22 percentage point increase in payments in lesser-of states whose Medicaid fee schedules had been less than 80 percent of Medicare's and to an approximately 10 percentage point increase in expected payments in lesser-of states whose fee scheduled had been at least 80 percent of Medicare's. The phase-out of the national fee bump led to nearly symmetric payment reductions in 2015.

Our simulated Medicaid payments were highly correlated ($\rho = 0.89$) with previously reported estimates of actual Medicaid payments using Medicaid claims for subset of states in 2005 and 2009 (Appendix S1).[7]

4 | DISCUSSION

State Medicaid programs vary in their payment of Medicare's cost sharing for physician office services provided to duals, with most limiting payments to the difference between Medicaid's fee schedule and Medicare's payment amount (lesser-of states), and only a few paying the cost sharing in full.

We catalogued states' payment policies over a 15-year period and constructed an index that summarized the net impact of these policies and Medicaid fee schedules on expected provider payments. We found a net increase in the number of states whose Medicaid programs had lesser-of policies (42 states in 2018 compared with 36 states in 2004). For the majority of lesser-of states and for most years in this period, state Medicaid physician fee schedules were less than 80 percent of Medicare's, meaning that providers in these states were paid considerably less for serving dual enrollees than other Medicare beneficiaries.

In 2013 and 2014, the ACA's Medicaid fee bump rendered these lesser-of policies moot for providers who qualified for the fee increase and led to large—and largely temporary—increases in Medicaid payments of Medicare cost sharing for fee bump-eligible services. (A small number of states extended the fee bump past 2014.[2]) The fee bump's effect was largest in states with lesser-of policies and relatively low Medicaid physician fee schedules; sizeable in states with lesser-of policies but higher Medicaid fee schedules; and had no impact on provider reimbursements in states that maintained full copayment policies. Providers in lesser-of states with low Medicaid fee schedules who did not qualify for these higher Medicaid payments continued to face sizeable differences in payments for office services provided to duals vs other Medicare beneficiaries. Evaluating the impacts of changes in Medicaid payments for duals, including those resulting from the Affordable Care Act's Medicaid fee bump, can provide new insight into how Medicaid payment policies affect duals' receipt of care from physicians and use of services that may be sensitive to ambulatory care access (eg, potentially preventable hospital admissions).

Our policy database and payment index have several limitations. First, we could not construct a complete longitudinal record of Medicaid payment policies for New Hampshire and South Dakota, and we were unable to construct a payment index for Tennessee, as all Medicaid beneficiaries in the state are enrolled in managed care programs that do not publish their payment rates. Second, our index reflects expected payments based on states' fee-for-service Medicaid payment rates. However, a growing number of states are moving duals into Medicaid managed care programs, in which managed care organizations (MCOs) negotiate payment rates with providers.[15] Lesser-of policies function similarly under Medicaid managed care, except that Medicaid MCOs pay the lesser-of (a) the difference between their negotiated provider rates and Medicare's payment amount, and (b) Medicare's cost sharing. However, to the extent payment rates negotiated by Medicaid MCOs differ from those in fee-for-service Medicaid, our payment index will not accurately reflect provider payments for duals enrolled in Medicaid MCOs. Third, we did not track Medicaid policies for paying the cost sharing for outpatient claims paid by Medicare Advantage (MA) plans. In 2018, MA plans covered 33 percent of duals with full Medicaid and 48 percent of duals with partial Medicaid, a subset of whom (Qualified Medicare Beneficiaries) receive Medicaid assistance with Medicare's cost sharing obligations.[16] Although many of the policy documents we reviewed indicated that states use similar methodologies to determine Medicaid payments of cost sharing for Medicare Advantage and traditional (ie, fee-for-service) Medicare claims, the impacts of these policies on payments may differ in Medicare Advantage plans vs traditional Medicare because of differences in benefit design—and thus cost sharing obligations—between these programs. Fourth, because of the complex structure of payments for services provided in hospital-owned facilities (eg, hospital outpatient departments), for which physicians and hospitals submit separate professional and facility claims,[17] we did not construct a payment index for outpatient hospital services covered by Medicare Part B. However, our payment index for physician office services captures variation in Medicaid payments where lesser-of policies may be more salient determinants of provider incentives to serve dual enrollees.

5 | CONCLUSION

We developed a national database and payment index to track Medicaid policies for paying the cost sharing for physician office services provided to dual Medicare-Medicaid enrollees at the state level from 2004 to 2018. Our database and index can facilitate monitoring of state Medicaid payment policies for duals and help researchers and policy makers understand the consequences of policy changes for dual enrollees.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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