United States Government Accountability Office

Report to Congressional Committees

July 2014

MEDICAID PAYMENT

Comparisons of Selected Services under Fee-for-Service, Managed Care, and Private Insurance

GAO-14-533

July 2014

MEDICAID PAYMENT

Comparisons of Selected Services under Fee-for-Service, Managed Care, and Private Insurance

GAO Highlights

Highlights of GAO-14-533, a report to congressional committees

Why GAO Did This Study

Medicaid provided health coverage for over 70 million individuals in fiscal year 2013 through a combination of FFS and managed care at a cost of about $460 billion. Yet, limited information is available on how provider payments per service under Medicaid FFS and managed care compare with private insurance and with one another. This report builds on a prior GAO study on Medicaid payments by comparing payments for E/M services under Medicaid FFS, managed care, and private insurance prior to 2013, when temporary Medicaid payment increases for these services took effect, as mandated by HCERA.

In this report, GAO examines: (1) how payments for E/M services under Medicaid FFS and Medicaid managed care compared with private health insurance prior to the HCERA-mandated increases; and (2) how payments for E/M services under Medicaid managed care compared with Medicaid FFS prior to the HCERA-mandated increases.

To compare these payments, GAO analyzed claims data from Medicaid FFS, managed care organizations, and private insurers. GAO compared payments to physicians for 26 E/M services in selected states, chosen on the basis of data availability. GAO compared Medicaid FFS payments with private insurance in 40 states; Medicaid managed care with private insurance in 23 states; and Medicaid managed care with Medicaid FFS in 20 states. Results were based primarily on 2010 data—the most recent Medicaid FFS data available for most states—but 2009 data were used when 2010 data were unavailable.

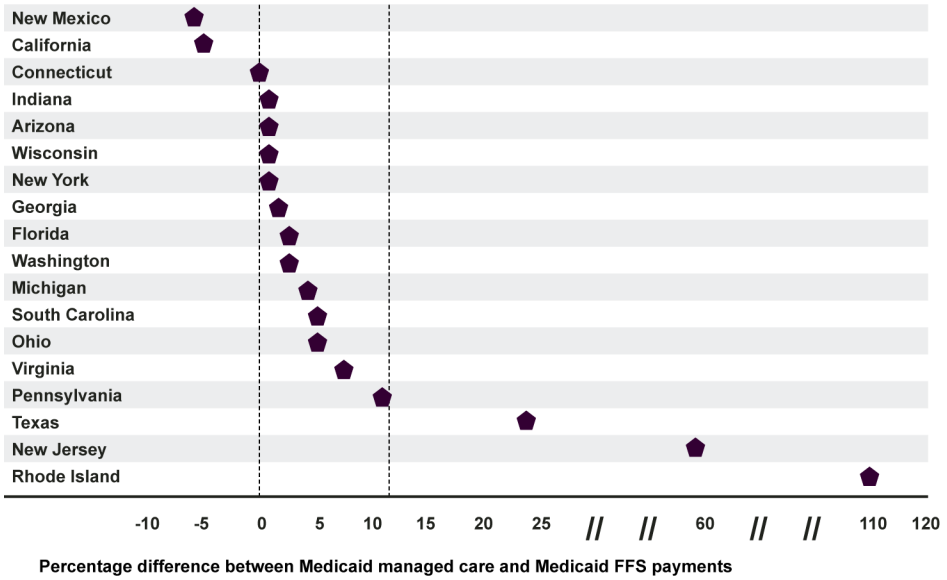
View GAO-14-533. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

Payments to physicians under Medicaid fee-for-service (FFS) and managed care for the 26 evaluation and management (E/M) services, such as office visits and emergency care, that GAO reviewed were generally lower than private insurance prior to the temporary increases mandated by the Health Care and Education Reconciliation Act of 2010 (HCERA). Specifically, in the 40 states where GAO compared Medicaid FFS payments to private insurance, FFS payments were 27 to 65 percent lower than private insurance in 31 states; and in the 23 states where GAO compared managed care payments to private insurance, managed care payments were 31 to 65 percent lower than private insurance in 18 states. Among the three types of E/M services analyzed (office visits, hospital care, and emergency care), Medicaid payments generally were lower than private insurance for all three types, but the magnitude of the difference was often largest for emergency care and smallest for office visits.

Within the Medicaid program, managed care payments for E/M services were generally equal to or higher than FFS prior to the HCERA-mandated increases. Specifically, in the 20 states where GAO compared managed care payments to FFS, managed care payments were 0 to 12 percent higher than FFS in 15 states. Managed care payments for emergency care and hospital care were approximately equal to FFS payments in most states, while office visits showed more variation.

Medicaid Managed Care Payments for Evaluation and Management Services Relative to Medicaid Fee-for-Service in Selected States



Source: GAO analysis of 2009 and 2010 claims data from Medicaid managed care organizations and the Centers for Medicare & Medicaid Services. | GAO-14-533

Note: To safeguard confidential information, results were excluded from the figure for 2 of the 20 selected states where the number of Medicaid managed care organizations was limited.

Contents

Figures

Abbreviations

CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology®
ED	emergency department
E/M	evaluation and management
FFS	fee-for-service
HCERA	Health Care and Education Reconciliation Act of 2010
MAX	Medicaid Analytic eXtract
MC	managed care
MCO	managed care organization
MedPAC	Medicare Payment Advisory Commission

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
441 G St. N.W.
Washington, DC 20548

July 15, 2014

Congressional Committees

Medicaid, a joint federal-state program for certain low-income individuals, provided health care coverage for over 70 million individuals in fiscal year 2013 through a combination of fee-for-service (FFS) and managed care at a total cost of about $460 billion.[1] Despite the size of the Medicaid program, limited information is available on how payments per service under Medicaid FFS and managed care compare with private insurance and with one another.[2] A previous GAO study used claims data to calculate Medicaid FFS payments for certain services and compared them with states' FFS fee schedules.[3] In this report, we build on that prior work and use claims data to calculate and compare payments to physicians for selected evaluation and management (E/M) services under different payers—Medicaid FFS, Medicaid managed care, and private insurance. The payment comparisons we present are not sufficient to assess the adequacy of payments made by a given payer, or whether one payer delivers care more or less efficiently than another. However, these comparisons can contribute to broader understanding of Medicaid payments and enhance program knowledge for the Centers for Medicare & Medicaid Services (CMS)—the agency that oversees the Medicaid program—as well as inform states and other policy makers. Furthermore, comparing payments prior to 2013 for E/M services can help provide a useful baseline for tracking the impact of the temporary Medicaid payment increases for these services in 2013 and 2014, which were

[1]Under FFS, Medicaid pays providers for each service provided to a Medicaid beneficiary. Under managed care, states typically contract with managed care organizations (MCO) to provide some or all Medicaid-covered services to beneficiaries. The state pays the MCO a set amount per beneficiary per month to provide all covered services and, in turn, the MCO pays providers for the services. As of July 2011, about 57 percent of Medicaid beneficiaries were enrolled in Medicaid MCOs.

[2]Throughout this report, we use the term "payments" to refer to "payments per service."

[3]In our previous study, we demonstrated that claims data have the potential to provide a more complete representation of payments per service than do fee schedules, as claims data capture both the distribution and frequency of actual payments to providers. See GAO, *Medicaid: Use of Claims Data for Analysis of Provider Payment Rates,* GAO-14-56R (Washington, D.C.: Jan. 6, 2014).

mandated by the Health Care and Education Reconciliation Act of 2010 (HCERA).[4]

We prepared this report under the authority of the Comptroller General to conduct work on GAO's initiative to assist Congress with its oversight responsibilities, which include oversight of the Medicaid program. This report describes: (1) how payments for E/M services under Medicaid FFS and managed care compared with private health insurance prior to the HCERA-mandated increases; and (2) how payments for E/M services under Medicaid managed care compared with Medicaid FFS prior to the HCERA-mandated increases.

To describe how payments for E/M services under Medicaid FFS and managed care compared with private insurance, and how Medicaid managed care payments compared with Medicaid FFS, we used claims data from the Medicaid Analytic eXtract (MAX) files,[5] selected Medicaid managed care organizations (MCO), and the Truven Health Analytics MarketScan® Commercial Claims and Encounters Database.[6] We generally reported on data from 2010—the most recent year for which Medicaid FFS data were available for most states at the time of our analysis—however, we reported on 2009 data for the limited number of states in which 2010 Medicaid FFS data were unavailable. We analyzed

[4]HCERA required that Medicaid payments for E/M services, as well as certain vaccines, furnished by family physicians, internists, and pediatricians during calendar years 2013 and 2014 must not be less than Medicare payments for these services. In implementing this requirement, the federal government must provide 100 percent of the funding for any increase in payments above the amount that the state's Medicaid program would have paid as of July 1, 2009. Pub. L. No. 111-152, § 1202, 124 Stat. 1029, 1052 (2010). This requirement resulted in a Medicaid payment increase for these services in all but two states. See S. Zuckerman and D. Goin, *How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, December 2012).

[5]MAX files are compiled based on data submitted from each state's Medicaid agency, and include information on each Medicaid FFS service rendered during a given calendar year and the payment for each service. We analyzed Beta-MAX files, which are preliminary versions of the MAX files, for states where these files were available, but the MAX files were not.

[6]The Truven Health Analytics MarketScan Commercial Claims and Encounters Database contains claims for over 50 million individuals paid by over 100 private insurers across 50 states and the District of Columbia in 2010.

claims data for professional services that were paid on a per-service basis.[7]

We based our analysis of payments for E/M services on 26 of the 143 E/M services identified in the 2010 Current Procedural Terminology® (CPT) guide. We selected these 26 services because they were used by Medicaid FFS, Medicaid managed care, and private insurance across a large number of states. Using these 26 selected services, we compared Medicaid FFS payments with private insurance in 40 states; Medicaid managed care payments with private insurance in 23 states; and Medicaid managed care payments with Medicaid FFS in 20 states.[8] Collectively, these 26 services accounted for over 80 percent of national Medicaid FFS utilization and spending on E/M services in 2009.[9] We grouped these selected services into the following 3 types of E/M services based on their definition in the 2010 CPT guide: (1) office visits, (2) hospital care, and (3) emergency care.[10] To safeguard confidential information when presenting our state-level results, we omitted certain states that did not meet the minimum requirements to protect the

[7]Specifically, our analysis did not include institutional claims, which may capture the separate amount paid to a facility to cover overhead costs, or claims for services paid on a capitated or bundled basis. We also excluded claims for which there was more than one payer (such as those paid by both Medicaid and Medicare) and, to ensure the reliability of the data, excluded claims with a payment less than or equal to $0 and those that may not have been properly adjusted. Lastly, to help ensure that our analysis reflected the payments of standard Medicaid programs, we excluded claims for Medicaid beneficiaries identified in the MAX or Beta-MAX data, or by Medicaid MCOs as those enrolled in special programs, such as home and community based services waiver programs, and those beneficiaries with unknown eligibility.

[8]We did not have data for all 26 E/M services in all 50 states and the District of Columbia for several reasons. For example, some states did not have Medicaid FFS data for all 26 services because these states covered most of their population under Medicaid managed care. Additionally, we did not have Medicaid managed care data for several states due to the limited number of MCOs from which we collected data.

[9]These utilization and spending percentages were calculated using 2009 Medicaid FFS data—the most recent year with data for all states—after performing the exclusions described above in footnote 7.

[10]Our selected services consist of 13 office visit services (including office or other outpatient visits, and office or other outpatient consultations), 8 hospital care services (including initial and subsequent hospital care, and inpatient consultations), and 5 emergency care services (including emergency department visits and critical care). See table 1 in appendix I for a list of the services in each type of E/M service.

confidentiality of entities that contributed private insurance data, and we also masked the identity of certain other states where the number of Medicaid managed care organizations was limited.

To help ensure that the payments we calculated for Medicaid FFS, Medicaid managed care, and private insurance were comparable and did not reflect payment differences based on factors such as provider type, care setting, and beneficiary age,[11] we restricted our analysis to claims for services provided by physicians to adults in a specific setting, such as an office, hospital, or emergency department (ED).[12] After applying these restrictions, we calculated the percentage difference in the median payment between payers for each service in each state. To summarize these results for a given state, we calculated the median percentage difference across all 26 E/M services and by type of service, weighted by 2009 national Medicaid FFS spending on each service.[13] To assess the reliability of the claims data we used in our analysis, we reviewed related documentation; interviewed knowledgeable officials from CMS, its contractor responsible for producing MAX data, each Medicaid MCO from which we received data, and Truven Health Analytics; and checked each data set for obvious errors. We determined that these data were sufficiently reliable for the purposes of our analysis.

Our analysis of the available data has five technical limitations:

[11]We previously found that some states varied payments based several factors, including provider type, care setting, and beneficiary age. GAO-14-56R.

[12]The specific setting to which we restricted our analysis varied by type of service: for office visits, we restricted to services provided in an office; for hospital care, we restricted to services provided in a hospital; and for emergency care, we restricted to services provided in an ED, except for critical care services, which we restricted to either an ED or a hospital. We chose to restrict to adults (instead of children), because over half of claims were for adults for a majority of our 26 selected services (and for all 26 services, at least a quarter of claims were for adults). For all 26 services, we also restricted our analysis to claims that did not have a modifier and that had a quantity of one. Approximately 29 percent of 2009 Medicaid FFS claims for these 26 services met these five restrictions (provider type, setting, beneficiary age, modifier, and quantity).

[13]For additional context on our state-level results, the tables in appendix II include the total Medicaid enrollment in each state, and the percentage of the Medicaid population in FFS or managed care.

1. The results we present are neither representative of all MCOs or private payers in a given state, nor are our results for selected states representative of all states.
2. Although the 26 selected services accounted for over 80 percent of national Medicaid FFS utilization and spending on E/M services, our payment comparisons are not representative of all E/M services. In addition, because we restricted our analysis to claims for services provided in specific circumstances (such as by a physician in a certain setting) to promote comparability across payers, our payment comparisons are not representative of our selected services provided in all circumstances (such as when the services were provided by non-physicians or in other settings).
3. Medicaid and private insurers may vary payments based on factors not accounted for in our analysis, such as physician specialty or geographic region within a state.
4. The payments we calculated do not account for payments that physicians may receive in addition to the base payments for services rendered—such as bonus payments linked to quality of care or other types of supplemental payments.[14]
5. The payments under private insurance include beneficiary cost sharing, but the Medicaid data generally do not. Federal law generally restricts cost sharing for Medicaid beneficiaries to nominal amounts; however, states may impose additional cost sharing on certain Medicaid populations and for certain services, such as non-emergency use of the emergency room.

We conducted this performance audit from July 2013 to July 2014 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that

[14]States can make payments to providers, such as hospitals and physician group practices, in addition to their base payments for providing services to Medicaid FFS beneficiaries. However, only a small portion of these types of supplemental payments are made for physician services, and such payments typically are not made on the basis of claims submitted for specific services provided. See GAO, *Medicaid: States Reported Billions More in Supplemental Payments in Recent Years,* GAO-12-694 (Washington, D.C.: July 20, 2012), and *Medicaid: More Transparency of and Accountability for Supplemental Payments Are Needed,* GAO-13-48 (Washington, D.C.: Nov. 26, 2012).

the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

Although few studies have directly compared Medicaid FFS payments to private insurance for E/M or other services, the collective results of the available studies suggest that Medicaid FFS payments for E/M services were lower than private insurance. Specifically, a recent study found that Medicaid FFS payments for E/M services were generally lower than Medicare.[15] Furthermore, other recent studies found Medicare payments for E/M and other physician services were lower than private insurance.[16]

Little information is publicly available on how Medicaid managed care payments for E/M or other services compare with other payers; however, one recent study suggested that shifting beneficiaries from FFS to managed care may have increased Medicaid spending, on average.[17] Findings from this study also suggest that, in states where Medicaid payments were below private insurance to a greater extent than in other states, shifting Medicaid FFS beneficiaries into managed care did not

[15]This study analyzed data from fee schedules and found that Medicaid FFS payments for E/M and certain other services were 28 percent lower than Medicare fees, on average, in 2008, and 34 percent lower in 2012. See S. Zuckerman and D. Goin, "Medicaid Physician Fees" (2012). Other studies have also analyzed data from fee schedules and found that Medicaid FFS payments generally were lower than Medicare. See American Academy of Pediatrics, *Medicaid Reimbursement Survey, 2010/11*, (Elk Grove, IL: American Academy of Pediatrics, 2011); and S. Zuckerman et al., "Trends in Medicaid Physician Fees," *Health Affairs*, vol. 28, no. 3 (2009).

[16]One study found that Medicare payments for physician services overall in 2009 were about 18 percent lower than the payments of private insurance, on average, and Medicare payments for E/M services were about 12 percent lower, on average. See N. Nguyen et al., "Comparing Physician Payment Rates between Medicare and Private Payers in 2009" (presentation at Academy Health, Washington, D.C.: June 2013). Similarly, the Medicare Payment Advisory Commission (MedPAC) reported that Medicare payments for services provided by physicians and other health professionals have been around 20 percent lower than the amounts paid by private insurers from 1999 through 2012. See MedPAC, *Report to the Congress: Medicare Payment Policy* (Washington, D.C.: March 2014).

[17]See M. Duggan and T. Hayford, "Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local-Level Mandates,"*Journal of Policy Analysis and Management*, vol. 32, no. 3 (2013). This study analyzed data for 1991 to 2009 on state-level Medicaid spending, and data for 1991 through 2003 on state- and local-level mandates for Medicaid managed care to investigate the relationship between Medicaid spending and the shift of Medicaid beneficiaries from FFS to managed care.

reduce spending. On the other hand, this study found that shifting Medicaid FFS beneficiaries into managed care did save money—on average—in states where Medicaid payments relative to private insurance were more generous than other states. One key limitation of these findings related to data used to measure the generosity of Medicaid payments. Specifically, because of the lack of information on how Medicaid payments compared with private insurance, the study relied on comparisons of payments in 1989 for a single service: the delivery of a newborn.[18]

Medicaid Payments for Evaluation and Management Services Were Generally Lower than Private Insurance Prior to Mandated Increases

Payments to physicians for E/M services under Medicaid FFS and managed care were generally 27 to 65 percent lower than private insurance prior to the HCERA-mandated increases.

- Under Medicaid FFS, payments for E/M services were 27 to 65 percent lower than private insurance in 31 of 40 states. Among the remaining 9 states, 3 states had Medicaid FFS payments between 72 and 74 percent lower than private insurance, and 6 states had Medicaid FFS payments that ranged from 23 percent lower to 12 percent higher than private insurance.
- Under Medicaid managed care, payments for E/M services were 31 to 65 percent lower than private insurance in 18 of 23 states. Among the remaining 5 states, 1 state had Medicaid managed care payments 72 percent lower than private insurance, and 4 states had Medicaid managed care payments between 8 and 20 percent lower than private insurance.

Payments under both Medicaid FFS and managed care were lower than private insurance for each of the three types of E/M services in almost all states, but the magnitude of the difference varied based on the type of E/M service. For example, the percentage difference between Medicaid FFS and private insurance was largest for emergency care and smallest for office visits in 23 of 40 states. This was also the case for Medicaid

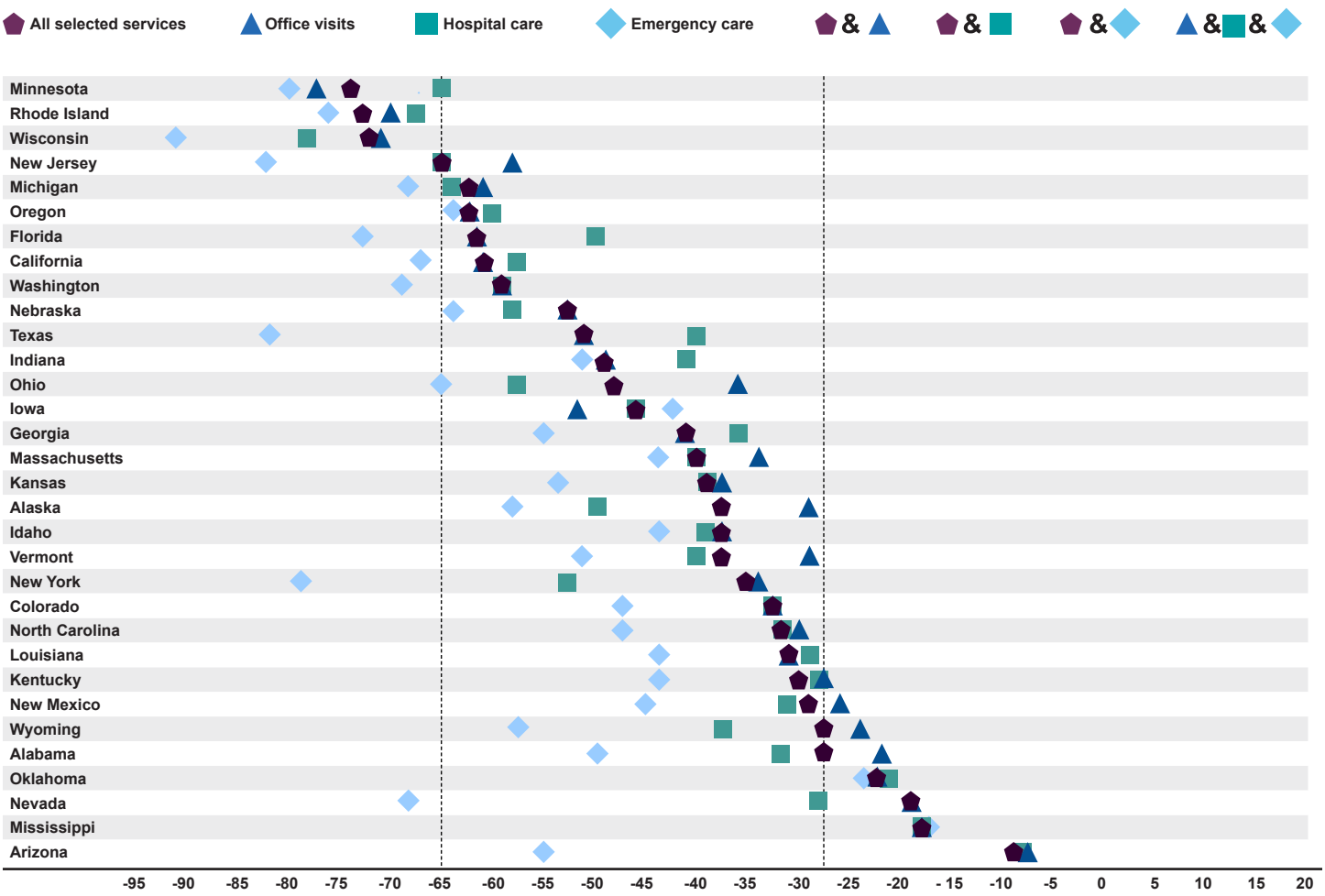
[18]M. Duggan and T. Hayford, "Shift to Managed Care," cited a previous study indicating that newborns accounted for the majority of all hospital discharges in Medicaid, and noted that this was likely to be the case for the Medicaid managed care population as well. See M. Duggan, "Hospital ownership and public medical spending," *Quarterly Journal of Economics*, vol. 115 (2000).

managed care payments in 16 of 23 states. Figures 1 and 2, below, present payment comparisons for most of our selected states.[19]

[19]To safeguard confidential information, we omitted results from figures 1 and 2 for certain states that did not meet the minimum requirements to protect the confidentiality of entities that contributed private insurance data, and we masked the names of certain other states where the number of Medicaid managed care organizations was limited.

Figure 1: Medicaid Fee-for-Service Payments for Evaluation and Management Services Relative to Private Insurance in Selected States, by Type of Service

Interactivity instructions: Roll over each legend icon or group of icons to see data points for only those types of services displayed. See table 2 in appendix II for additional details.

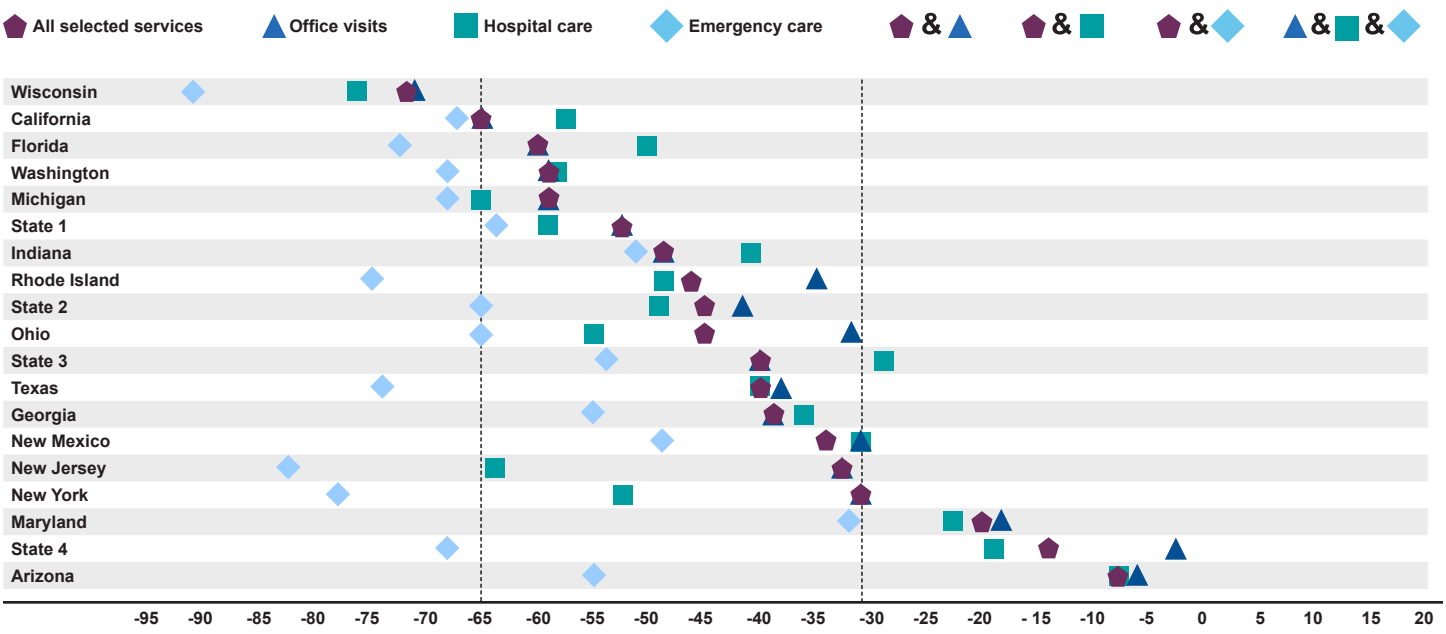


Source: GAO analysis of 2009 and 2010 claims data from the Centers for Medicare & Medicaid Services and Truven Health Analytics. | GAO-14-533

Note: The icons in the figure show the median percentage difference between Medicaid fee-for-service (FFS) and private insurance payments to physicians across 26 evaluation and management services, weighted by 2009 national Medicaid FFS spending on each service. To safeguard confidential information, results were omitted for 8 of the 40 selected states that did not meet the minimum requirements to protect the confidentiality of entities that contributed private insurance data. Results were based on 2010 data for the states in the figure except for Idaho, Kansas, Massachusetts, Nevada, New Jersey, and Wisconsin, which were based on 2009 data.

Figure 2: Medicaid Managed Care Payments for Evaluation and Management Services Relative to Private Insurance in Selected States, by Type of Service

Interactivity instructions: Roll over each legend icon or group of icons to see data points for only those types of services displayed. See table 3 in appendix II for additional details.



Source: GAO analysis of 2009 and 2010 claims data from Medicaid managed care organizations and Truven Health Analytics. | GAO-14-533

Note: The icons in the figure show the median percentage difference between Medicaid managed care and private insurance payments to physicians across 26 evaluation and management services, weighted by 2009 national Medicaid FFS spending on each service. To safeguard confidential information, results were omitted for 4 of the 23 selected states that did not meet the minimum requirements to protect the confidentiality of entities that contributed private insurance data, and state names were masked for an additional 4 states where the number of Medicaid managed care organizations was limited. Results were based on 2010 data for the states identified by name in the figure except for New Jersey and Wisconsin, which were based on 2009 data.

In addition to the variation across the 3 types of E/M services, Medicaid payments relative to private insurance varied among individual services of the same type. For example, among the individual services classified as office visits, Medicaid FFS payments relative to private insurance varied by at least 25 percentage points in 13 of 40 states, and this also was the case for managed care payments in 4 of 23 states. (See tables 5 and 6 in appendix III for more detail.) Despite this variation, Medicaid FFS payments were below private insurance for all 26 selected services in 37 of 40 states, and managed care payments were below private insurance for all 26 selected services in 20 of 23 states.

Medicaid Managed Care Payments for Evaluation and Management Services Were Generally Equal to or Higher than Medicaid Fee-for-Service Prior to Mandated Increases

Medicaid managed care payments to physicians for E/M services were 0 to 12 percent higher than Medicaid FFS in 15 of 20 states prior to the HCERA-mandated increases. Among the remaining 5 states, 3 states had managed care payments that exceeded FFS by 24 to 110 percent,[20] and 2 states had managed care payments that were 5 and 6 percent lower than FFS.

Although managed care payments in most states were approximately equal to or higher than FFS for each of the three types of E/M services, payments for the two payers were more similar for emergency care and hospital care than for office visits. In 18 of 20 states, managed care payments for all three types of E/M services were approximately equal to FFS (that is, differed by 0 or 1 percent) or exceeded FFS.

- For emergency care and hospital care, managed care payments were approximately equal to FFS in most states. Specifically:
  - Managed care payments for emergency care were approximately equal to FFS in 16 states, and exceeded FFS by at least 10 percent in only 1 state.
  - For hospital care, managed care payments were approximately equal to FFS in 13 states, and exceeded FFS by at least 10 percent in 4 states.

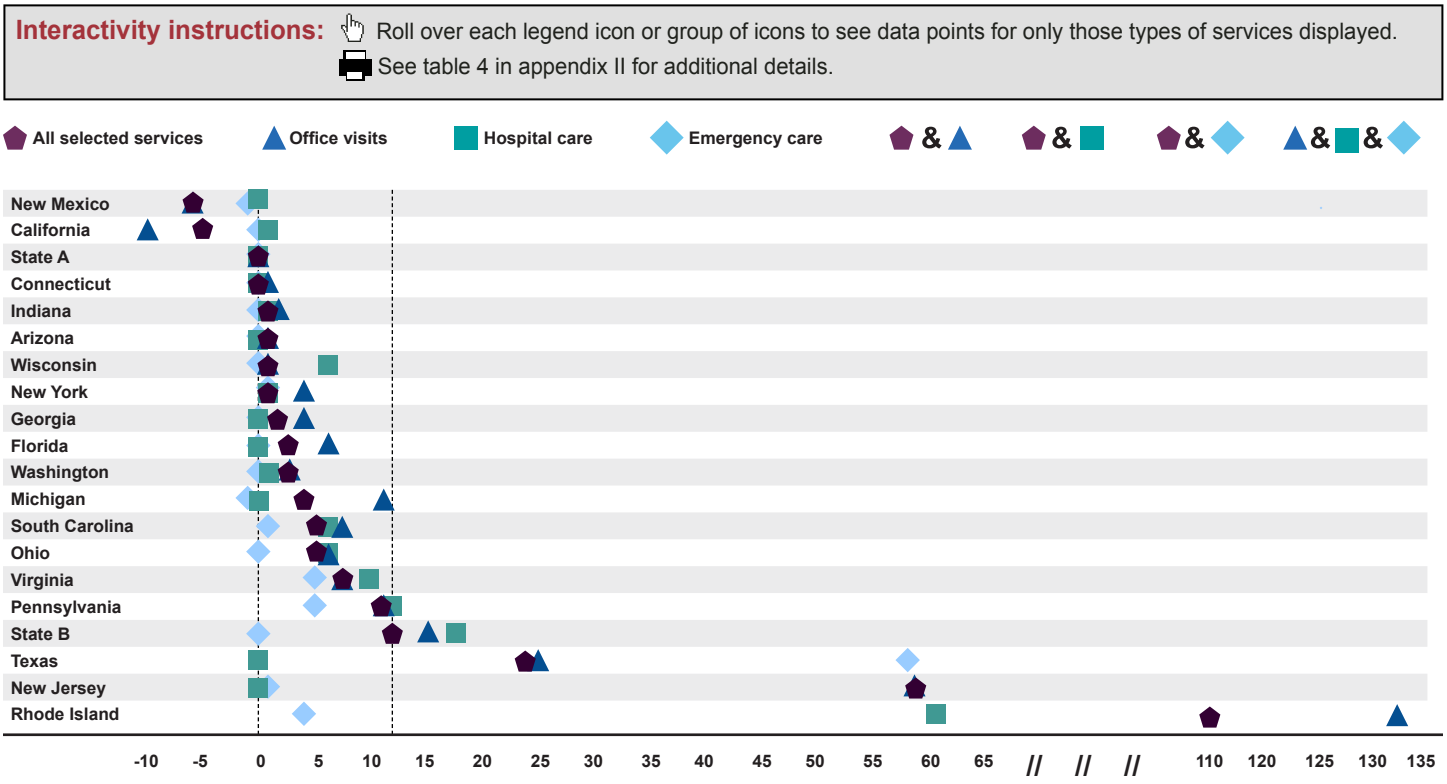
[20]In these three states, Medicaid FFS payments to physicians for E/M services were 51 to 73 percent lower than private insurance. (See fig. 1.)

- For office visits, managed care payments were approximately equal to FFS in only 4 states, exceeded FFS by at least 10 percent in 6 states, and were lower than FFS by at least 10 percent in 1 state.

Figure 3 presents payment comparisons for our selected states.[21]

[21]To safeguard confidential information, we masked the names of 2 of the 20 selected states where the number of Medicaid managed care organizations was limited.

Figure 3: Medicaid Managed Care Payments for Evaluation and Management Services Relative to Medicaid Fee-for-Service in Selected States, by Type of Service



Source: GAO analysis of 2009 and 2010 claims data from Medicaid managed care organizations and the Centers for Medicare & Medicaid Services. | GAO-14-533

Note: The icons in the figure show the median percentage difference between Medicaid managed care and Medicaid fee-for-service (FFS) payments to physicians across 26 evaluation and management services, weighted by 2009 national Medicaid FFS spending on each service. To safeguard confidential information, state names were masked for 2 of the 20 selected states where the number of Medicaid managed care organizations was limited. Results were based on 2010 data for the states identified by name in the figure except for New Jersey and Wisconsin, which were based on 2009 data.

Medicaid managed care payments relative to FFS varied not only across types of E/M services, but also among individual services of the same type.

- Among the individual services classified as office visits, the percentage difference between managed care and FFS payments varied by less than 10 percentage points in 7 of 20 states, and by more than 25 percentage points in 4 states.
- Among the individual emergency care services, the percentage difference between managed care and FFS payments varied by less than 10 percentage points in 15 states, and by more than 25 percentage points in 3 states. (See table 7 in appendix III for more detail.)

Despite the variation within each type of E/M service, managed care payments in 18 of 20 states were approximately equal to or exceeded FFS for at least 22 of 26 services.

Concluding Observations

Comparisons of payments to physicians under Medicaid FFS and managed care with private insurance and with one another can contribute to a broader understanding of Medicaid payments to providers. In comparing payments for E/M services, we found general patterns: Medicaid payments were generally lower than private insurance, and Medicaid managed care payments were generally equal to or higher than Medicaid FFS. However, we also found significant variation in relative payments, not only across states, but also across types of E/M services and across similar E/M services. This variation highlights the challenges of using payment comparisons to help assess the adequacy of Medicaid payments, or the financial implications of shifting enrollment between Medicaid FFS and managed care. However, they also highlight the importance and utility of future studies, including those that explore which factors affect how Medicaid FFS and managed care payments compare with private insurance and with one another.

Agency Comments

We provided a draft of this product to the Department of Health and Human Services for comment, and the agency stated that it had no comments.

We are sending a copy of this report to the Secretary of Health and Human Services. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix IV.

Carolyn L. Yocom
Director, Health Care

List of Committees

The Honorable Ron Wyden
Chairman
The Honorable Orrin G. Hatch
Ranking Member
Committee on Finance
United States Senate

The Honorable Thomas R. Carper
Chairman
The Honorable Tom Coburn, M.D.
Ranking Member
Committee on Homeland Security and Governmental Affairs
United States Senate

The Honorable Fred Upton
Chairman
The Honorable Henry Waxman
Ranking Member
Committee on Energy and Commerce
House of Representatives

The Honorable Darrell E. Issa
Chairman
The Honorable Elijah Cummings
Ranking Member
Committee on Oversight and Government Reform
House of Representatives

Appendix I: List of 26 Selected Evaluation and Management Services

The table below lists the 26 evaluation and management (E/M) services included in our analysis, by type of E/M service (office visits, hospital care, and emergency care).

Table 1: List of 26 Selected Evaluation and Management Services, by Type of Service

Office visits (13 services)
Office or other outpatient visit, new patient, 20 minutes
Office or other outpatient visit, new patient, 30 minutes
Office or other outpatient visit, new patient, 45 minutes
Office or other outpatient visit, new patient, 60 minutes
Office or other outpatient visit, established patient, 5 minutes
Office or other outpatient visit, established patient, 10 minutes
Office or other outpatient visit, established patient, 15 minutes
Office or other outpatient visit, established patient, 25 minutes
Office or other outpatient visit, established patient, 40 minutes
Office consultation, 30 minutes
Office consultation, 40 minutes
Office consultation, 60 minutes
Office consultation, 80 minutes
Hospital care (8 services)
Initial hospital care, 50 minutes
Initial hospital care, 70 minutes
Subsequent hospital care, 15 minutes
Subsequent hospital care, 25 minutes
Subsequent hospital care, 35 minutes
Inpatient consultation, 55 minutes
Inpatient consultation, 80 minutes
Inpatient consultation, 110 minutes
Emergency care (5 services)
Emergency department visit, low to moderate severity
Emergency department visit, moderate severity
Emergency department visit, high severity but no immediate threat
Emergency department visit, high severity and immediate threat
Critical care, first 30-74 minutes

Source: American Medical Association. | GAO-14-533

Appendix II: Payment Comparisons for Evaluation and Management Services

The three tables below compare payments for selected evaluation and management (E/M) services under Medicaid fee-for-service (FFS), Medicaid managed care, and private insurance prior to the temporary 2013 and 2014 Medicaid payment increases for E/M services mandated by the Health Care and Education Reconciliation Act of 2010.[1] In addition to showing the state-level percentage difference in payments for E/M services in general, each table shows the percentage difference in payments by type of E/M service (office visits, hospital care, and emergency care), as well as the total Medicaid enrollment in each state, and the percentage of the Medicaid population in FFS or managed care. In summary, we found the following:

- Medicaid FFS payments were 27 to 65 percent lower than private insurance in 31 of 40 selected states. Table 2 presents payment comparisons for most of our selected states.[2]
- Medicaid managed care payments were 31 to 65 percent lower than private insurance in 18 of 23 selected states. Table 3 presents payment comparisons for most of our selected states.[3]
- Medicaid managed care payments were 0 to 12 percent higher than Medicaid FFS in 15 of 20 selected states. Table 4 presents payment comparisons for our selected states.[4]

[1]HCERA required that Medicaid payments for E/M services, as well as certain vaccines, furnished by family physicians, internists, and pediatricians during calendar years 2013 and 2014 must not be less than Medicare payments for these services. Pub. L. No. 111-152, § 1202, 124 Stat. 1029, 1052 (2010).

[2]To safeguard confidential information, we omitted results for 8 of the 40 selected states that did not meet the minimum requirements to protect the confidentiality of entities that contributed private insurance data.

[3]To safeguard confidential information, we omitted results for 4 of the 23 selected states that did not meet the minimum requirements to protect the confidentiality of entities that contributed private insurance data, and we masked the names of 4 additional states where the number of Medicaid managed care organizations was limited.

[4]To safeguard confidential information, we masked the names of 2 of the 20 selected states where the number of Medicaid managed care organizations was limited.

Table 2: Medicaid Fee-for-Service Payments for Evaluation and Management Services Relative to Private Insurance in Selected States, by Type of Service

	Percentage difference between Medicaid FFS and private insurance payments				Medicaid enrollees[a]	
State	All selected services	Office visits	Hospital care	Emergency care	Number (millions)	Percentage in FFS
Minnesota	-74%	-77%	-65%	-80%	0.7	36%
Rhode Island	-73%	-70%	-68%	-76%	0.2	33%
Wisconsin	-72%	-71%	-78%	-91%	1.1	40%
New Jersey	-65%	-58%	-65%	-83%	1.0	23%
Michigan	-63%	-61%	-64%	-68%	1.8	35%
Oregon	-63%	-63%	-60%	-64%	0.6	29%
Florida	-62%	-62%	-50%	-73%	2.9	62%
California	-61%	-61%	-57%	-67%	7.3	45%
Washington	-59%	-59%	-59%	-69%	1.1	42%
Nebraska	-53%	-53%	-58%	-64%	0.2	83%
Texas	-51%	-51%	-40%	-82%	3.8	56%
Indiana	-49%	-49%	-41%	-51%	1.0	32%
Ohio	-48%	-36%	-57%	-65%	2.1	27%
Iowa	-46%	-52%	-46%	-43%	0.4	100%
Georgia	-41%	-41%	-36%	-55%	1.5	38%
Massachusetts	-40%	-34%	-40%	-44%	1.4	67%
Kansas	-39%	-37%	-39%	-54%	0.3	50%
Alaska	-37%	-29%	-50%	-58%	0.1	100%
Idaho	-37%	-37%	-39%	-44%	0.2	100%
Vermont	-37%	-29%	-40%	-51%	0.2	43%
New York	-35%	-34%	-53%	-79%	4.7	33%
Colorado	-33%	-33%	-33%	-47%	0.6	92%
North Carolina	-32%	-30%	-32%	-47%	1.5	100%
Louisiana	-31%	-31%	-29%	-44%	1.2	100%
Kentucky	-30%	-27%	-28%	-44%	0.8	80%
New Mexico	-29%	-26%	-31%	-45%	0.5	27%
Wyoming	-27%	-24%	-37%	-57%	0.1	100%
Alabama	-27%	-22%	-32%	-50%	0.9	100%
Oklahoma	-23%	-23%	-21%	-24%	0.7	100%
Nevada	-19%	-19%	-28%	-68%	0.3	45%
Mississippi	-18%	-18%	-18%	-17%	0.7	100%
Arizona	-9%	-7%	-8%	-55%	1.3	10%

Source: Medicaid and CHIP Payment and Access Commission, and GAO analysis of 2009 and 2010 claims data from the Centers for Medicare & Medicaid Services and Truven Health Analytics.
| GAO-14-533

Note: The table contains the median percentage difference between Medicaid fee-for-service (FFS) and private insurance payments to physicians across 26 evaluation and management services, weighted by 2009 national Medicaid FFS spending on each service. To safeguard confidential information, results were omitted for 8 of the 40 selected states that did not meet the minimum requirements to protect the confidentiality of entities that contributed private insurance data. Results were based on 2010 data for the states in the table except for Idaho, Kansas, Massachusetts, Nevada, New Jersey, and Wisconsin, which were based on 2009 data. The payment comparisons in this table are also presented in interactive figure 1 of this report.

[a]Medicaid enrollment is as of July 2010, and the percentage in FFS was calculated as the percentage of Medicaid enrollees who were not in a comprehensive, risk-based managed care plan.

Table 3: Medicaid Managed Care Payments for Evaluation and Management Services Relative to Private Insurance in Selected States, by Type of Service

	Percentage difference between Medicaid managed care (MC) and private insurance payments				Medicaid enrollees[a]	
State	All selected services	Office visits	Hospital care	Emergency care	Number (millions)	Percentage in MC
Wisconsin	-72%	-71%	-76%	-91%	1.1	60%
California	-65%	-65%	-57%	-67%	7.3	55%
Florida	-60%	-60%	-50%	-73%	2.9	38%
Washington	-59%	-57%	-58%	-68%	1.1	58%
Michigan	-59%	-59%	-65%	-68%	1.8	66%
State 1	-53%	-53%	-59%	-64%	—	—
Indiana	-48%	-48%	-41%	-51%	1.0	68%
Rhode Island	-46%	-35%	-48%	-75%	0.2	67%
State 2	-45%	-42%	-49%	-65%	—	—
Ohio	-45%	-32%	-55%	-65%	2.1	74%
State 3	-40%	-40%	-29%	-54%	—	—
Texas	-40%	-38%	-40%	-74%	3.8	44%
Georgia	-39%	-39%	-36%	-55%	1.5	62%
New Mexico	-34%	-31%	-31%	-49%	0.5	73%
New Jersey	-33%	-33%	-64%	-83%	1.0	77%
New York	-31%	-31%	-53%	-78%	4.7	67%
Maryland	-20%	-18%	-23%	-32%	0.9	75%
State 4	-14%	-3%	-19%	-68%	—	—
Arizona	-8%	-6%	-8%	-55%	1.3	91%

Source: Medicaid and CHIP Payment and Access Commission, and GAO analysis of 2009 and 2010 claims data from Medicaid managed care organizations and Truven Health Analytics. | GAO-14-533

Note: The table contains the median percentage difference between Medicaid managed care and private insurance payments to physicians across 26 evaluation and management services, weighted by 2009 national Medicaid fee-for-service spending on each service. To safeguard confidential information, results were omitted for 4 of the 23 selected states that did not meet the minimum requirements to protect the confidentiality of entities that contributed private insurance data, and state names (and Medicaid enrollment) were masked for an additional 4 states where the number of Medicaid managed care organizations was limited. Results were based on 2010 data for the states identified by name in the table except for New Jersey and Wisconsin, which were based on 2009 data. The payment comparisons in this table are also presented in interactive figure 2 of this report.

[a]Medicaid enrollment is as of July 2010, and the percentage in managed care (MC) was calculated as the percentage of Medicaid enrollees in a comprehensive, risk-based managed care plan.

Table 4: Medicaid Managed Care Payments for Evaluation and Management Services Relative to Medicaid Fee-for-Service in Selected States, by Type of Service

	Percentage difference between Medicaid managed care (MC) and Medicaid FFS payments				Medicaid enrollees[a]	
State	All selected services	Office visits	Hospital care	Emergency care	Number (millions)	Percentage in MC
New Mexico	-6%	-6%	0%	-1%	0.5	73%
California	-5%	-10%	1%	0%	7.3	55%
State A	0%	0%	0%	0%	—	—
Connecticut	0%	1%	0%	0%	0.5	70%
Indiana	1%	2%	1%	0%	1.0	68%
Arizona	1%	1%	0%	0%	1.3	91%
Wisconsin	1%	1%	6%	0%	1.1	60%
New York	1%	4%	1%	1%	4.7	67%
Georgia	2%	4%	0%	0%	1.5	62%
Florida	3%	6%	0%	0%	2.9	38%
Washington	3%	3%	1%	0%	1.1	58%
Michigan	4%	11%	0%	-1%	1.8	66%
South Carolina	5%	7%	6%	1%	0.8	49%
Ohio	5%	6%	6%	0%	2.1	74%
Virginia	7%	7%	10%	5%	0.9	59%
Pennsylvania	11%	11%	12%	5%	2.0	54%
State B	12%	15%	17%	0%	—	—
Texas	24%	25%	0%	58%	3.8	44%
New Jersey	59%	59%	0%	1%	1.0	77%
Rhode Island	110%	132%	61%	4%	0.2	67%

Source: Medicaid and CHIP Payment and Access Commission, and GAO analysis of 2009 and 2010 claims data from Medicaid managed care organizations and the Centers for Medicare & Medicaid Services. | GAO-14-533

Note: The table contains the median percentage difference between Medicaid managed care and Medicaid fee-for-service (FFS) payments to physicians across 26 evaluation and management services, weighted by 2009 national Medicaid FFS spending on each service. To safeguard confidential information, state names (and Medicaid enrollment) were masked for 2 of the 20 selected states where the number of Medicaid managed care organizations was limited. Results were based on 2010 data for the states identified by name in the table except for New Jersey and Wisconsin, which were based on 2009 data. The payment comparisons in this table are also presented in interactive figure 3 of this report.

[a]Medicaid enrollment is as of July 2010, and the percentage in managed care (MC) was calculated as the percentage of Medicaid enrollees in a comprehensive, risk-based managed care plan.

Appendix III: Variation in Relative Payments within Three Types of Evaluation and Management Services

Tables 5 through 7 below summarize the extent to which the percentage differences in payments varied among individual services within each of our three types of evaluation and management (E/M) services (office visits, hospital care, and emergency care) prior to the temporary 2013 and 2014 Medicaid payment increases for E/M services mandated by the Health Care and Education Reconciliation Act of 2010.[1] Each table summarizes the range in the percentage difference in payments across individual services within each of the three types of E/M services. The range for a given state and type of E/M service is calculated as the difference (in percentage points) between the smallest and largest percentage difference in payments. Specifically:

- Table 5 shows the variation in Medicaid FFS payments relative to private insurance;
- Table 6 shows the variation in Medicaid managed care payments relative to private insurance; and
- Table 7 shows the variation in Medicaid managed care payments relative to Medicaid FFS.

[1]HCERA required that Medicaid payments for E/M services, as well as certain vaccines, furnished by family physicians, internists, and pediatricians during calendar years 2013 and 2014 must not be less than Medicare payments for these services. Pub. L. No. 111-152, § 1202, 124 Stat. 1029, 1052 (2010).

Table 5: Variation in Medicaid Fee-for-Service Payments for Evaluation and Management Services Relative to Private Insurance in Selected States, by Type of Service

	Number of states		
Range of percentage difference in payments	**Office visits (13 services)**	**Hospital care (8 services)**	**Emergency care (5 services)**
< 10 percentage points	5	21	5
10 to 25 percentage points	22	15	21
> 25 percentage points	13	4	14
Total	**40**	**40**	**40**

Source: GAO analysis of 2009 and 2010 claims data from the Centers for Medicare & Medicaid Services and Truven Health Analytics. | GAO-14-533

Note: The table shows the number of states with a specified range in the percentage difference between Medicaid fee-for-service (FFS) and private insurance median payments among individual services of a given type of evaluation and management (E/M) service. The range for a given state and type of E/M service was calculated as the difference (in percentage points) between the smallest and largest percentage difference in the median payments of Medicaid FFS and private insurance among services of that type.

Table 6: Variation in Medicaid Managed Care Payments for Evaluation and Management Services Relative to Private Insurance in Selected States, by Type of Service

	Number of states		
Range of percentage difference in payments	**Office visits (13 services)**	**Hospital care (8 services)**	**Emergency care (5 services)**
< 10 percentage points	4	12	5
10 to 25 percentage points	15	9	9
> 25 percentage points	4	2	9
Total	**23**	**23**	**23**

Source: GAO analysis of 2009 and 2010 claims data from Medicaid managed care organizations and Truven Health Analytics. | GAO-14-533

Note: The table shows the number of states with a specified range in the percentage difference between Medicaid managed care and private insurance median payments among individual services of a given type of evaluation and management (E/M) service. The range for a given state and type of E/M service was calculated as the difference (in percentage points) between the smallest and largest percentage difference in the median payments of Medicaid managed care and private insurance among services of that type.

Table 7: Variation in Medicaid Managed Care Payments for Evaluation and Management Services Relative to Medicaid Fee-for-Service in Selected States, by Type of Service

	Number of states		
Range of percentage difference in payments	**Office visits (13 services)**	**Hospital care (8 services)**	**Emergency care (5 services)**
< 10 percentage points	7	13	15
10 to 25 percentage points	9	4	2
> 25 percentage points	4	3	3
Total	**20**	**20**	**20**

Source: GAO analysis of 2009 and 2010 claims data from Medicaid managed care organizations and the Centers for Medicare & Medicaid Services. | GAO-14-533

Note: The table shows the number of states with a specified range in the percentage difference between Medicaid managed care and Medicaid fee-for-service (FFS) median payments among individual services of a given type of evaluation and management (E/M) service. The range for a given state and type of E/M service was calculated as the difference (in percentage points) between the smallest and largest percentage difference in the median payments of managed care and FFS among services of that type.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

Carolyn L. Yocom, (202) 512-7114 or yocomc@gao.gov

Staff Acknowledgments

In addition to the contact named above, William Black, Assistant Director; Christine Brudevold, Assistant Director; Eric Anderson; Alison Binkowski; Greg Dybalski; Nancy Fasciano; Sandra George; Dan Lee; Drew Long; Vikki Porter; and Hemi Tewarson made key contributions to this report.