



Medicaid Physician Fees after the ACA Primary Care Fee Bump

19 States Continue the Affordable Care Act's Temporary Policy Change

Stephen Zuckerman, Laura Skopec, and Marni Epstein

March 2017

Introduction

Medicaid has historically paid physicians lower fees than either private insurance or Medicare for the same services (Zuckerman and Goin 2012; Zuckerman, Skopec, and McCormack 2014; Zuckerman, Williams, and Stockley 2009). Research has shown that before the Affordable Care Act (ACA) was implemented, low Medicaid fees created a barrier to health care access for Medicaid enrollees because of physicians' reluctance to take on new Medicaid patients (Berman et al. 2002; Davidson 1982; Decker 2012; Sloan, Mitchell, and Cromwell 1978; Zuckerman et al. 2004). Still, policymakers included an expansion of Medicaid eligibility in the ACA to increase access to health insurance coverage. The 2012 Supreme Court decision that preserved most ACA provisions made the Medicaid expansion optional for states. As of July 2016, 31 states and the District of Columbia had expanded Medicaid to low-income adults,¹ adding an estimated 9 million enrollees by early 2016 (Blumberg and Holahan 2016).

Even if the Medicaid expansion had remained mandatory, low Medicaid physician fees could impact physicians' willingness to accept newly enrolled Medicaid patients. To address this, the ACA included a mandatory two-year increase in fees for primary care services to Medicare levels for both Medicaid fee-for-service and managed care in 2013 and 2014. The federal government paid for the full costs of this increase, raising fees for primary care physicians including pediatricians. Implementation difficulties and delays in federal rulemaking meant that most eligible physicians did not begin receiving higher fees until mid- to late 2013, though physicians received the higher primary care fees retroactively through the beginning of 2013.

Initial evidence is mixed on whether the increase in primary care fees, or "fee bump," successfully increased access to primary care for Medicaid enrollees. One study found a 7.7 percentage-point increase in the availability of appointments for Medicaid enrollees between 2012 and 2014 in 10 states

(Polsky et al. 2015). The increase in availability was greater for states with larger increases in reimbursement rates, suggesting that the fee bump likely contributed to the greater availability of physicians. The Medicaid and CHIP Payment and Access Commission conducted semistructured interviews with officials in eight states and found that the increased payments had, at most, a modest effect on provider willingness to take on new Medicaid patients (MACPAC 2015). Respondents cited initial operational difficulties and the delayed start of the increased payments as major challenges. Another study found no overall increase in primary care physicians' acceptance of new Medicaid patients from 2011 to 2014, using the National Electronic Health Records Survey and the National Health Interview Survey (Decker 2016).

Federal lawmakers did not reauthorize funding for the increased payments to primary care services, ending the fee bump in December 2014. States could continue to finance the higher primary care payments using their own funds and conventional federal matching rates, or they could drop fees back down to pre-fee bump levels. Though most states rolled fees back, a number of states continued the fee bump in whole or in part. This paper updates previous research on Medicaid physician fees by considering how fees vary both across states and relative to Medicare payments, with a special focus on states that chose to continue the fee bump with state funds (Zuckerman and Goin 2012; Zuckerman, Skopec, and McCormack 2014; Zuckerman, Williams, and Stockley 2009).

Data and Methods

The Urban Institute has been tracking Medicaid physician payment rates through a survey of Medicaid physician fees in 49 states and the District of Columbia since 1993.² We collected publicly available July 2016 Medicaid fees from state websites for 27 procedures, including primary care, obstetrical care, and other services (appendix table A.1).³ We calculated comparable Medicare fees using the relative value units, geographic adjusters, and conversion factor available on the Centers for Medicare and Medicaid Services (CMS) website.

We constructed three indexes to compare Medicaid payment rates across states: the Medicaid fee index, which compares Medicaid fees across states in 2016; the Medicaid-to-Medicare fee index, which compares Medicaid-to-Medicare payments within states; and the Medicaid fee change index, which compares 2016 Medicaid fees with 2014 fees within states. These three indexes use primary care fees for providers who were ineligible for the fee bump. For each index, we first computed a simple average fee for each service in each state. The Medicaid fee index measures each state's average fee relative to the national average. We computed the ratio of each state's fee for a given service to the national average. The national average Medicaid fee for a service is a weighted average fee across states, using 2016 Medicaid enrollment numbers as weights. We then aggregated these fee ratios across procedure codes for each state, defining procedure weights as the share of total US Medicaid spending across the surveyed procedures in 2000, based on Medicaid spending data obtained from CMS.

The Medicaid-to-Medicare fee index measures the ratio of each state's average Medicaid fee to the Medicare fee for the same service. We combined these fee ratios into a single state index using the same

Medicaid spending weights as in the Medicaid fee index. We computed an overall index and indexes by type of service (primary care, obstetric care, and other services). These indexes used fees for providers ineligible for the fee bump.

We then computed the same Medicaid-to-Medicare primary care fee index for states that partially or fully continued the fee bump, using the same methods as in the previous index with fees for providers eligible for the fee bump.

Finally, we computed the Medicaid fee change index, comparing 2016 Medicaid fees with 2014 Medicaid fees. We calculated the difference in the 2016 and 2014 fee for all 27 services for each state and then aggregated them to the state and national level using the same service weighting as in the previously described fee indexes.

The services included in the primary care index are different from those included in the primary care index in previous iterations of this study. To simplify our discussion of the primary care fee bump, the new primary care index includes only those seven services that were eligible for the fee bump and for which we collected data in past years.⁴ We identified states continuing the fee bump either by a separate primary care fee schedule provided by the state or by changes in the primary care index from 2012 to 2016.

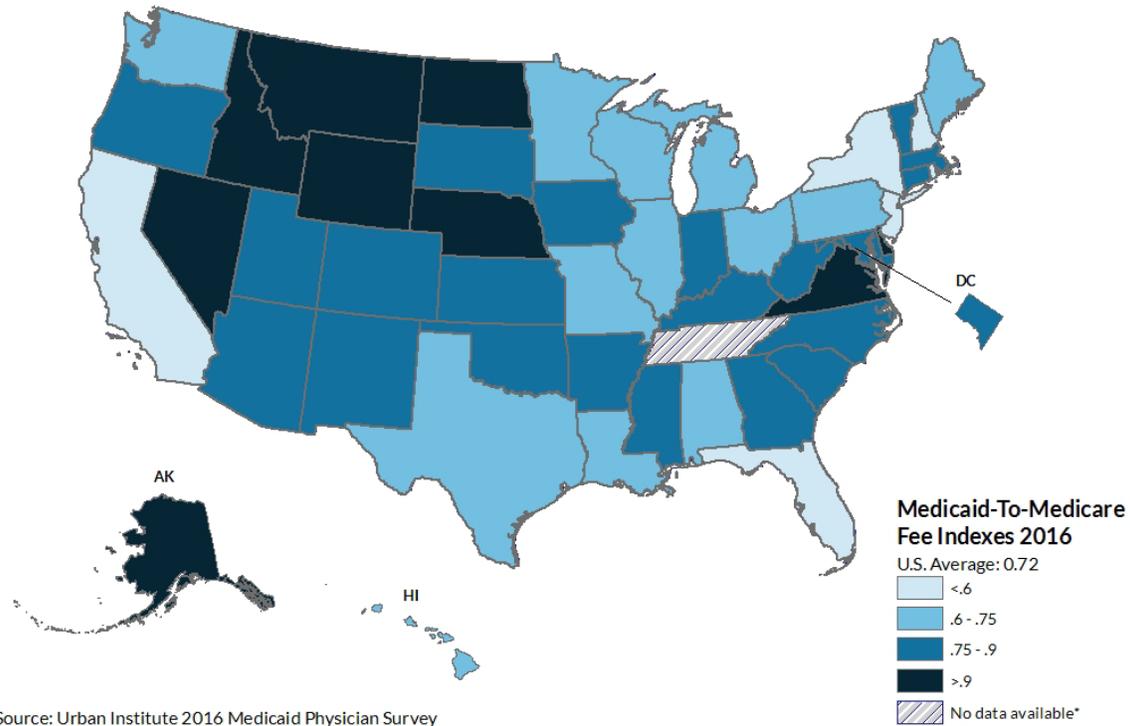
Results

As of July 2016, Medicaid programs paid physicians fees at 72 percent of Medicare rates (index value of 0.72).⁵ Across the country, state Medicaid-to-Medicare fee indexes range from 0.38 in Rhode Island to 1.26 in Alaska (see figure 1 and table 1). In general, the 2016 Medicaid-to-Medicare fee index is lower for primary care (0.66) than for obstetric care or other services (0.81 and 0.82, respectively). Medicaid fees have been fairly stable relative to Medicare fees over time, hovering around 70 percent of Medicare for more than a decade (69 percent in 2003, 72 percent in 2008, 66 percent in 2012, and 66 percent in 2014; Zuckerman and Goin 2012; Zuckerman, Skopec, and McCormack 2014; Zuckerman, Williams, and Stockley 2009).

Between 2014 and 2016, Medicaid physician fees increased by an average of 4.1 percent (see appendix table A.2). Fee increases were greater for primary care and obstetric care than for other services, on average. Though a few states saw average fee reductions of more than 2 percent between 2014 and 2016, most had fairly stable or increasing Medicaid fees.

FIGURE 1

Medicaid-to-Medicare Fee Indexes for All Services for Physicians Ineligible for the Fee Bump, 2016



Source: Urban Institute 2016 Medicaid Physician Survey

As of July 2016, 19 states fully or partially continued the primary care fee bump in 2016, according to publicly available fee schedules.⁶ Of the 19 states, 14 have Medicaid-to-Medicare primary care fee ratios above 0.80 for eligible providers. These 19 states fall into three broad categories:

- States that fully continued the fee bump for primary care providers: Alabama, Iowa, Maine, Mississippi, Nebraska, New Mexico, and South Carolina (table 2)
- States that partially continued the fee bump for primary care physicians: Florida, Georgia, Michigan, New Jersey, Oregon, and Vermont (table 2)
- States that maintained higher primary care fees for all types of physicians following the 2013–14 fee bump: Colorado, Idaho, Indiana, Maryland,⁷ Nevada, and Utah (table 1)

For states that continued a partial fee bump for primary care, Medicaid primary care fees stayed between 11 percent (Georgia) and 47 percent (Florida and New Jersey) below Medicare. Medicaid primary care fees in Alaska, Montana, and North Dakota were at or above Medicare fees for all types of physicians before the implementation of the fee bump and are not included in these lists.

TABLE 1

Medicaid-to-Medicare Fee Index by Service Type in 2016

State	All services	Primary care ^a	Obstetric care	Other services
US	0.72	0.66	0.81	0.82
AL	0.75	0.65	0.88	0.84
AK	1.26	1.27	1.25	1.24
AZ	0.80	0.73	0.92	0.84
AR	0.80	0.65	0.70	1.34
CA	0.52	0.41	0.60	0.76
CO	0.80	0.84 ^b	0.67	0.84
CT	0.76	0.76	0.81	0.68
DE	0.96	0.99	0.84	0.97
DC	0.79	0.80	0.79	0.78
FL	0.56	0.48	0.82	0.58
GA	0.77	0.65	0.85	0.99
HI	0.62	0.54	0.64	0.83
ID	0.95	1.00 ^b	0.89	0.88
IL	0.61	0.48	0.85	0.79
IN	0.77	0.75 ^b	1.00	0.75
IA	0.82	0.72	0.83	1.10
KS	0.78	0.73	0.74	0.96
KY	0.77	0.67	0.93	0.92
LA	0.70	0.67	0.70	0.80
ME	0.64	0.60	0.66	0.73
MD	0.88	0.92 ^b	0.86	0.81
MA	0.79	0.79	0.96	0.81
MI	0.65	0.57	0.91	0.55
MN	0.75	0.78	0.67	0.72
MS	0.89	0.90	0.89	0.88
MO	0.60	0.55	0.57	0.79
MT	1.09	1.06	1.17	1.05
NE	0.92	0.71	1.05	1.33
NV	0.95	0.95 ^b	0.97	0.92
NH	0.58	0.56	0.59	0.60
NJ	0.42	0.42	0.35	0.52
NM	0.89	0.78	0.98	1.05
NY	0.56	0.44	0.73	0.68
NC	0.78	0.79	0.67	0.91
ND	0.98	1.00	0.99	0.92
OH	0.63	0.59	0.65	0.74
OK	0.86	0.87	0.85	0.84
OR	0.81	0.71	1.12	0.68
PA	0.69	0.51	1.06	0.68
RI	0.38	0.33	0.41	0.51
SC	0.79	0.70	1.30	0.87
SD	0.84	0.71	0.89	1.11
TX	0.65	0.58	0.66	0.85
UT	0.86	0.86 ^b	0.90	0.80
VT	0.80	0.81	0.79	0.78
VA	0.92	0.84	1.03	0.97
WA	0.71	0.65	0.93	0.58
WV	0.81	0.74	1.04	0.71
WI	0.62	0.48	0.63	1.00
WY	0.98	0.93	1.05	1.04

Source: Urban Institute 2016 Medicaid Physician Survey.

Notes: ^a Primary care is defined as services subject to the Affordable Care Act's Medicaid primary care parity provision. ^b These states paid increased fees for primary care to all physician types in 2016.

TABLE 2

Medicaid-to-Medicare Primary Care^a Fee Index for States That Fully or Partially Continued the Fee Bump for Primary Care Physicians, 2016

State	Physicians <i>ineligible</i> for fee bump– increased rates	Physicians <i>eligible</i> for fee bump– increased rates
<i>Full fee bump</i>		
AL	0.65	1.00
IA	0.72	0.98
ME	0.60	1.00
MS	0.90	1.00
NE	0.71	1.01
NM	0.78	1.00
SC	0.70	1.00
<i>Partial fee bump</i>		
FL	0.48	0.53
GA	0.65	0.89
MI	0.57	0.71
NJ	0.42	0.53
OR	0.71	0.77
VT	0.81	0.84

Source: Urban Institute 2016 Medicaid Physician Survey.

Note: ^a Primary care is defined as services subject to the Affordable Care Act's Medicaid primary care parity provision.

Limitations

Our study only includes fees for fee-for-service Medicaid and does not include fees for Medicaid managed care. According to CMS, 77 percent of Medicaid beneficiaries were enrolled in a managed care organization as of 2014, the most recent year for which data are available (DMCP 2016). A 20-state survey conducted by the US Government Accountability Office found that managed care plans paid fees quite similar to those for fee-for-service Medicaid, with some variation among states (GAO 2014). The differences were small (5 percent or less) for most states. In this study, we may misstate true Medicaid-to-Medicare fee ratios to a greater extent for physicians with larger shares of patients in Medicaid managed care plans.

We identified states continuing the fee bump by comparing publicly available data on their fees in 2016 to publicly available fees in 2014. We did not review state budgets, regulations, or other documents to assess each state's rationale for its approach to primary care fees in 2016. Our list of states continuing the fee bump does not completely correspond to reports of state plans gathered from a survey of state Medicaid programs.⁸

Discussion

The ACA included a federally funded Medicaid primary care fee bump, in part to address health care access concerns related to historically low Medicaid reimbursement and an expected increase in

Medicaid beneficiaries in 2014. The fee was limited to two years in order to minimize its budget impact. Some argued that such a short-term fee increase would do little to encourage additional physicians to accept Medicaid, but others noted that physicians already accepting Medicaid may have seen additional Medicaid patients (Tollen 2015). This brief explores how state choices about the fee bump affected Medicaid fees for primary care and other services.

Operational challenges delayed the start of the ACA Medicaid primary care payment changes and may have shortened the period during which physicians could adjust to these new fees. Implementation delays also made it more difficult to measure the effect of the fee bump on provider participation and access to care. In addition, many changes occurred simultaneously in the health system between 2012 and 2014, complicating efforts to link changes in access to care to the primary care fee bump. To date, evidence on the effectiveness of the fee bump is mixed, though some studies suggest it may have had a modest effect in increasing Medicaid enrollees' access to primary care (Polsky et al. 2015). States had to decide whether to continue the primary care fee bump with very little evidence about its effectiveness. Our results show that when the temporary federal policy expired, many states continued to pay higher fees for primary care than they did in 2012, suggesting that even a temporary federal policy had lasting effects on some states' approaches to Medicaid reimbursement.

Continuing the fee bump with regular Medicaid financing may furnish additional evidence of the policy's effects on access to care, particularly if these state-level initiatives are longer-lived than the ACA fee bump. Additionally, the natural experiment created by states' choices—continuing the fee bump, not continuing the fee bump, and various options in between—could allow for more definitive estimates of the effects of Medicaid fees on physician participation and beneficiary access to care.

Appendix A

APPENDIX TABLE A.1

Mean, Maximum, and Minimum Medicaid Fees and Standard Deviations for Selected States, 2016

Code	Procedure	Share of expenditures (%)	Mean fee (\$)	Maximum fee (\$)	Minimum fee (\$)	Coefficient of variation
Primary care^a						
99203	Office visit, new patient, 30 minutes	2.7	73.08	174.87	29.00	25.42
99204	Office visit, new patient, 45 minutes	2.3	106.60	271.74	45.00	29.04
99213	Office visit, established patient, 15 minutes	25.5	45.45	118.70	20.64	33.62
99214	Office visit, established patient, 25 minutes	9.5	68.63	176.19	27.00	31.92
99222	Initial hospital care, new or established patient, 50 minutes	1.4	91.18	236.05	29.50	28.03
99232	Hospital visit, new patient, 45 minutes	4.4	46.90	124.81	17.00	29.27
99283	Emergency department visit	8.1	47.26	109.36	24.17	19.66
Obstetric care						
59400	Total obstetric care, vaginal delivery	8.6	1,636.01	3,447.30	815.00	23.04
59409	Vaginal delivery only, no postpartum care	4.7	750.75	1,371.90	277.00	24.47
59410	Vaginal delivery and postpartum care	6.7	914.81	1,747.50	296.00	20.54
59510	Total obstetric care, cesarean delivery	2.9	1,756.36	3,816.70	815.00	25.07
59514	Cesarean delivery and no postpartum care	1.7	816.81	1,544.80	398.50	26.70
59515	Cesarean delivery and postpartum care	2.0	1,085.24	2,113.00	417.50	28.67
Other services						
43235	Upper gastrointestinal endoscopy	0.4	216.42	476.46	124.03	21.85
43239	Upper gastrointestinal endoscopy with biopsy	1.3	261.21	603.32	126.00	25.33
58120	Dilation and curettage	0.2	199.12	421.99	123.14	18.97
58150	Total hysterectomy	0.3	776.76	1,706.50	518.50	18.65
66984	Cataract removal with lens implant	1.5	647.98	1,550.60	358.76	33.64
69436	Tympanostomy	1.5	127.14	262.52	80.50	21.02
70450	Computerized axial tomography scan, head or brain	1.9	140.48	276.10	64.78	31.29
71020	X-ray, chest, two views	3.1	24.77	42.63	15.00	22.09
76805	Echography, pregnant uterus	3.7	106.21	218.07	36.00	24.61
88305	Surgical pathology	1.4	56.64	116.51	18.72	23.60

Code	Procedure	Share of expenditures (%)	Mean fee (\$)	Maximum fee (\$)	Minimum fee (\$)	Coefficient of variation
92004	Ophthalmological services, new patient	1.1	88.35	99.93	28.07	35.21
92014	Ophthalmological services, established patient	0.8	71.49	241.90	28.07	35.14
93000	Electrocardiogram	0.5	19.95	240.53	9.51	57.81
93307	Echocardiography, transthoracic	1.4	127.61	198.53	48.00	25.94

Source: Urban Institute 2016 Medicaid Physician Survey.

Note: ^a Primary care is defined as services subject to the Affordable Care Act's Medicaid primary care parity provision.

APPENDIX TABLE A.2

Cumulative Change in Medicaid Fees by Service Type, 2014–16, and Medicaid Fee Indexes, 2016

State	Cumulative Change in Medicaid Fee, 2014–16				2016 Medicaid Fee Indexes			
	All services	Primary care ^a	Obstetric care	Other services	All services	Primary care ^a	Obstetric care	Other services
US	4.1%	5.1%	5.5%	0.3%	1.00	1.00	1.00	1.00
AL	-0.2%	2.7%	-10.4%	5.8%	0.95	0.93	0.98	0.93
AK	-1.2%	-0.6%	-0.8%	-3.7%	2.28	2.55	1.99	1.94
AZ	-0.5%	-0.2%	-0.3%	-1.7%	1.11	1.11	1.13	1.07
AR	0.0%	0.0%	0.0%	0.0%	0.98	0.92	0.78	1.44
CA	2.9%	0.0%	17.7%	-2.8%	0.76	0.66	0.79	1.00
CO	25.3%	15.4%	2.5%	84.3%	1.13	1.31	0.84	1.04
CT	-4.0%	-2.3%	-5.9%	-6.3%	1.16	1.27	1.09	0.92
DE	-1.5%	1.1%	-8.5%	-3.3%	1.40	1.55	1.02	1.28
DC	-0.1%	1.0%	-0.5%	-2.6%	1.27	1.39	1.11	1.15
FL	-1.0%	0.2%	0.9%	-5.5%	0.79	0.74	1.05	0.75
GA	2.7%	0.0%	10.1%	0.0%	1.02	0.97	1.03	1.14
HI	0.0%	0.0%	0.0%	0.0%	0.89	0.86	0.79	1.09
ID	8.0%	16.5%	-1.6%	-2.7%	1.25	1.45	1.00	1.03
IL	0.1%	0.1%	0.0%	0.0%	0.85	0.76	1.11	0.93
IN	35.9%	49.0%	19.1%	4.5%	1.05	1.10	1.06	0.90
IA	1.0%	0.0%	0.0%	4.9%	1.04	1.03	0.92	1.22
KS	-1.6%	-2.9%	0.0%	0.0%	1.01	1.07	0.85	1.09
KY	0.0%	0.0%	0.0%	0.0%	0.98	0.96	1.03	1.01
LA	-0.5%	-0.8%	0.0%	0.0%	0.97	1.00	0.81	0.93
ME	0.3%	0.0%	0.0%	1.7%	0.85	0.89	0.77	0.87
MD	-3.9%	-6.3%	0.0%	0.0%	1.35	1.51	1.09	1.09
MA	0.5%	0.9%	0.0%	0.0%	1.12	1.11	1.18	1.07
MI	24.4%	34.7%	24.2%	-4.4%	0.90	0.86	1.14	0.69
MN	0.0%	0.9%	0.0%	-2.6%	1.04	1.18	0.73	0.92
MS	-0.2%	1.2%	-1.0%	-3.4%	1.17	1.29	0.95	1.01
MO	1.0%	1.0%	1.0%	1.0%	0.79	0.81	0.69	0.88
MT	5.4%	6.5%	4.9%	2.9%	1.56	1.65	1.51	1.36
NE	2.4%	1.0%	4.0%	4.1%	1.14	1.02	1.14	1.45
NV	25.0%	50.2%	-5.7%	-3.3%	1.37	1.50	1.23	1.21
NH	0.1%	0.0%	0.0%	0.3%	0.81	0.88	0.73	0.74
NJ	-0.4%	0.0%	0.0%	-1.9%	0.64	0.70	0.48	0.71
NM	-1.4%	-0.6%	-0.1%	-5.2%	1.19	1.16	1.21	1.25
NY	0.0%	0.0%	0.0%	0.0%	0.85	0.74	1.03	0.92
NC	0.0%	0.0%	0.0%	0.2%	1.05	1.17	0.79	1.06
ND	-29.8%	-30.2%	-31.0%	-27.7%	1.35	1.52	1.16	1.15
OH	4.4%	5.9%	0.0%	5.4%	0.85	0.88	0.78	0.87
OK	-2.9%	-2.0%	-3.2%	-4.9%	1.14	1.26	1.00	0.99
OR	0.5%	1.5%	0.5%	-2.1%	1.11	1.08	1.34	0.87
PA	3.7%	6.8%	0.0%	0.0%	0.93	0.78	1.31	0.81
RI	0.0%	0.0%	0.0%	0.0%	0.53	0.51	0.50	0.62
SC	-0.2%	-0.2%	0.0%	-0.2%	1.05	1.03	1.40	1.00
SD	4.4%	4.4%	4.4%	4.4%	1.10	1.06	1.00	1.34
TX	0.2%	0.4%	0.0%	-0.4%	0.88	0.86	0.75	1.04
UT	17.6%	15.9%	31.3%	3.4%	1.19	1.30	1.13	0.95
VT	-0.2%	0.7%	0.1%	-3.0%	1.11	1.23	0.95	0.99
VA	-0.6%	0.1%	0.0%	-3.7%	1.10	1.11	1.08	1.07
WA	-1.3%	1.2%	-5.5%	-2.3%	0.98	1.01	1.10	0.76
WV	-0.6%	0.3%	-0.8%	-2.7%	1.08	1.07	1.29	0.82
WI	-0.4%	-0.7%	0.0%	0.0%	0.80	0.71	0.72	1.17
WY	2.8%	0.0%	0.0%	14.3%	1.38	1.44	1.35	1.27

Source: Urban Institute 2016 Medicaid Physician Survey.

Note: ^a Primary care is defined as services subject to the Affordable Care Act's Medicaid primary care parity provision.

Notes

1. “Medicaid Expansion States,” Centers for Medicare and Medicaid Services, <https://www.medicaid.gov/medicaid/program-information/downloads/medicaid-expansion-state-map.pdf>.
2. Tennessee was excluded because its Medicaid program does not have a fee-for-service component.
3. We contacted state Medicaid offices directly through phone calls or emails when the information available online did not seem plausible or was unclear.
4. Though the ACA increased primary care fees for nearly 150 services, only seven are included in our index. Our earlier research indicates that these seven fees provide a reasonable estimate of the overall change in primary care fees attributable to the fee bump. See Zuckerman and Goin (2012).
5. Fees are for physicians ineligible for the increased primary care rates in states that continued the fee bump.
6. These findings differ from the Kaiser Family Foundation’s list of states that would continue the fee bump. They reported that 10 states fully continued the fee bump in 2015: Alabama, Colorado, DC, Hawaii, Iowa, Maine, Mississippi, Nebraska, Nevada, and New Mexico. Nine of these states indicated that they would continue the full increase in 2016 (Smith et al. 2015, 50).
7. Maryland maintained higher fees for all primary care services but did not fully match Medicare levels in 2016.
8. See note 6.

References

- Berman, Steve, Judith Dolins, Suk-fong Tang, and Beth Yudkowsky. 2002. “Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients.” *Pediatrics* 110 (2): 239–48.
- Blumberg, Linda J., and John Holahan. 2016. “Early Experience with the ACA: Coverage Gains, Pooling of Risk, and Medicaid Expansion.” *Journal of Law, Medicine & Ethics* 44 (4): 538–45.
- Davidson, Stephen M. 1982. “Physician Participation in Medicaid: Background and Issues.” *Journal of Health Politics, Policy and Law* 6 (4): 703–17.
- Decker, Sandra. 2012. “In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help.” *Health Affairs* 31 (8): 1673–79.
- Decker, Sandra. 2016. “[The 2013–2014 Medicaid Primary Care Fee Bump, Primary Care Physicians' Medicaid Participation, and Patient Access Measures](#).” Paper presented at the Association for Public Policy Analysis and Management annual fall research conference, Washington, DC, November 3–5.
- DMCP (Division of Managed Care Programs). 2016. [Medicaid Managed Care Enrollment and Program Characteristics, 2014](#). Baltimore, MD: Centers for Medicare and Medicaid Services.
- GAO (US Government Accountability Office). 2014. [Comparisons of Selected Services under Fee-for-Service, Managed Care, and Private Insurance](#). Washington, DC: GAO.
- MACPAC (Medicaid and CHIP Payment and Access Commission). 2015. “[An Update on the Medicaid Primary Care Payment Increase](#).” In *March 2015 Report to Congress on Medicaid and CHIP*, 129–38. Washington, DC: MACPAC.
- Polisky, Daniel, Michael Richards, Simon Basseyn, Douglas Wissoker, Genevieve M. Kenney, Stephen Zuckerman, and Karin V. Rhodes. 2015. “[Appointment Availability after Increases in Medicaid Payments for Primary Care](#).” *New England Journal of Medicine* 372 (6): 537–45.
- Sloan, Frank, Janet Mitchell, and Jerry Cromwell. 1978. “Physician Participation in State Medicaid Programs.” *Journal of Human Resources* 13 (Suppl): 211–45.

- Smith, Vernon K., Kathleen Gifford, Eileen Ellis, Robin Rudowitz, Laura Snyder, and Elizabeth Hinton. 2015. *Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016*. Menlo Park, CA: Kaiser Family Foundation.
- Tollen, Laura. 2015. "Health Policy Brief: Medicaid Primary Care Parity." Bethesda, MD: Health Affairs.
- Zuckerman, Stephen, and Dana Goin. 2012. "How Much Will Medicaid Physician Fees for Primary Care Rise in 2013? Evidence from a 2012 Survey of Medicaid Physician Fees." Washington, DC: Kaiser Family Foundation.
- Zuckerman, Stephen, Joshua McFeeters, Peter Cunningham, and Len Nichols. 2004. "Trends: Changes in Medicaid Physician Fees, 1998–2003: Implications for Physician Participation." *Health Affairs* (Jan–Jun Suppl Web Exclusive): W4-374–W4-384.
- Zuckerman, Stephen, Laura Skopec, and Kristen McCormack. 2014. "Reversing the Medicaid Fee Bump: How Much Could Medicaid Physician Fees for Primary Care Fall in 2015?" Washington, DC: Urban Institute.
- Zuckerman, Stephen, Aimee F. Williams, and Karen E. Stockley. 2009. "Trends in Medicaid Physician Fees, 2003–2008." *Health Affairs* 28 (3): 510–19.

About the Authors

Stephen Zuckerman is a senior fellow and codirector of the Health Policy Center at the Urban Institute. He has studied health economics and health policy for almost 30 years and is a national expert on Medicare and Medicaid physician payment, including how payments affect enrollee access to care and the volume of services they receive. He is currently examining how payment and delivery system reforms can affect the availability of primary care services, and he is studying the implementation and impact of the Affordable Care Act.

Laura Skopec is a research associate in the Urban Institute's Health Policy Center, where her research focuses on health insurance coverage, health care access, and health care affordability, with a particular focus on the effects of the Affordable Care Act.

Marni Epstein is a research assistant in the Health Policy Center at the Urban Institute. She graduated from the Johns Hopkins University with a BA in public health and a concentration in biostatistics.

Acknowledgments

This brief was funded by the National Institute of Aging (grant number R01 AG043513). We are grateful to them and to all our funders, who make it possible for Urban to advance its mission.

The views expressed are those of the authors and should not be attributed to the Urban Institute, its trustees, or its funders. Funders do not determine research findings or the insights and recommendations of Urban experts. Further information on the Urban Institute’s funding principles is available at www.urban.org/support.



2100 M Street NW
Washington, DC 20037
www.urban.org

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is dedicated to elevating the debate on social and economic policy. For nearly five decades, Urban scholars have conducted research and offered evidence-based solutions that improve lives and strengthen communities across a rapidly urbanizing world. Their objective research helps expand opportunities for all, reduce hardship among the most vulnerable, and strengthen the effectiveness of the public sector.

Copyright © March 2017. Urban Institute. Permission is granted for reproduction of this file, with attribution to the Urban Institute.