

Health and Human Services Joint Legislative Oversight Committee

Overview of Medicaid Provider Payments

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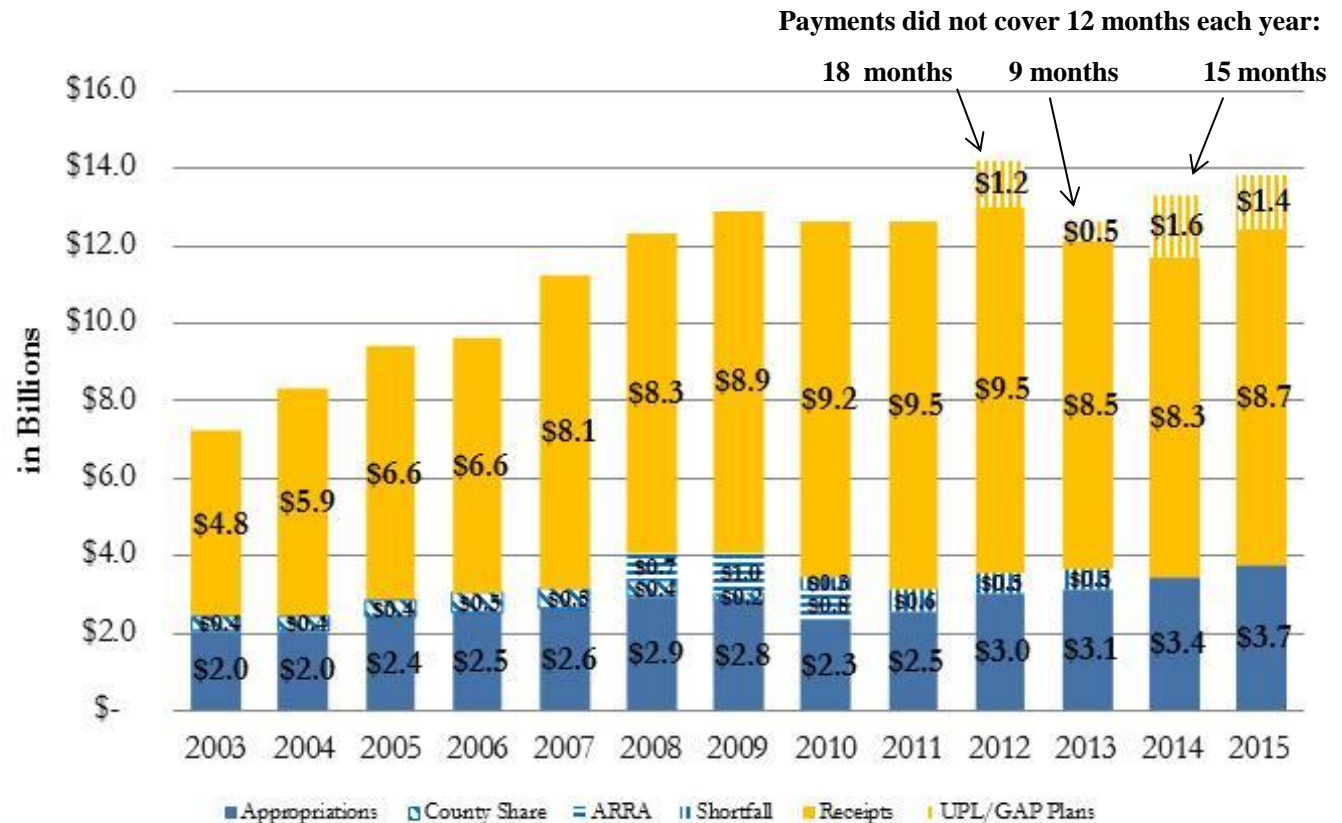
Medicaid Payment Primer

- *Basics of Medicaid Payment and Drivers*
 - *Provider Payment Methodologies and Economic Incentives*
 - *Health Department Payment Methodology*
 - *Skilled Nursing Payment Methodology*
 - *Physician Payment Methodology*
 - *Drug and Dispensing Fee Methodology*
 - *LME/MCO Payment Methodology*
 - *Hospital Payment Methodologies*
- } **Presentation
on 3/24/15**

Source:

Medicaid Spending Trends

Chart reflects total net Medicaid spending including claims, administration, contracts, settlements, program integrity, transfers and other spending



SFY 2014-15 FRD budget does not include the \$186 M contingency reserve

Source: NC Office of the State Controller and NCAS BD701 and FRD estimate for SFY 2014-15

Medicaid Payment Primer

- What this is not
 - Presentation of provider payment adequacy
 - Presentation of equitability of provider payments
 - History or discussion of provider payment policies
 - Spending Analysis
- This is intended to be
 - Educational presentation on the methodologies used to pay providers for Medicaid services



Basics of Medicaid Payment and Drivers

- Medicaid Spending Equation =

$$\underline{\textit{Enrollment * Utilization * Mix * PRICE * Benefits}}$$

- **PRICE**/Medicaid payments to providers can be comprised of a complex set of methodologies, formulas and processes that have evolved through the years based on federal government practice (Medicare), market forces and North Carolina's need to manage spending on the Medicaid program.
- Like nearly all changes to Medicaid, changes in **PRICE** require approval by CMS, key considerations by CMS related to the impact of changes include:
 - Recipient access to care
 - Comparability of rates for similar/deemed same services
 - Market rates for similar services
 - Provider cost in delivering service
- DHHS/DMA has staff dedicated and consultants engaged to support the current rate setting and oversight process.

Provider Payment Methodologies

North Carolina utilizes a variety of methodologies to reimburse providers for services.

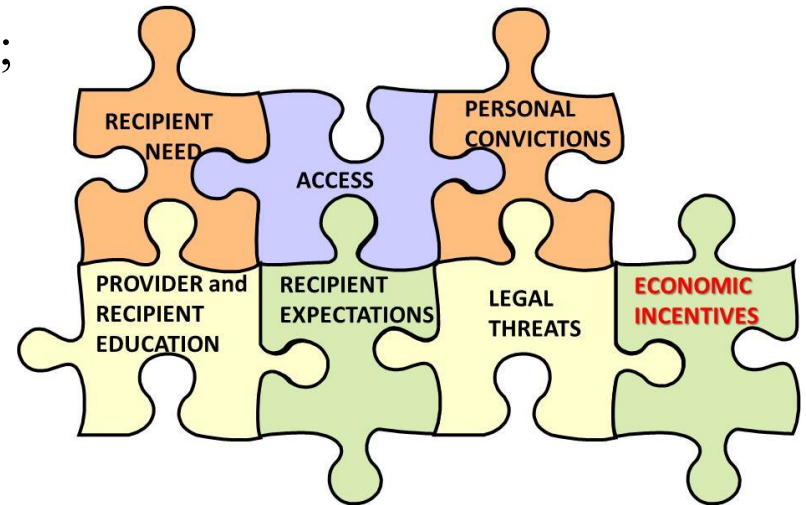
The methodologies in the chart cover the vast majority of providers where the payment is a single rate or amount.

Health Departments, Skilled Nursing, Physicians, Drugs, Behavioral Health and Hospitals which represent 64% of the total spending budget for claims in FY 2014-15, will be discussed in detail.

| Method | NC Providers Impacted | Payment Calculation |
|----------------------|--|--|
| Fee Schedule | Laboratory, Dental, Optical, Chiropractic, Podiatrist, Hearing Aids, DME, Therapies, Hospice | Code * Rate = Payment |
| Per Unit Rate | Personal Care Services, Home Health, Ambulance, Dispensing Fees | Rate * Units = Payment (Units can be items, hours, minutes, days, visits, encounters, procedures) |
| Cost | FQHC (or CMS Rate), Rural Health Centers, Health Departments, DME | Interim Rate * Billed Charges = Payment (Additional payment as a settlement after cost report filed to equal cost less interim payments or cost based in the providers invoice) |
| Indexed Fee | Prescribed drug product | Current: Brand-WAC by Drug * 1.027 = Payment Current: Generic-SMAC by Drug * 1.925 = Payment Effective 1/1/15-Average Acquisition Cost = Payment |
| Case Rates | Ambulatory Surgery | Procedure Code = Rate = Payment |
| Premium | Medicare Parts A, B and D, HIPP plan | Recipients Covered * Premium = Payment |
| Per Member Per Month | CCNC, PACE and Medsolutions | Recipients Covered * PMPM Rate = Payment |

Role of Payment Methodologies in Care Delivery

- “Decision Drivers” – it isn’t just clinical; health care decisions are comprised of many factors or components, including:
- We start with the assumption that all people want to provide good care that helps people....do no harm.....
- However, payment and economics may provide incentives that may conflict with this premise
- Physical health services are predominately paid by Medicaid under a fee for service (FFS) model
- While Behavioral Health is paid by Medicaid under a capitated model, underlying providers are paid FFS



Fee for Service Payment Model

PRO's

- Emphasis on productivity – encourages delivery of care and maximizing visits.
- Relatively flexible and easily adaptable regardless of the size or organizational structure, type of service provided, place of service provision or geographic location of care.
- Easily understood by providers.
- Supports accountability for patient care processes.
- Reimburses provider for all services rendered

CON's

- Lacks incentives to deliver efficient care.
- Lacks incentives to prevent unnecessary care.
- Can be limited to face to face visits – which may impede activities such as care coordination and telemedicine.
- Economically rewards volume.
- Complexity makes it difficult for patients/recipients to understand billing .
- Because payment is generally limited to one provider for one interaction does little to encourage management of care across the continuum.

Source: Janet Silversmith, Health Policy Director, Minnesota Medical Association – www.minnesotamedicine.com/Past-Issues-2011/February-2011

NC Provider Payment Economic Incentives

Payment methodologies can create incentives that divert focus from outcomes

- Fee Schedule
- Complete coding of all services, volume of services or intensity of codes billable
- Per Unit Rate
- Volume or intensity of justifiable units
- Cost Reimbursement
- Allocation of cost to services with higher Medicaid utilization
- Indexed Fee
- Coding to highest level of service reimbursable, more services
- Case Rates
- Coding to highest level of service reimbursable, more cases
- Premium
- Ensure highest appropriate enrollment category
- Per Member Per Month
- Ensure highest appropriate enrollment category

Health Department Medicaid Payment Methodologies

- Like hospitals, Health Department receipts come from a variety of sources including State and Federal, Local, Grants, Medicaid (claims and settlements), Fees from individuals and commercial payers and Donations. The proportions vary from Health Dept. to Health Dept.
- Medicaid claims payments for service are based on the same fee schedule as any provider of that service.
- Health Departments also receive a unique payment that other providers don't; that is the federal share of the difference between the cost of providing Medicaid billable services and the Medicaid claims payment.

Skilled Nursing Payment Methodologies

- Skilled nursing facilities are paid a per diem rate - that ultimately is unique to each facility.
- The last rebasing of rates to cost occurred in 2009, using 2005 cost reports.
- There are 3 components to per diem rates – Direct Care, Indirect Service and Fair Rental Value

Skilled Nursing Payment Methodologies

- Direct Care
 - COVERS*** • Reimburses the skilled nursing facility for 2 factors a) nursing & aide costs; historically subject to a CMI adjustment quarterly, which was frozen in the FY 2015 budget; & b) nursing supplies, food, activities, social services & ancillary services, which are not subject to CMI adjustment
 - BASIS FOR PAYMENT*** • Base per diem the same for all facilities, CMI adjustment results in a unique rate for each skilled nursing facility.

Skilled Nursing Payment Methodologies

- Indirect Service
 - COVERS** • Reimburses the skilled nursing facility for administration, laundry and linen, housekeeping, operation, maintenance of the plant and indirect cost of ancillary services
 - BASIS FOR PAYMENT** • Same for all facilities; set at state-wide day weighted median rates
- Fair Rental Value
 - COVERS** • Reimburses the skilled nursing facility for capital related costs for building, equipment and leases
 - BASIS FOR PAYMENT** • Unique for each facility, supposed to be updated annually based on national construction cost index per the State Plan

Physician Payment Methodologies

- Physicians are paid based on a percentage of the Medicare fee schedule.
- Evaluation and management (E&M) codes are currently paid at an estimated 78% of Medicare and all other CPT codes are paid an estimated 84% of Medicare after 4/1/14.
- Some other provider fee schedules are a derivative of the physician fee schedule.
- UNC and ECU have a supplemental payment plan that provides an additional payment for the difference between the Medicaid rate and the average commercial rate. The state share of this annual payment is funded by UNC and ECU.

Drug and Dispensing Fee Payment Methodologies

- Pharmacies are paid for product cost based on national or state developed indices.
- Brand drug prices are based on the national wholesale acquisition cost (WAC) and generic prices are calculated by the state on the State Medicaid Average Cost (SMAC) list.
- Brand drugs are paid at 1.027 times WAC for non-specialty drugs and 1.01 times for specialty drugs and generics are paid at 150% of SMAC.
- These indices are updated monthly in the CSC system
- Pharmacies are also paid a dispensing fee based on the individual pharmacy's average generic dispensing percentage.

Drug and Dispensing Fee Payment Methodologies

- Why is there a difference in dispensing fees based on generic dispensing rates
- The overall average generic drug is 17% of the overall average brand drug; therefore encouraging generics reduces cost to the State
- The product price is not the only consideration**
- Medicaid receives rebates for drugs; generic rebate % is fixed; whereas the Brand rebate is set by CMS at a minimum %, with no cap.
- Additionally there is a supplemental rebate for NC

FY 2014-15 BUDGET

| | |
|-----------------|------------|
| BRAND DRUGS | \$ 1,165 B |
| GENERIC DRUGS | \$ 245 M |
| DISPENSING FEES | \$ 112 M |
| DRUG REBATES | \$ (616) M |

REAL EXAMPLE

| | <u>Medicaid Rate</u> | <u>Rebate Collected</u> | <u>Net Cost to NC</u> |
|--------------------|----------------------|-------------------------|-----------------------|
| Brand Drug A | \$ 283.22 | -198.87 | \$ 84.35 |
| Generic Equivalent | \$ 189.41 | -25.01 | \$ 164.40 |

*Rebates compiled,
computed and
collected quarterly*

QUESTIONS

LME/MCO's and Hospitals on March 24, 2015

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