Health and Human Services
Joint Legislative Oversight Committee

Overview of
Medicaid Provider Payments

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Medicaid Payment Primer

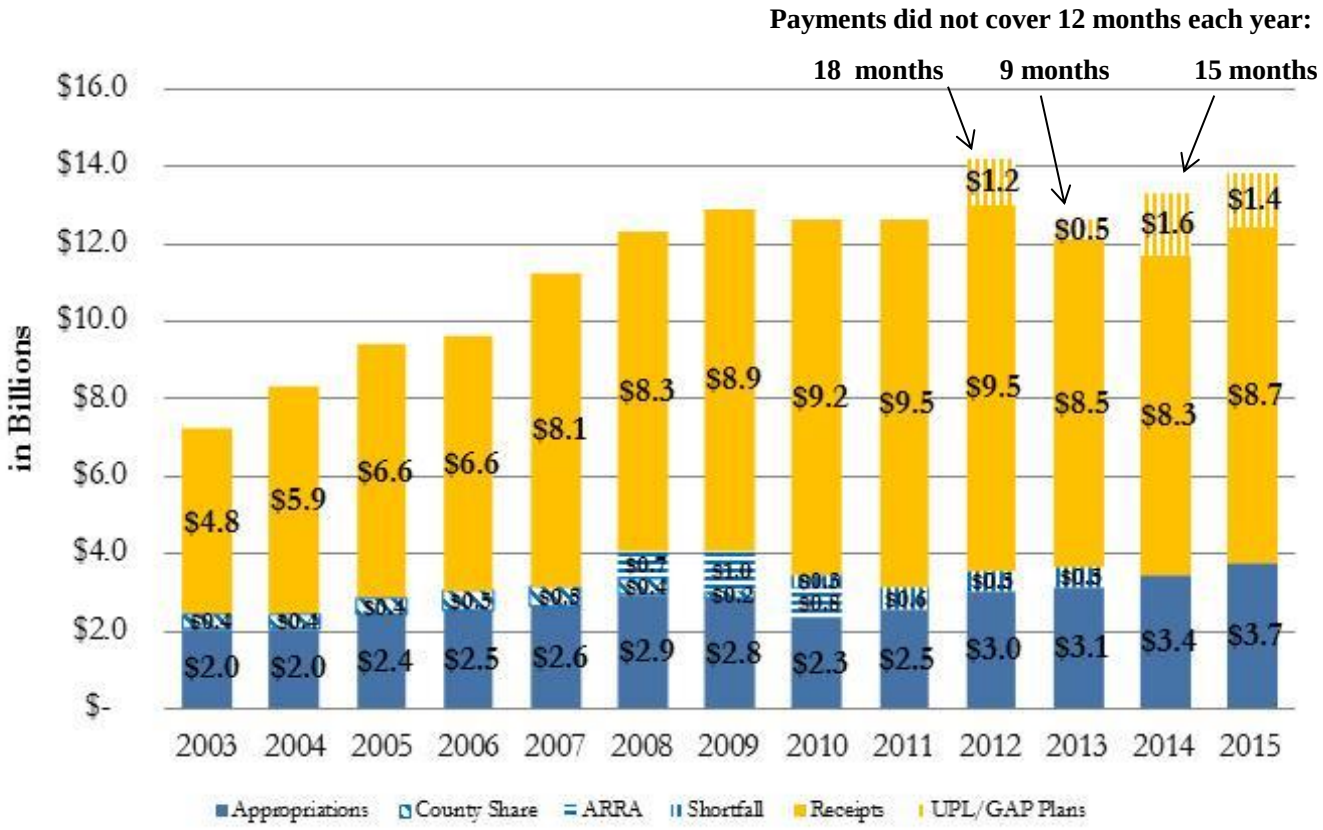
- *Basics of Medicaid Payment and Drivers*
- *Provider Payment Methodologies and Economic Incentives*
- *Health Department Payment Methodology*
- *Skilled Nursing Payment Methodology*
- *Physician Payment Methodology*
- *Drug and Dispensing Fee Methodology*

Presentation on 3/19/15

- *LME/MCO Payment Methodology*
- *Hospital Payment Methodologies*

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 =

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.

LME/MCO Payment Methodologies

- The LME/MCO's contract with DMA for an array of behavioral health services on a capitated basis.
- The capitation rates were originally actuarially established based on historical spending, with an adjustment for trending factors and anticipated lower costs related to utilization management.
- LME/MCO rates include a 2% add-on payment until organizations reserves at a contracted level
- The LME/MCO contract covers services previously paid as FFS that include hospital services (inpatient, outpatient and emergency), physician and non-physician services, CAP services and ICF-MR.
- CMS approves a rate range; DMA must negotiate with the LME/MCO within that approved range.
- One significant exclusion in the calculation of the rates has been drugs, which remain a FFS payment by DMA.

LME/MCO Payment Methodologies

- Future updates to the PMPM or capitated rates should be actuarially based on actual claims experience by the LME/MCO.
- The positive side of this is that the State can realize the benefit of utilization improvements beyond actuarial expectations, the downside is that the state could reclaim all gains, leaving the LME/MCO with the only option to maintain or enhance profits being further reduction in utilization or rates paid to providers.
- An additional concern is that continually relying on historical expenditures as a basis for negotiating rates, may result the only alternative for providers to remain financially viable is to cut needed services.

Hospital Payment Methodologies

- Hospital payments are the most complex of all provider groups, their methodologies include claims payments, cost settlements, uncompensated care, supplemental payments for allowable cost, equity and inpatient upper payment limits (MRI and GAP Plans).

- Hospital payments are funded by federal receipts, provider funding (intergovernmental transfers and assessments) and State appropriations. The State also benefits from an "add on" retention percentage of 28.85% of all assessments paid by hospitals.

- When all payments are considered Hospitals receive 100% of cost outpatient/emergency services and the equivalent of Medicare rates for inpatient services. Understanding the funding for each component is important in understanding the net impact of payments to hospitals – hospitals fund the state share of most supplemental payments above claims.

Hospital Payment Methodologies

DSH Specific Limit = Medicaid Costs + Uninsured Costs

INPATIENT

		100% Medicaid Costs			Unins	Medicare Rates
Public	Federal	Claims - CMS FMAP	**MRI Enhanced Payments**		**DSH**	GAP UPL - CMS
	State Share	State Appropriation	Public Hospital IGT		Pub Hosp CPE	Hospital Assessment + **State Retention**
Non - Public	Federal	Claims - CMS FMAP	**MRI Enh Pmts**	GAP Equity - CMS FMAP	**DSH**	GAP UPL - CMS FMAP
	State Share	State Appropriation	Public Hospital CPE	Hospital Assessment + **State Retention**	Pub Hosp CPE	Hospital Assessment + **State Retention**
UNC	Federal	Claims - CMS FMAP	Settlement - CMS FMAP		**DSH**	UNC UPL - CMS
	State Share	State Appropriation	State Appropriation		State Approp	Hospital IGT
ECU	Federal	Claims - CMS FMAP	Settlement - CMS FMAP		**DSH**	GAP UPL - CMS
	State Share	State Appropriation	State Appropriation		State Approp	Other Hospital Assessment + **State Retention**
Critical Access	Federal	Claims - CMS FMAP	Settlement - CMS FMAP		**DSH**	GAP UPL - CMS
	State Share	State Appropriation	State Appropriation		State Approp	Other Hospital Assessment + **State Retention**

OUTPATIENT

Public	Federal	Claims and Settlement - CMS FMAP	**MRI Enhanced Pmts**		**DSH**
	State Share	State Appropriation	Public Hospital IGT		Pub Hosp CPE
Non - Public	Federal	Claims and Settlement - CMS FMAP	**MRI Enh**	GAP Equity - CMS	**DSH**
	State Share	State Appropriation	Public Hospital CPE	Hospital Assessment + **State Retention**	Pub Hosp CPE
UNC	Federal	Claims and Settlement- CMS FMAP	**MRI Enhanced Pmts**		**DSH**
	State Share	State Appropriation	Public Hospital IGT		State Approp
ECU	Federal	Claims and Settlement- CMS FMAP	**MRI Enhanced Pmts**		**DSH**
	State Share	State Appropriation	Public Hospital IGT		State Approp
Critical Access	Federal	Claims - CMS FMAP	Settlment - CMS FMAP		**DSH**
	State Share	State Appropriation	State Appropriation		State Approp

FUNDING FOR HOSPITAL PAYMENTS THROUGH MEDICAID

Federal Share Sources

- Traditional federal match at the annually approved rate
- MRI plan enhanced payments, state share funded from public hospital IGT

State Share Sources

- Annual state share of spending appropriated through the budget
- Intergovernmental Transfers (IGT) to fund the state share of supplemental DSH payments
- ECU Certified Public Expenditures (CPE) used to fund the state share of DSH payments
- Assessments on hospitals to fund the state share of GAP plan equity and UPL payments
- Assessment on other hospitals used to fund the state share of GAP plan payments to specific hospitals

NOTES

1) Hospital assessments equal the state share required to match the federal portion of the payment plus the state retention percentage appproved by the General Assembly
2) The relative size of the bars in the table are not a precise measure of the relative size of the payments as they change from year to year based on changes in Medicaid rates and policy, changes in Medicare rates, changes in hospital cost and CMS policy changes.

KEY DEFINITIONS:

1) **Public Hospital or Qualified Public Hospital (QPH) is a North Carolina designation that relates to the county involvement in governance and the ability to use intergovernmental transfers to move funds to the state.**
2) **MRI Plan – a plan approved by CMS that defines how the federal DSH allotment and supplemental enhanced payments are paid to hospitals.**
3) **Hospital GAP Plan – a plan approved by CMS and General Assembly that defines the methodology for payment of supplemental equity and upper payment limit amounts to hospitals, and related funding.**
4) **Critical Access Hospital – CMS designation for certain small rural hospitals meeting criteria that allows additional funding for services as a "safety net" hospital.**
5) **Medicaid Costs – annual report completed by each hospital that calculates the total costs of providing services to Medicaid patients.**
6) **Medicare Rates – amount that Medicare would have paid for inpatient services based on the Medicaid DRG times the Medicare DRG rate.**
7) **Certified Public Expenditures (CPE) - amounts that CMS allows in limited situations to count as state share in drawing federal funds.**

Hospital Payment Methodologies – Outpatient/Emergency Services

Definition – outpatient includes all diagnostic and treatment services for which an overnight stay at the hospital is not required. Emergency services include those services rendered in the hospital emergency room to a patient not admitted to the inpatient units as part of that visit to the hospital

Payment	*Method*	*Funding*
• Claims ***Paid weekly as claims are billed to CSC***	• Effective 7/1/14 all hospitals are paid an interim payment of 70% of estimated cost based on the billed charges.	• NC funds the state share
• Settlements ***Paid annually following submission of a cost report by each hospital***	• Annually, based on the hospital's cost report, the hospitals receive or pay back the difference in the claims payment and 70% of actual cost.	• NC funds the state share

Hospital Payment Methodologies – Outpatient/Emergency Services

Payment	Method	Funding
• MRI- Enhanced Payments ***Paid quarterly***	• Qualified Public hospitals are paid the difference between the claim plus settlement and 100% of costs. Non-QPH hospitals receive a portion of the difference in claim plus settlements and 100% of costs.	• QPH hospitals IGT the state share of supplemental payments for public hospitals; CPE's fund non-QPH payments
• Equity Payments ***Paid quarterly***	• Non-QPH hospitals receive the difference between the claims plus settlement plus the enhanced payment and 100% of costs as a supplemental payment.	• Non-QPH hospitals fund the state share through an assessment plus 28.85% for state retention

Hospital Payment Methodologies – Inpatient Services

Definition – inpatient services reflect those services provided by a hospital as part of an admission to the inpatient facilities, generally an overnight stay in a hospital inpatient bed.

Payment

- Claims

  Paid weekly when claims are billed to CSC

Method

- There are 740 diagnostic related groups (DRG's) that NC uses that reflect the service provided on inpatient basis in hospitals. Each DRG has a weight that reflects the relative cost/complexity or intensity of services provided. These weights are multiplied by a "base rate" to determine the amount of the payment.
- Hospitals can receive an additional claim payment if the patient stay exceeds standards or costs are outside a specified standard deviation of costs

Funding

- NC funds the state share

Hospital Payment Methodologies – Inpatient Services

Payment	Method	Funding
• Settlement ***Paid annually following submission of cost report***	• UNC and Vidant Medical Center (ECU) receive an annual payment equal to the difference in the DRG payment and 100% of Medicaid costs for inpatient services	• NC funds the state share
• MRI - Enhanced Payments ***Paid quarterly***	• Qualified Public hospitals are paid the difference between the DRG and 100% of costs. Non-QPH hospitals receive a portion of the difference in DRG and 100% of costs.	• QPH hospitals IGT the state share of supplemental payments for public hospitals; CPE's fund non-QPH payments

Hospital Payment Methodologies – Inpatient Services

Payment	Method	Funding
• Equity Payments ***Paid quarterly***	• Non-QPH hospitals receive the difference between the DRG plus the enhanced payment and 100% of costs as a supplemental payment.	• Non-QPH hospitals fund the state share through an assessment plus 28.85% for state retention
• UPL Payments ***Paid quarterly***	• All hospitals except UNC receive a supplemental payment equivalent to the difference between the DRG plus enhanced payments plus equity payments and Medicare rates. • UNC has their own UPL plan	• Hospitals fund the state share through an assessment plus 28.85% for state retention • UNC IGT's the state share of payments

DSH Specific Limit must be considered for both inpatient and outpatient payments

This presentation highlights that North Carolina Medicaid payment system currently focuses more on how much is paid and who is paid than rather than the outcomes achieved. Can the current Medicaid payment system support an outcomes based program?

QUESTIONS

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