



Understanding Medicaid Provider Payments

Fiscal Brief

March 18, 2015

Executive Summary

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.

This brief presents a summary of the various payment methodologies utilized by Medicaid to compensate providers for services covered by Medicaid with the following objectives. It is not intended to assess the amount of payment or its equitability.

- 1) Understanding of the Medicaid payment system and how the various pieces fit together for a comprehensive understanding of the total payments by Medicaid to providers.
- 2) Understanding one of the points of control, payment and rates, under the current system for the management of Medicaid spending.

Medicaid payments to providers for services must all be approved by the federal Government. The agency at the federal government that oversees the State's Medicaid programs is the Centers for Medicare and Medicaid Services (CMS). All payment methodologies, rates and basis for payment are included as part of the State Plan or waiver documents approved by CMS.

Medicaid payment and the ability to control medical spending in a largely fee for service environment is complex.

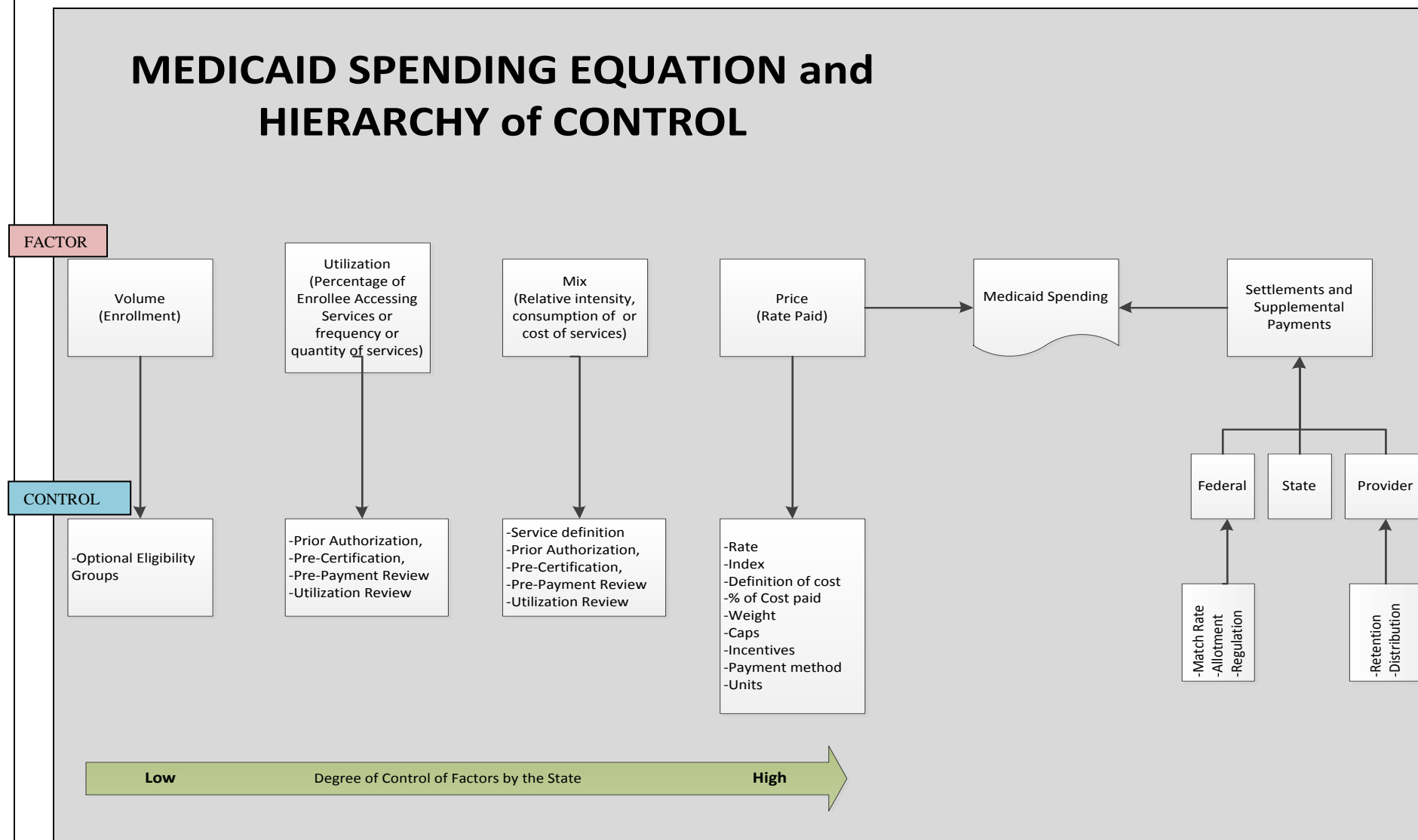
Many payment methodologies are more complicated than just a rate times a unit, or a fee in a fee schedule. There are two major elements to Medicaid payments, the federal share (approximates 65% of the payment) and the State share. The State share can be funded by appropriation, provider assessments or other sources. NC must comply with section 1902(a)(30)(A) of the Social Security Act when establishing Medicaid reimbursement amounts.

The brief begins with a general overview of provider payment approaches and then provides specific information for selected provider group's payment methodologies that include:

- Hospitals,
- Physicians,
- Skilled Nursing Facilities,
- Prescribed Drugs, and
- Local Management Entities/Management Service Organizations (LME/MCO) which include capitated payments for behavioral health services.



The following chart reflects elements for consideration in managing Medicaid spending in the current physical health environment:





Payments to other providers, not listed in the executive summary, are much more straight-forward. They are basically a set rate times a unit to calculate a payment. The chart below summarizes the many payment methodologies utilized by North Carolina Medicaid to compensate these providers:

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, HIPD plan	Recipients Covered * Premium = Payment
Per Member Per Month	CCNC, PACE and Medsolutions	Recipients Covered * PMPM Rate = Payment



Spending on provider payments from all sources in SFY 2014-15 is budgeted as follows:

Hospitals	\$ 3,347,592,601
LME/MCO-Behavioral Health	\$ 2,854,082,559
Drugs	\$ 1,522,224,300
Physicians	\$ 1,438,472,457
Skilled Nursing Facilities	\$ 1,186,152,764
Medicare Parts A, B and D	\$ 749,395,198
Personal Care Services	\$ 500,669,463
Dental	\$ 350,646,856
CAP Programs	\$ 322,695,179
All Other Services	\$ 1,216,638,819

HOSPITAL SERVICES

Overall hospital payments are one of the most complicated of all provider groups because there are four distinct components that can comprise the overall Medicaid reimbursement to a hospital that must be considered in all situations to understand the complete economic impact on the State or hospitals for changes in Medicaid policy and how changes affect each component.

Additional factors that impact the amounts that Hospitals will receive, when all funds flows are considered, include uncompensated care and Medicare. Uncompensated care is one aspect of the Disproportionate Share Hospital (DSH) payments. Medicare rates are used to set the limit for inpatient supplemental payments under the Hospital GAP plan. The four distinct payments to hospitals are:

- 1) **Claim payments:** Inpatient claim's payments are calculated by multiplying a hospital's base rate times a weighting factor for each diagnostic related group (DRG). Similar to Medicare, historically there have also been add-on factors to teaching hospital's rates for medical education.

The FY 2014-15 budget included a provision to standardize the base rates for hospital inpatient services into a single state wide rate, with no add on payments. The add on or graduate medical education costs would no longer be paid through the claims, but would be paid through a combination of the supplemental payment plans (MRI and GAP) and settlements.

DRG weighting factors are updated annually, based on relative changes NC hospital costs, so long as the aggregate changes result no overall increase in spending. In FY 2014-15 these weights were reduced by 2.1%.

Outpatient claim's payments are set to pay an estimated 70% of cost on an interim basis for all services other than lab and high tech imaging services, based on the last filed and audited cost report. Billed charges are multiplied by the hospital's last filed cost report's ratio of cost to charges (RCC) times 70% to calculate an interim payment. The settlement of the interim payment to 70% of cost is discussed in the next section. Lab services are paid based a fee schedule that is set at no more than Medicare.



Outpatient high tech imaging (CT, MRI and PET scans) performed at a hospital are paid through the Medsolution's capitated contract.

The FY 2014-15 budget also contains a provision that reduces UNC Hospitals and Vidant Medical Center outpatient reimbursement to 70% of cost, which will require changes to either the UNC UPL, MRI or GAP plans.

Critical Access Hospitals claims are paid on an interim basis the same as other hospitals, but are settled to 100% of their cost in the annual settlement.

All of the claims payments are made weekly as claims are submitted for payment to DMA.

Cost Settlements: UNC Hospitals - In order to effectively settle UNC's estimated payments to 100% of their actual cost of inpatient services they receive a credit against the State share of their supplemental payments under their UPL plan that is equivalent to this amount.

Vidant Medical Center is paid an additional payment for inpatient claims, based on their filed cost reports to settle the difference between DRG payments and 100% of costs.

Outpatient services hospitals can receive an additional annual payment for outpatient service only, excluding lab and high tech imaging, based on their filed cost reports to settle interim payments to 70% of the actual cost of services for each hospital. Should interim payments exceed costs, the provider must repay that amount to DMA. Cost reports are due 5 months after the end of the provider's fiscal year.

- 2) **Disproportionate Share Hospital (DSH) or Medicaid Reimbursement Initiative (MRI) plan:** Annually the federal government allots funds to each state for additional payments to qualifying hospitals serving a large number of Medicaid or uninsured patients. North Carolina has created a plan, called the MRI plan that is the basis for distribution of this allotment. The major components of the plan include:
- a) Public and non-public hospitals receive enhanced Medicaid payments representing all or a portion of the cost deficits incurred for treating Medicaid patients. The cost deficit in the MRI plan is defined as the difference between inpatient and outpatient costs and Medicaid claims payments.
 - b) Teaching hospitals receive additional payments for uninsured patients.

Overall, there are six types of payments under the NC plan. In 2013 they include IMD payments to state operated mental health hospitals (18% of total), UNC Hospitals uninsured costs (7% of total), uncompensated care (UCC – 3% of total), inpatient and outpatient enhanced payments (70% of total) and HMO and basic DSH payments (2% of total).

Depending on whether the hospital is classified as a public or non-public hospital there is an IGT to provide the state share of the enhanced payments. The IGT rate varies for public hospitals depending what is defined as the Medicaid deficit.



Non-public hospitals are not required, nor permitted, to make an IGT for the State share of the enhanced payments.

Public hospital enhanced payments are funded through the MRI plan before non-public hospitals receive any enhanced payments. Enhanced payments are intended to increase the Medicaid payments to hospitals for services to 100% of costs. Generally, public hospitals do receive 100% of their costs and non-public hospitals recover a portion of the difference in claims payments and 100% of costs.

DSH payments are supposed to be made not more than quarterly. CMS regulations state that the combination of claims, settlements and DSH payments cannot exceed the Medicaid cost of care.

- c) **Hospital GAP/UPL plan:** Provides a supplemental payment to hospitals equal to Medicare rates for inpatient services less Medicaid claims, settlements and DSH payments. Outpatient supplemental payments are equal to 100% of cost less Medicaid claims, settlements and DSH payments. Hospitals fund the state share of the Hospital GAP plan through an assessment or provider tax. The assessment is allocated to each hospital based on their proportional cost from the latest closed cost report.

The State retains a percentage (28.85%) of the total amount assessed through the GAP plan. Since the supplemental payments are intended to ensure all hospitals are paid at Medicare rates for inpatient services and 100% of cost for outpatient when claims, settlements, DSH and GAP are considered, the assessment must be grossed up for the hospitals to generate the state's 28.85% and not dilute the supplemental payment to the hospitals.

Vidant Medical Center and Critical Access hospitals receive a supplemental payment through the GAP plan to raise inpatient payments to Medicare without contributing an assessment. UNC Hospital does not participate in the GAP plan, as they have their own UPL payment plan for inpatient services, where they fund the State share with an IGT. As with the GAP plan, the UNC UPL plan provides a supplemental payment equal to the difference in Medicaid costs and what Medicare would have paid.



To understand how any change approved by the General Assembly impacts an individual hospital, the hospital industry or the State requires a calculation of the impact on claims payments, settlements, DSH/MRI plan, whether funds are shifted from public to non-public hospitals, whether there is a public IGT impact and finally the impact on the GAP/UPL plans, assessments and state retention. The following table reflects breakdown of the hospital funds flow:

DSH Specific Limit = Medicaid Costs + Uninsured Costs						
100% Medicaid Costs					Unins	Medicare Rates
INPATIENT						
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

- Hospital assessments equal the state share required to match the federal portion of the payment plus the state retention percentage approved by the General Assembly
- 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.



Public hospitals are generally a NC determination, and include state operated facilities like UNC and ECU hospitals, but also include county designations and hospitals like those owned by Carolina Health System, based in Mecklenburg County. Overall there are 44 hospitals designated as public out of the 110 short term acute care hospitals included in the MRI plan in North Carolina.

Also it is important to note that the Affordable Care Act calls for reductions in the federal DSH allotment in each year from 2014-2020. The following table reflects the proposed reductions in the national allotment:

<i>FFY</i>	<i>Reduction Amount</i>
2014	\$ 500 million
2015	\$ 600 million
2016	\$ 600 million
2017	\$ 1.8 billion
2018	\$ 5.0 billion
2019	\$ 5.6 billion
2020	\$ 3.0 billion

The assumption in the ACA is that with expanded Medicaid and health benefit exchanges there would decrease uncompensated care and thus lower need for additional federal reimbursement.

LME/MCO

The LME/MCO's contract with DMA for an array of behavioral health services on a capitated basis. The capitation rates were originally established based on historical spending, with an adjustment for trending factors and anticipated lower costs related to utilization management efforts and the incentives of a capitated arrangement.

The LME/MCO contract covers services previously paid as FFS that include hospital service (inpatient, outpatient and emergency), physician and non-physician services, CAP services and ICF-MR. A noticeable exclusion has been drugs, which remain a FFS payment by DMA.

Updates to the PMPM or capitated rates will be based on actual expenditures, 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 will 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.

This last dynamic is a fundamental flaw in current health system financing, which results in providers being placed in a position to have to increase the impact of lower utilization to maintain or improve profits or cost sharing to make the arrangement economically attractive beyond the initial years.

PHYSICIANS

While general payments to physicians are relatively straightforward, there are supplemental or related payments that make the overall methodology for the calculation of total payments to some physicians are different than from most providers.

Physicians use Medicare CPT codes to describe the services they provide to Medicaid recipients, these codes reflect the relative time, intensity and/or complexity of the services provided.

Medicare's CPT codes contain three elements that include professional time (physician service), practice (costs of the office and staff) and malpractice that are combined to produce a weighting factor. There is a



Medicare schedule for all CPT codes that contains the weighting factor for each code, that NC utilizes. Similar to hospitals, there is a conversion factor or “base rate”, which is set nationally by CMS at least annually that is multiplied times the CPT code weight to determine the amount that will be paid for each CPT code by Medicare.

Through 2011, North Carolina used a percentage of the Medicare schedule as a basis for payment of physician services. NC fees were frozen at that point, so a precise relationship of NC payments to the national fee schedule no longer exists, as changes to the Medicare rates have been implemented.

The following summarizes the NC Medicaid payment methodologies to the different categories of physician services:

- 1) Primary Care Physicians – includes internal medicine, family practice or medicine, OB/GYN and pediatric specialties. These physicians are primarily paid under the evaluation and management codes (E&M) of the Medicaid fee schedule which represent basic office visits and services provided by the physician during those visits¹.
- 2) Other Physicians – this category includes all other specialties of physicians. Psychiatrists are the only physician specialty that is not paid under the methodology described in this document. They are paid through the LME/MCO for behavioral health services as part of the monthly capitated payments paid by Medicaid. LME/MCO provider rates are not controlled by the State, therefore, LME/MCO’s are free to establish or negotiate whatever rate they deem appropriate or can negotiate.
- 3) Physician extenders such as nurse practitioners and physician’s assistants that are directly enrolled utilize the same methodology for computing payments as physicians. The actual payment to extenders is a percentage of the physician fee schedule, based on their specialty or license.
- 4) UNC and ECU Physicians –the state operated medical schools at UNC and Brody School of Medicine receive a supplemental payment for physician services that increases the total payments from Medicaid to the average commercial rate. The state share of this supplemental payment is funded by UNC and Brody.
- 5) CCNC physicians, networks and NCCCN – payments are negotiated as part of a three way contract with Medicaid, CCNC and the physician that cover care management functions and participation in CCNC care initiatives. These groups are compensated through an per member per month (PMPM) payment that is in addition to the claims payment for each individual service billed to Medicaid. The fixed monthly payment to the CCNC physician is an incentive to participate in CCNC/NCCCN care protocols to manage the health of populations covered. PMPM payments paid to NCCCN are for population care management, informatics and specialized pharmacy and behavioral health support. NCCCN retains a portion of the PMPM payment from Medicaid; then passing the remaining amount to the 14 CCNC networks for the

¹ Effective 1/1/13, all primary care physicians, excluding OB/GYN were mandated under the Affordable Care Act (ACA) to paid at 100% of Medicare fees until 1/1/15.



services that directly support the physician in managing the care for the covered populations. PMPM's for all segments vary based on whether the assigned member is aged, blind, disabled (ABD), a pregnant woman or other category of enrollee.

SKILLED NURSING FACILITIES

Skilled nursing facilities are a more complex structure for payment than average, even though it does not include a supplemental payment plan.

Unlike many other Medicaid providers, North Carolina SNF's are not paid on a fee service basis. Instead are paid a prospectively set per diem for each day a recipient is a resident of the facility. Each SNF has a unique rate which is comprised of a number of components.

Direct Care Component - is broken into two categories 1) services eligible for a case mix index (CMI) adjustment and 2) services not eligible for a CMI adjustment. The direct care component eligible for a CMI adjustment includes the salary/benefits or contract costs for nurses, LPN's and aides. The other elements of direct care, which are not eligible for a CMI adjustment, include the costs for nursing supplies, food, activities, social services and ancillary services. Although the base rate for all skilled nursing facilities is the same, the CMI adjustment results in a unique rate for each facility.

Indirect Care Component- includes the costs for administration, laundry and linen, housekeeping, operation, maintenance of the plant and indirect cost of ancillary services. This component of the rate is set at the statewide day weighted median rate for all facilities.

Fair Rental Value Component (Facility Costs) - includes the cost of land, land improvements, buildings, fixed equipment and movable equipment. This rate is unique for each facility. Fair rental value rates are supposed to be updated annually based on an external index for construction costs.

The State Plan rate setting methodology provides for an annual increase in direct and indirect care rates based on a market basket update factor. However, update factors other than case mix index have been frozen since 2008.

Direct care rate components eligible for CMI adjustments have historically been updated quarterly for changes in the average case mix by facility. Case mix is a measure of the acuity levels of the residents in each skilled nursing facility. The case mix level may increase or decrease from one quarter the next. However, the SFY 2014-15 budget freezes CMI adjustments effective January 1, 2015.

There is a cap on direct costs at 102.6% of the state wide median. Facilities with cost below that median receive an incentive bonus added to their rates. No skilled nursing facility is receiving more than the direct cost cap.

With past adjustments to rate methodologies, the base direct care rate currently averages 98.3% of the median and the indirect rate averages 95.8% of the median.

Finally, skilled nursing facilities have paid a provider assessment since 2004. DMA currently uses 94% of the assessment paid to increase the per diem direct and indirect rates, by funding the state share of the increase in the rates. The state retains approximately 6% of the assessment from nursing homes to defray State costs.



PRESCRIBED DRUGS

The complexity of Medicaid payment for prescribed drugs lies in a structure in NC that provides a payment to pharmacies for dispensing the medication, a payment to the pharmacy or physician for the medication itself and that a portion of the product cost is recovered by the state through a drug rebate program. The magnitude of the components in the SFY 2014-15 budget is reflected in the table below:

Brand Drugs	\$ 1,165,487,273
Generic Drugs	\$ 244,702,792
Dispensing Fees	\$ 112,034,235
Drug Rebates	\$ (615,739,375)

Net drug spending has increased in the last 3 years as follows:

FY 2012-13	6.4%
FY 2013-14	12.6%
FY 2014-15 Budget	34.4%

The net cost of prescribed drugs to NC Medicaid in SFY 2014-15 is budgeted to be \$906M. The payment for prescribed drugs also includes different calculations based on whether the medication is a brand or generic drug.

Prior to January 1, 2015, brand drugs are priced as a multiple of the national wholesale acquisition cost index (WAC), NC pays WAC plus 2.7%. Generic drugs are priced based on an index developed for the state called the State Medicaid Average Cost (SMAC). These drugs are paid to the pharmacy at 192.5% of that index.

Dispensing fees are also differentiated based on whether the drug is brand or generic. Pharmacies are currently paid \$2 per prescription to dispense a brand medication. Dispensing fees for generic drugs are based on a tiered system that ranges from \$1 per prescription to \$7.75 per prescription. The tiered rate is based on the overall generic prescribing rate for each pharmacy.

The basis for the generic tiered rates system relates to the general assumption that generic medications product costs are less expensive for the State than brand medications. Although it will be discussed later that rebates can make this assumption incorrect in some cases.

Effective January 1, 2015, all drugs will be paid from a single schedule that is designed to represent the average acquisition cost for all pharmacies in NC. Dispensing fees will have to be modified to more closely align with the cost of dispensing, since the new product pricing methodology will eliminate any margin that currently exists in the product price paid by NC.

Rebates are an integral part of the consideration for understanding the net cost of prescribed drugs for the State. There are two forms of rebates; 1) CMS mandated rebates – these occur when the manufacturer signs an agreement with the federal Department of Health and Human Services. Based on that agreement, if a rebate is offered all states must include that medication in their formulary. 2) Supplemental rebates – NC, like many other states, participates in a supplemental rebate program. The program is based on the adoption of a preferred drug list and negotiation with manufacturers for inclusion and relative placement on that list. Manufacturers will pay an additional rebate to states that have this program.

One example of the impact of rebates that the Department provided in December 2014 is below:



	Paid to Pharmacy	Rebate Collected	Net Cost to NC
Brand Drug A	\$283.22	\$198.87	\$ 84.35
Generic Equivalent	\$189.41	\$ 25.01	\$164.40

While generally not the norm, the above table reflects a real example of how rebates can change the net cost to the state for prescribed drugs.

It is also important to understanding that rebates are billed to manufacturers quarterly, so there can be at a 4 to 6 month lag between when the State pays the gross price to the pharmacy and the rebates is actually collected.

COUNTY HEALTH DEPARTMENTS

County Health Departments, like hospitals, can receive receipts from a variety of sources including Local/State and Federal, Grants, Medicaid (claims and settlements), fee payments from individuals and commercial insurance and donations.

Medicaid payments for claims are paid from provider fee schedules, in other words, the payments to a Health Department for Medicaid billable services are paid at the same rate as any other provider would receive.

Additionally, Health Departments receive a settlement payment that represents the federal share of the difference between their Medicaid cost to provide services and the claims payment received from Medicaid. The State uses the Health Department's cost as the state share for these payments, therefore there is no appropriations impact for these payments to the Health Department.

Health Departments prepare an annual cost report to support their determination of Medicaid costs, that is submitted to DHHS for review and audit.



Summary

This brief highlights the need to identify or focus on what it is that North Carolina expects or wants to buy in terms of health outcomes for the citizens that we cover, rather than exclusively on what we pay for service.

Additionally, it is important to understand that since North Carolina has either frozen or reduced fee for service rates since 2009, CMS has become increasingly concerned with adequate access to care for Medicaid enrollees.

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ACRONYMS AND DEFINITIONS



- **ACA** – Affordable Care Act:
- **CAP** – Community Alternative Program: waiver program approved by CMS as an alternative to FFS that is tasked with achieving specific objectives, such as avoiding institutionalization.
- **Capitation** – Single monthly payment for a comprehensive array of services, whether the organization assumes risks for utilization, price and consumption.
- **CCNC** – Community Care of North Carolina: 14 networks of primary care providers that at contracted with NCCCN (North Carolina Community Care Network) and Medicaid for care and case management services on a PMPM basis.
- **CMI** – Case mix index: a relative indicator of the complexity of services or resources required to provide services.
- **CMS** – Centers for Medicare and Medicaid Services: federal agency responsible for oversight and approval of Medicaid programs and practices.
- **CPE** – Certified public expenditures: Expenditure of funds by a public provider where CMS allows that spending to count as the State share to draw federal funds under Medicaid.
- **CPT** – Current Procedural Terminology: universal listing of codes that describe health services provided by individuals. Codes include a relative value or weight that is used by NC Medicaid and other payers to determine payments to providers.
- **CSC** – Computer Sciences Corporation: organization that DHHS contracted with to develop and operate the Medicaid Management Information System.
- **DHHS** – Department of Health and Human Services: NC Department that oversees DMA.
- **DMA** – Division of Medical Assistance: entity responsible for the operation of the Medicaid program in NC.



- **DME** – Durable medical equipment: equipment and supplies billable to the Medicaid program.
- **DSH** – Disproportionate Share Hospital: federal allotment for uncompensated care payments to hospitals.
- **E&M** – Evaluation and Management Codes: billing codes used by NC Medicaid and other payers to define services provided as part of an office visit.
- **FFS** – Fee for service: basis for payment of most physical health services.
- **FQHC** – Federally Qualified Health Center: federal designation for an organization qualifying for enhanced reimbursement from Medicare and Medicaid. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.
- **ICF-MR** – Intermediate Care Facility – Mental Retardation: NC facility that provides services if individuals with specific disabilities.
- **IGT** – Intergovernmental transfer: funds transfer between governmental units; that is allowed under CMS regulations.
- **GAP** – Hospital supplemental payment plan: defines methodology for calculating equity and upper payment limit payments to hospitals and the associated assessment to fund the State share.
- **GME** – Graduate Medical Education: payment made to teaching hospitals to cover the additional cost to the hospital or service provided in connection with medical education.
- **LME/MCO** – Local Management Entity/Managed Care Organization: NC organizations that contract with Medicaid for behavioral health services on a capitated basis.
- **MRI** – Medicaid Reimbursement Initiative: plan developed by NC and approved by CMS that defines how NC utilizes the federal DSH allotment and CPE's.



- **PACE** – Program of All Inclusive Care for the Elderly: alternative capitation payment model to FFS for individuals at risk for institutionalization in a skilled nursing facility. Objective is to avoid institutionalization.
- **PMPM** – Per member per month: calculation of the amount of spending per enrollee per month, or a payment that is based on the number of people enrolled rather than specific services provided.
- **SMAC** – State Medicaid Average Costs: NC developed and maintained index of the average cost of generic drugs which is used as a basis for generic drug pricing in NC.
- **WAC** – Wholesale acquisition costs: national index of the wholesale acquisition of cost of drugs. This index is used as a basis for pricing brand drugs in NC.