



MEDICAID FINANCING AND PAYMENT INTEGRITY

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Topics for Discussion

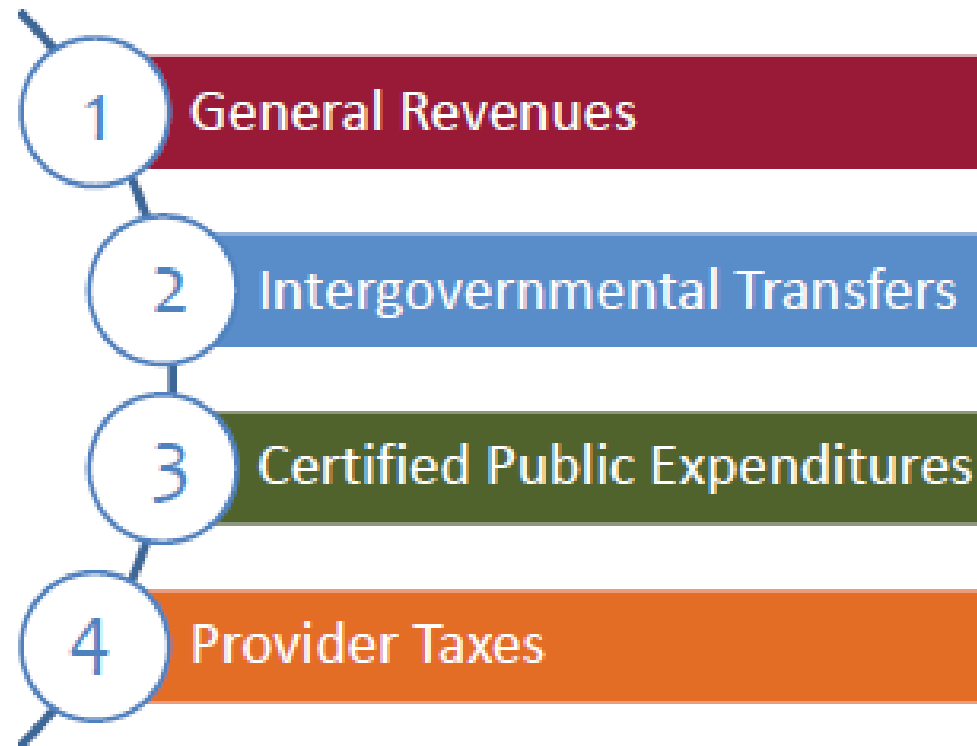
- ❑ Medicaid Financing
- ❑ Rate Setting
- ❑ Payment and Program Integrity

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Medicaid Financing Overview

- Joint state and federal funding.
- States administer Medicaid program but have to abide by federal requirements to receive federal matching funds.
- The federal share, referred to as federal financial participation (FFP), or federal match, is calculated using a Federal Medical Assistance Percentage (FMAP).
- FMAP varies by state, can vary from year to year, and is based on per capita income:
 - Lower per capita income = higher FMAP. Minimum FMAP is 50%.
- At least 40% of the non-federal share of total Medicaid expenditures must be financed by the state.

Sources of Non-Federal (State) Share



Upper Payment Limit (UPL)

- UPL is a federally-authorized program that provides payments to providers to supplement revenue from Medicaid patients so that it is comparable to that for Medicare patients.
- States have established UPL programs a number of provider categories such as nursing facility, ICF/IDD, PRTF.
- UPL dollars have to be redistributed back to providers, but is a source of funds for payment to recognize quality.

Provider Taxes

- States also use provider taxes to fund the state share of Medicaid Expenditures.
- Provider tax revenue cannot exceed 25% of the State Share of Medicaid expenditures.
- Medicaid providers usually benefit from a provider tax because the additional funds generated are often used to increase Medicaid payment rates for a class of providers.
- Lower volume Medicaid providers may not receive the same benefit from the tax as higher volume Medicaid providers within that class.

MEDICAID REIMBURSEMENT AND MATCHING RATES



GENERAL ADMINISTRATION: 50/50

EXCEPT:

- Salaries for skilled health care professionals
- Computer systems

COMPUTER SYSTEMS.

- 90/10 for updates or new systems
- 75/25 for on-going operations.

PROGRAMS.

- The state's Federal Medical Assistance Percentage (FMAP) except:
 - Family planning.
 - Medicaid expansion population.

MEDICAID RATE-SETTING: OVERVIEW

- **Requirements:** Federal law requires rates to be sufficient to generate access on a par with general population (SSA Section 1902(a)(30)(A)).
“Payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area”
- **State Plan:** Must describe the policy and the methods used in setting payment rates for each type of service.
- **Flexibility:** States have great flexibility in establishing rates and rate methodologies.

MEDICAID RATE-SETTING: HCBS

- **Fee Schedule**
 - Base fee
 - Acuity factors
 - Geographic adjustments
- **Negotiated Market Price**
- **Tiered Rates:** The characteristic of the individual is often identified by an assessment tool such as:
 - Supports Intensity Scale (SIS),
 - Inventory for Client and Agency Planning (ICAP) or
 - Another tool that classifies the individual's needs on an established scale
- **Bundled Rates**
- **Cost Reconciliation:** Cost-based with a reconciliation process

MEDICAID RATE-SETTING: INSTITUTIONS (Ex. Hospitals, Nursing Facilities)

- Various payment methods for facility-based care, including:
 - “Cost-based” reimbursement
 - Includes cost reporting, interim payments and cost reconciliation
 - “Price-based” methodology is based on payments using a fixed-fee methodology, generally DRGs for hospital inpatient, Outpatient Prospective Payment System for outpatient services, and Resource Utilization Group (RUG) based payments for nursing homes.
- Hospitals and nursing homes often receive lump-sum “supplemental” payments not directly tied to individual services (Ex. Upper Payment Limit Payments, Quality Incentive Payments, etc.).

MEDICAID RATE-SETTING: OTHER EXAMPLES

- **Hospice:** Base Medicaid hospice rates are published annually by CMS.
 - Per diem rate.
 - Linked to intensity of services furnished
 - States may pay more
- **Physicians:** Traditionally a fee-for-service payment based on a rate schedule. Rate schedule is often established as a percent of Medicare rates.
- **Pharmacy:** Two major components: ingredient cost and professional dispensing fee.

Value-Based Payment (VBP) Overview



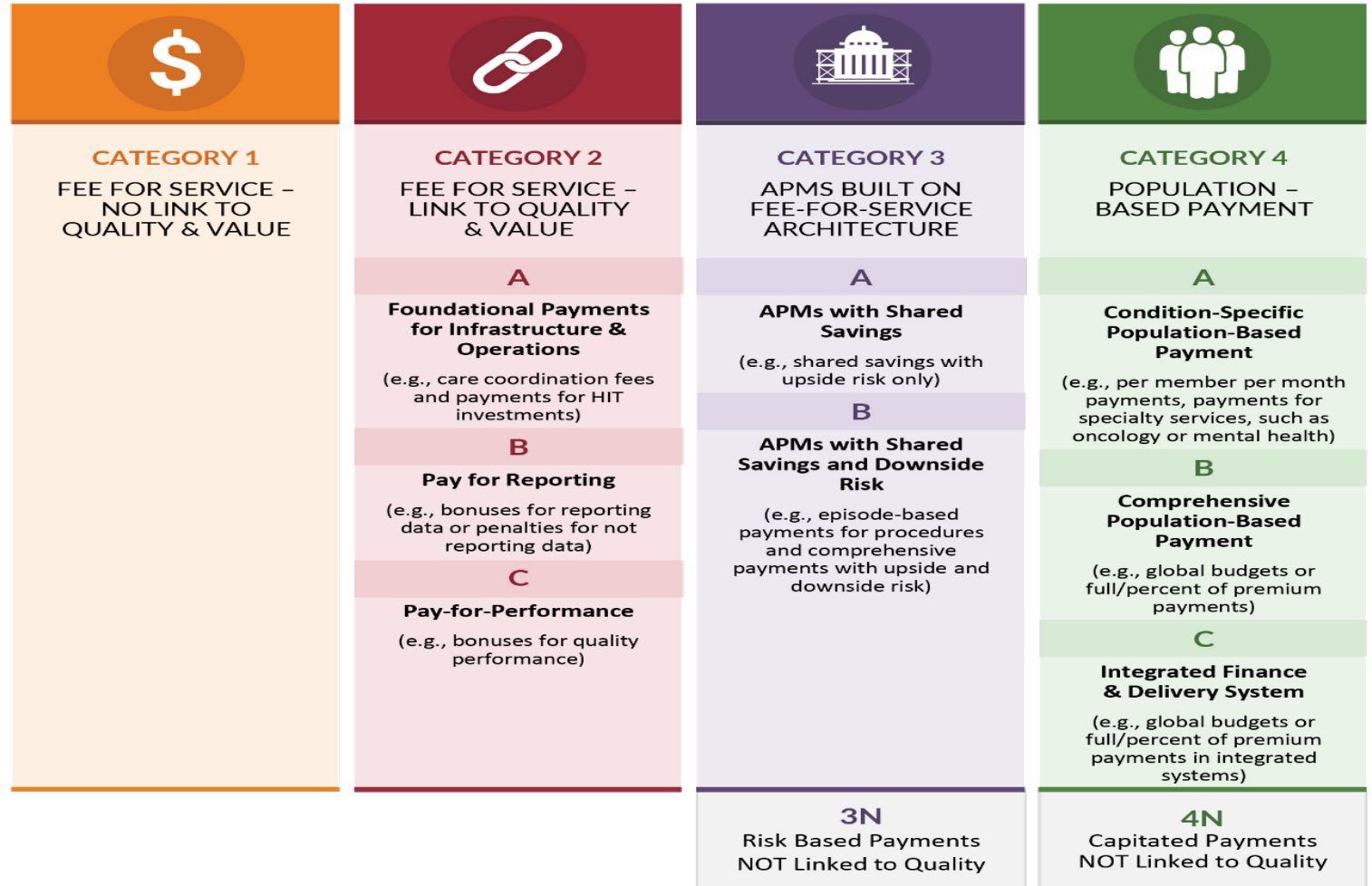
BACKGROUND

- Traditional Medicaid payments have paid for volume of services – not their value.
- VBPs seek to improve the value of the health care delivery system, by improving the quality of the care provided while at the same time, reducing the costs.

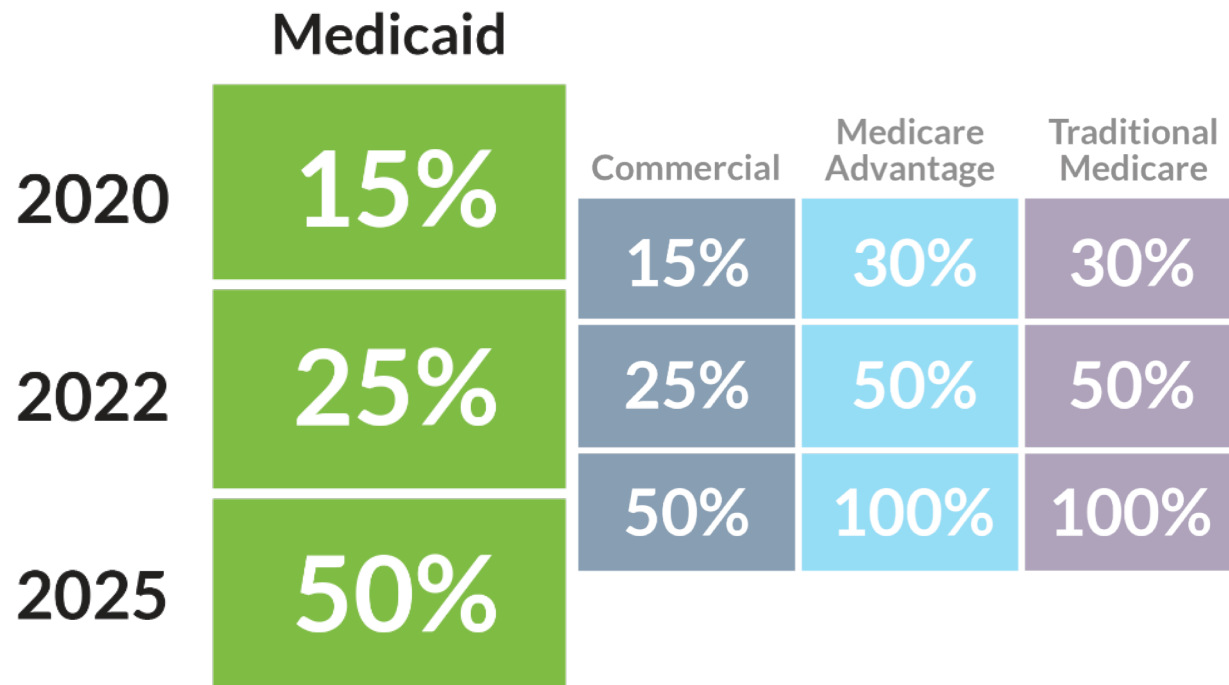
VBP: Key Definitions

- **Value Based Payments**
 - Linking provider payments to improved performance by health care providers. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers.
- **Alternative Payment Models (APMs)**
 - An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

HCPLAN Alternative Payment Model Framework



LAN Goals: Medicaid



Percentage of payments flowing through two-sided risk models (Categories 3B & 4* in the LAN APM Framework)

2017

7.4%

2018

8.3%

*Category 3B: APMs with Shared Savings and Downside Risk
 Category 4: Population-Based Payments

Payment and Program Integrity



OVERVIEW

- Payment and program integrity consists of initiatives to detect and deter fraud, waste, and abuse and improve program administration.
- Ensures federal and state dollars are spent appropriately
- General payment and program integrity domains:
 - Beneficiaries
 - Providers
 - Services
 - Payments

State plan requirement for the identification, investigation, and referral of suspected fraud and abuse cases.

Definitions

- **Abuse.**
Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
- **Fraud.**
When someone intentionally deceives or makes misrepresentations to obtain money or property of any health care benefit program
- **Waste.**
Inappropriate utilization of services and misuse of resources.

The primary difference between fraud and abuse is intention.

MEDICAID PAYMENT INTEGRITY: TOOLS AND ACTIVITIES

RESOURCES AND REQUIREMENT.

- Medicaid agency is responsible for payment integrity. Agency investigators, auditors, compliance, and program staff all contribute.
- CMS efforts are now consolidated in the Payment Error Rate Measurement (PERM) program.
- All states implement MMIS-related Surveillance and Utilization Review Systems (SURS).

CORE ACTIVITIES.

- Reporting
- Pattern recognition
- Investigations
- Referral and prosecution.
- Recovery
- Remediation, avoidance, and prevention

Payment Error Rate Measurement (PERM)

- The purpose of the payment error rate measurement (PERM) program is to measure and report an unbiased national improper payment rate for Medicaid and the State Children's Health Insurance Program (CHIP) as required under the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA, P.L. 112-248).
- PERM reviews are held with each state every three years on a rotating basis.
- PERM findings can be used to identify potential problem areas that can inform corrective actions.
- PERM is not designed to identify fraud.
- Most common cause of improper payments in 2019 PERM was insufficient documentation.

MEDICAID PAYMENT INTEGRITY: COORDINATION WITH OTHER ENTITIES

- Medicaid Fraud Control Units (MFCU).
 - Investigates and prosecutes Medicaid provider fraud
 - Usually a part of the State Attorney General's office
- State auditors (e.g., Legislative, Agency, State Inspectors General).
- Centers for Medicare and Medicaid Services.
- Federal HHS Office of Inspector General.
- Federal Government Accountability Office.
- Law enforcement (e.g., Prosecutors, FBI).

MEDICAID PAYMENT INTEGRITY: MANAGED CARE ORGANIZATIONS (MCOs)

- Nearly 54 Million Americans access health care through a Medicaid MCO.
- Medicaid regulations define fraud and abuse in the same way for fee for service and managed care (42 CFR 455.2).
- States are responsible for exercising oversight over their MCOs.
- Contractual requirements to proactively minimize fraud, waste, and abuse.
- Best MCO payment integrity practices:
 - Clear MCO contractual language.
 - Accountability, coordination, and communication with Medicaid agency payment integrity team.
 - Encounter data validation.
 - Performance reviews.

Payment Integrity and Value Based Payment Model Challenges

- Increasing payment complexities require updated payment integrity strategies.
- VBP modeling has to consider the possibility of incentivizing unintended behaviors and payments.
- What is the proper payment integrity strategy to validate payments for activities that were avoided/never occurred?
- What strength of documentation will be required to validate activities that are not individually billable?
- How will we leverage health information technology to validate outcomes?

CLOSING THOUGHTS

- Medicaid financing is complex but can be leveraged to maximize federal funding and provide additional payments to providers and create quality incentive payment programs.
- States have great flexibility in setting reimbursement rates.
- Medicaid is responsible for the accuracy of payments notwithstanding which state agency operationalizes the program.
- Provider reimbursement models are evolving to pay for value of services over the volume of services provided.
- Policy and program staff should work closely with program integrity staff to ensure the integrity of the program and corresponding payments.

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