We Make Healthcare Reimbursement Easy

Getting to Know Medicaid: Program Basics and Reimbursement Opportunities

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With You Today

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Brooke offers extensive expertise related to Medicaid programs. Her experience includes the developed and implementation of methodologies for supplemental payment programs totaling over $2.25 billion. She has coordinated with federal regulators, state legislators, industry stakeholders, other state agencies, and agency upper management to resolve any pending issues, working toward a fair outcome for all involved parties, and has proven to be instrumental in negotiations with CMS to get new supplemental payment programs approved.

Currently, Brooke focuses on Medicaid payment optimization and obtaining additional Medicaid enhanced reimbursement for providers.

Today's Talking Points

- Overview of Medicaid
- Background on Medicaid
- Eligibility
- Enrollment Trends
- Reimbursement Methodologies
- Funding Basics
- Reimbursement Opportunities
- Supplemental Payments
- Questions

Overview of Medicaid

Medicare vs. Medicaid

Medicare

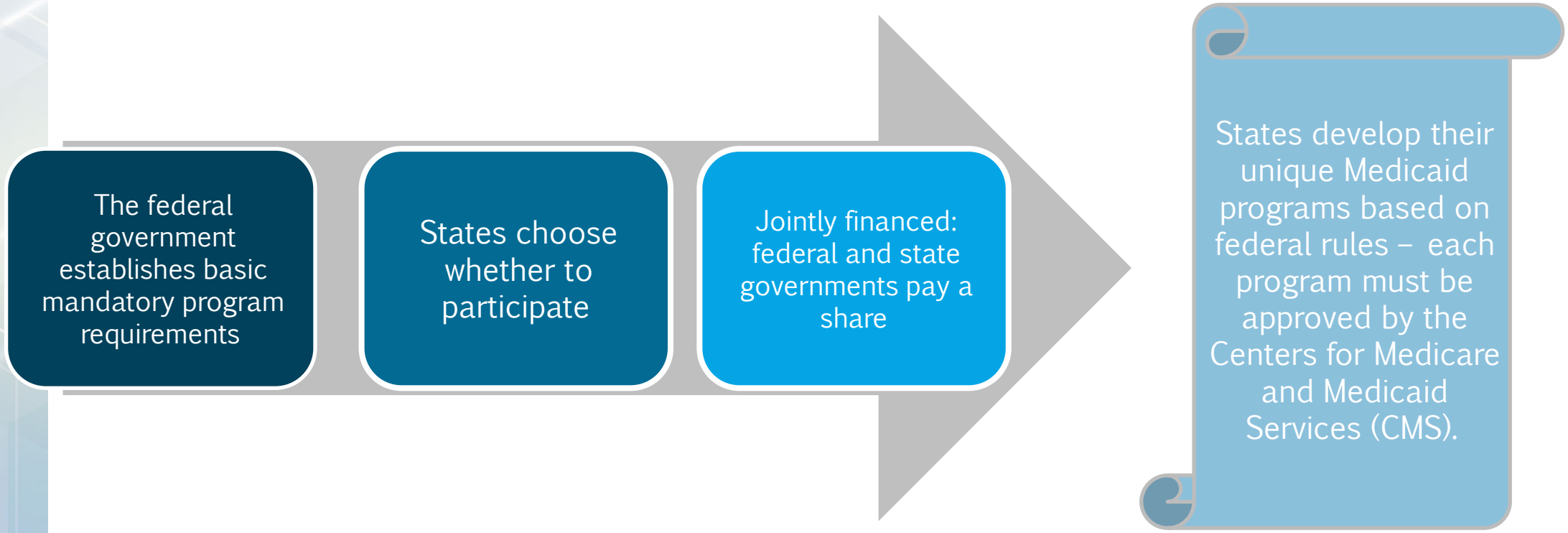
- Federally Administered
- Federally Funded
- Healthcare coverage for people age 65 or older and certain people under 65 with disabilities, and people of any age with ESRD
- Coverage
  - Inpatient (Part A)
  - Outpatient (Part B)
  - Pharmacy (Part D)
  - Limited Post Hospitalization
- Primary Payor

Medicaid

- State Administered
- Jointly State and Federally Funded
- Health care coverage for people with disabilities, elderly people, Pregnant Women, Low-income adults and children
- Coverage varies by State
  - Mandatory and Optional benefits
- Payor of Last Resort

What is Medicaid?

Medicaid is a federal program through which states partner with the federal government to provide health care coverage to low-income children, families, elders, and people with disabilities.



Children's Health Insurance Program (CHIP)

- Provides health coverage to eligible children through Medicaid and separate CHIP programs.
- CHIP is administered by states, according to federal requirements.
- Jointly funded by states and federal government.

Eligibility

Eligibility

- Mandatory Eligibility Groups
  - Low-income families
  - Qualified pregnant women and children
  - Individuals receiving SSI
- Optional Eligibility Groups
  - Individuals receiving home and community-based services
  - Children in foster care
  - Medically Needy Programs
  - 209(b)

Medicaid Benefits

Mandatory Services

- Doctor visits
- Inpatient and outpatient hospital services
- Mental Health services
- Prescription drugs
- Prenatal and maternity care
- Preventive care such as immunizations, mammograms, and colonoscopies

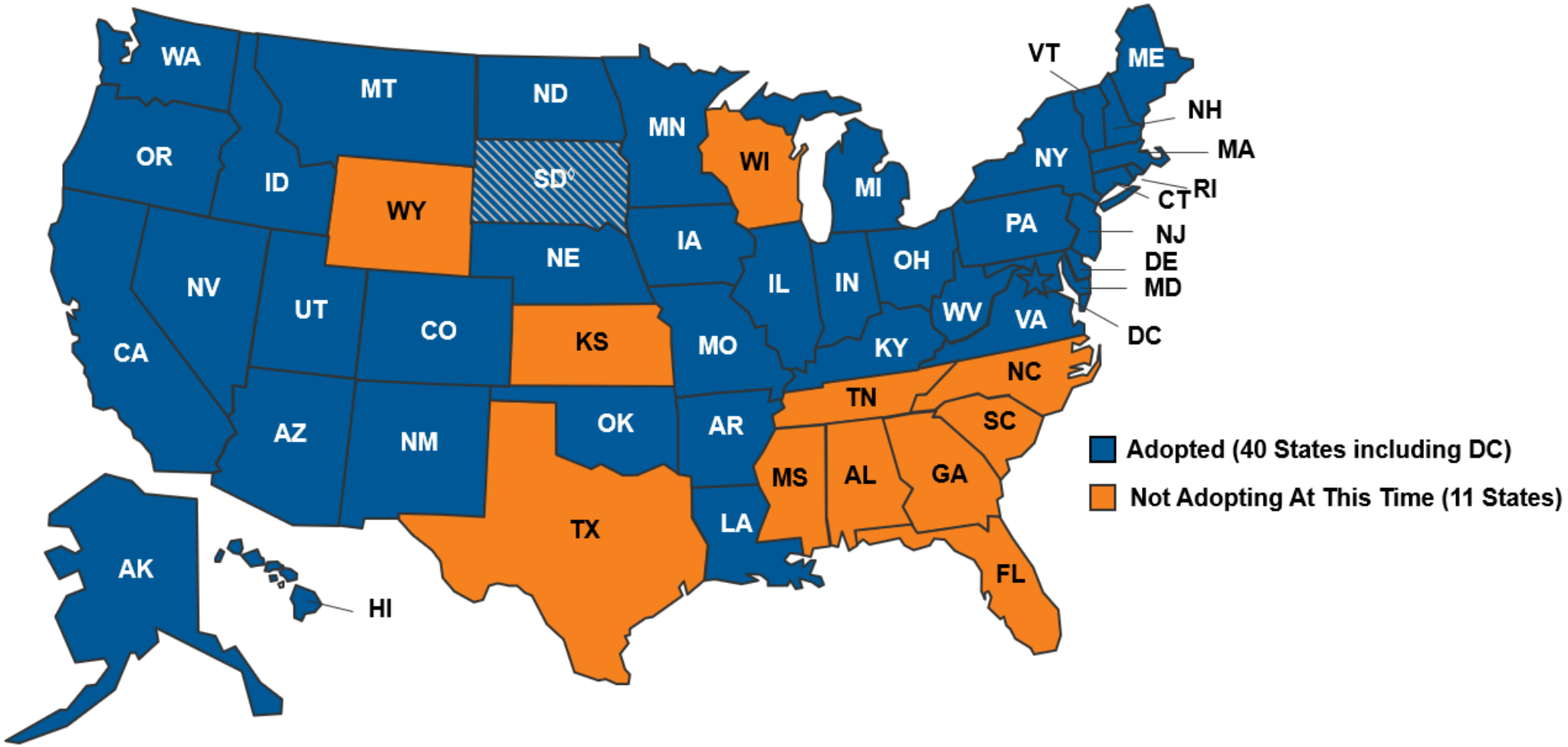
Optional Services

- Dental services
- Home and community-based care
- Physical Therapy
- Prosthetic devices
- Vision and eyeglasses

Affordable Care Act of 2010

- Under the Act, states have the opportunity to expand coverage to nearly all low-income Americans under the age of 65
- FPL extended to at least 133% for children in every state
- Option to expand eligibility to adults with income at or below 133% of FPL
  - 37 States have expanded
- States can choose to expand at anytime

Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KFF tracking and analysis of state activity. ◊Expansion is adopted but not yet implemented in SD. See link below for additional state-specific notes.

SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated February 16, 2023. https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

KFF

Enrollment Trends

Enrollment – As of June 2022

- 89.4 million people enrolled in Medicaid & CHIP
- 7.1 million enrolled in CHIP
- 40.8 children enrolled in CHIP or Medicaid program (45.6% of total Medicaid enrollment)
- Enrollment has increased 26.5% since February 2020 as a result of the Public Health Emergency

Enrollment

Figure 1. National Medicaid and CHIP enrollment, July 2019 to June 2020, CMS Performance Indicator Data

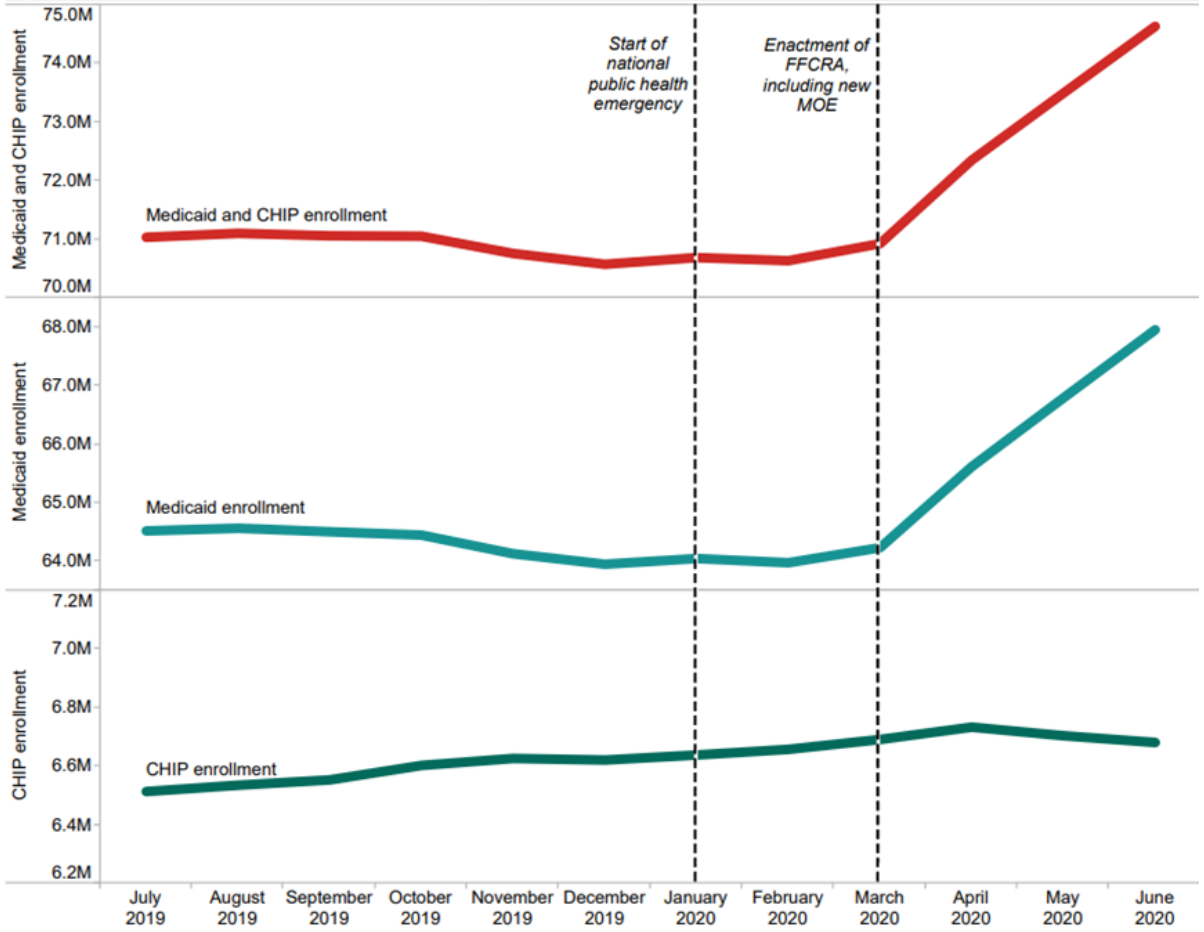
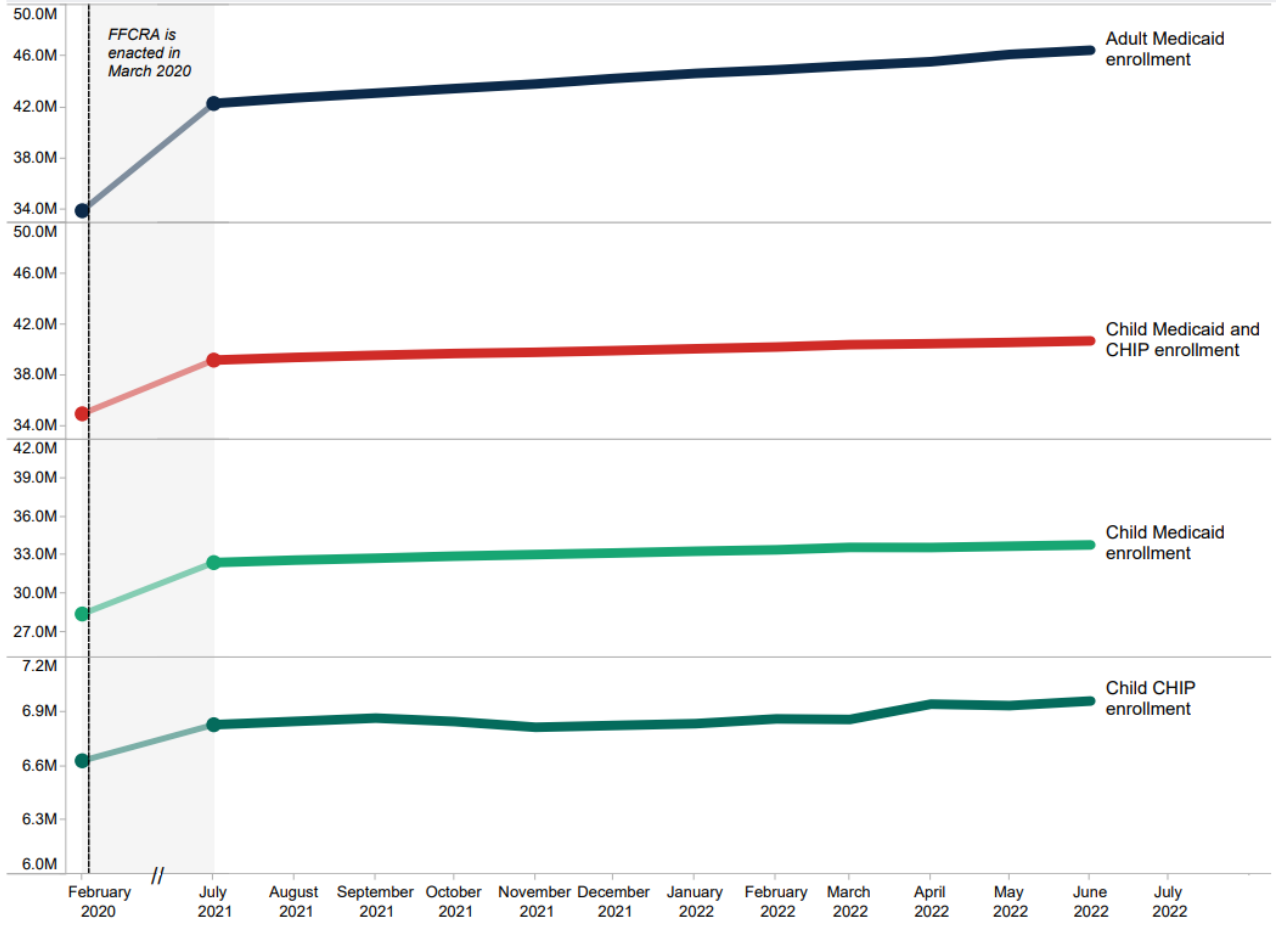


Figure 2. National adult and child enrollment in Medicaid and CHIP, February 2020 to June 2022, CMS Performance Indicator Data



Source: Medicaid and CHIP Eligibility and Enrollment Performance Indicator Data as of August 22, 2022.

Medicaid Redetermination

- Consolidated Appropriations Act, 2023 was enacted on December 29, 2022
- Ends the continuous enrollment condition on March 31, 2023
- States are beginning to develop timeline for the redetermination process
- Reimbursement impact

Reimbursement Methodologies

Medicaid Reimbursement

- Medicaid reimbursement varies by state
- Delivery Systems
  - Fee-for-Service
  - Managed Care
- Combination of both
- Medicaid payments have historically been below costs, resulting in shortfalls
  - Supplemental payments

Fee-For-Service

- Reimbursement to providers comes directly from Medicaid
- Each service receives a specific reimbursement in exchange for services provided
- Uses a fee schedule or base rate
- Cost based reimbursement – Medicaid cost reports
- Prospective Payment System
  - Diagnostic Related Groups (DRGs) - Inpatient
  - Enhanced Ambulatory Patient Grouping (EAPG) – Outpatient

Managed Care

- Health care delivery system organized to manage cost, utilization, and quality
- Provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and MCOs
- States pay a per-member per-month (capitation) rate to MCOs
- Actuarially sound
- Approximately 70% of Medicaid recipients are currently enrolled in managed care

Benefits of Managed Care

- Reduce program costs
- Better manage utilization of health services
- Improve health plan performance
- Improve health care quality
- Improve outcomes
- Providers negotiate contract with each MCO

Medicaid Funding

Medicaid programs are jointly funded through the federal and state government.

What is FMAP?

- The Federal Medical Assistance Percentage (FMAP) is used to calculate the amount of federal share of state Medicaid program expenditures.
  - Varies from state-to-state
  - Updated annually
- The FMAP formula is based on the ratio of the state per capita income to the national per capita income.
- Uses three most recent calendar years for which satisfactory data are available from the Department of Commerce, Bureau of Economic Analysis.
  - The lower the state's average per capita income, the more FMAP and vice versa.
  - All states receive at least 50% FMAP.

Enhanced FMAP

- January 31, 2020: Federal Department of Health and Human Services declared a Public Health Emergency (PHE).
- The CARES Act provides a **6.2 percentage point increase** in federal Medicaid matching funds to help states respond to the COVID-19 pandemic.
- Enhanced FMAP is effective January 1, 2020 through the end of the quarter in which the PHE ends.
  - Extended until April 1, 2023, gradually phasing down the increase until December 31, 2023
  - Amended conditions States must meet to claim
- State accepting the enhanced FMAP must provide continuous Medicaid eligibility through the end of the month in which the PHE ends.
  - Applies to people enrolled as of March 18, 2020, or who enroll at any time thereafter during the PHE.
- States may request to stop receiving the enhanced FMAP at any time without losing what they claimed previously.

State Share Funding

- General Revenue
- Intergovernmental Transfers (IGTs)
  - Transfer of funds from a governmental entity (other than Medicaid)
  - Counties, healthcare taxing districts, providers operated by state or local governments
  - Bona fide donation
- Certified Public Expenditures (CPEs)
  - CMS requires cost reimbursement methodologies for providers using CPEs to document actual cost of providing services
    - Statistical time studies, periodic cost reporting, and reconciliation of any interim payments
- Provider Fees/Tax/Assessment
  - Must be uniform and broad based to be allowable by CMS
  - 6% max of net patient revenue
  - Inpatient and outpatient assessment

Reimbursement Opportunities

- Optimizing Medicaid costs
- Amending Medicare Cost Reports
- Medicaid rate reviews
- Supplemental Payments

Medicaid Cost Calculation

- Per federal guidelines – providers can not be paid from Medicaid more than their cost for providing services to Medicaid and uninsured populations.
- Medicaid cost calculation
- How can we optimize Medicaid cost?
  - Medicare cost-to-charge ratios
  - Allocation of cost/charges to correct department

Supplemental Payments

Supplemental Payments

- Payments made to Medicaid providers in addition to the Medicaid reimbursement they received for services provided.
- The state share funding source is generally funded through non-general revenue funds.
- Authorized by the legislature either through statute or the General Appropriations Act and approved by the Centers for Medicare and Medicaid Services.
- Typically approved by CMS through 1115 Waivers or state plans.

Supplemental Payment Programs

- Disproportionate Share Hospital (DSH) Program
- Uncompensated Care Pools/Low Income Pool Program
- Charity Care Pools
- Upper Payment Limit
- Directed Payments Programs
- Graduate Medical Education
- Medicaid Enhanced Payments
- Ambulance Services Supplemental Payment Programs
- School Based Programs

Disproportionate Share Hospital (DSH) Program

- DSH was created under federal law to compensate hospitals that have provided a disproportionate share of Medicaid or charity care services.
- Federal law establishes an annual DSH allotment for each state that limits Federal Financial Participation (FFP) for payments made to hospitals.
- FFP is not available for state DSH payments that are more than the hospital's eligible uncompensated care cost.
- Uncompensated care cost – cost of providing inpatient and outpatient hospital services to Medicaid patients and the uninsured, minus payments received.
- $13.2 billion total allotment for FY 2022.

DSH Audit and Reporting Requirements

- States are required to submit an independent certified audit describing DSH payments made to each DSH hospital.
- Any payments in excess of uncompensated care must be returned to the state.
- States have option to redistribute or return to CMS.
- Myers & Stauffer conducts most audits in the country.

Consolidated Appropriations Act, 2021

- Creates new supplemental payment reporting requirements for states
- Changes the calculation of hospital specific DSH limits, effective October 1, 2021
- Eliminates reduction in FY 2021
- Also delays remaining 4 years of cuts until FY 2024

	FY 2021	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
Previous Reduction Amounts	$4 billion[2]	$8 billion	$8 billion	$8 billion	$8 billion	-	-
Modified Reduction Amounts	-	-	-	$8 billion	$8 billion	$8 billion	$8 billion

DSH Rule – Reinstatement of CMS FAQs 33 & 34

- On April 30, 2017, CMS issued a final rule, withdrawing FAQs 33 & 34 from the Medicaid DSH guidance that was issued in January 2010 titled "Additional Information on the DSH Reporting and Audit Requirements"
- Uncompensated costs include only those costs for Medicaid eligible individuals that remain after accounting for all payments received, including Medicare and other third-party payments.
- As of December 30, 2018, FAQs 33 and 34 are no longer operative.
- States had option to revise DSH audits to remove third party payments for services provided before June 2, 2017.
- August 13, 2019 final rule reinstated for services provided on or after June 2, 2017.
  - Third party payments will now be included in the calculation of uncompensated care (UC) costs.
  - This will reduce UC costs
- How will this effect your hospitals DSH limits?

Uncompensated Care Pools

- Allows states to draw down federal funds to pay hospitals for care provided to the uninsured and underinsured
- Approved through 1115 Medicaid Waivers
- Florida (Low Income Pool), Tennessee, Texas, California, Kansas, Massachusetts, New Mexico
- States have not expanded eligibility to low income adults
- Audit/reconciliation required to be submitted to CMS
- Payments in excess of uncompensated care costs will be recouped from hospital

Charity Care Updates

- HHS can continue to use S-10 to calculate uncompensated care payments
- Audits starting with FY 2017 cost reports
- Financial assistance/charity care/bad debt policies
- Are hospitals including all appropriate charity care patients?
  - Review and revise policies to maximize charity care claimed on S-10 as needed
- Impact on Medicaid supplemental payments in the future

Upper Payment Limit (UPL)

- Lump-sum payments that supplement low FFS base payment rates
- If base payments are below the UPL, states can make UPL supplemental payments to make up the difference
- Hospitals, nursing facilities, physicians, and other providers
- In the aggregate for a class of providers, FFS base payments and UPL payments cannot exceed a reasonable estimate of what providers would have been paid according to Medicare payment principles
  - Classes of providers are based on ownership
  - States do not use actual Medicare payment rates when calculating the UPL
  - Some providers can receive UPL payments that exceed what Medicare would have paid as long as total payments for each class of providers are below the UPL in the aggregate

UPL Demonstration Requirements

- In 2013, CMS issued guidance requiring states to demonstrate compliance with UPL requirements annually
- States submit hospital-specific data to CMS in a standard format
  - Medicaid FFS base and supplemental payments
  - Estimates of what would have been paid according to Medicare payment principles
  - Some hospitals paid on a cost basis, such as critical access hospitals, are not included

Graduate Medical Education

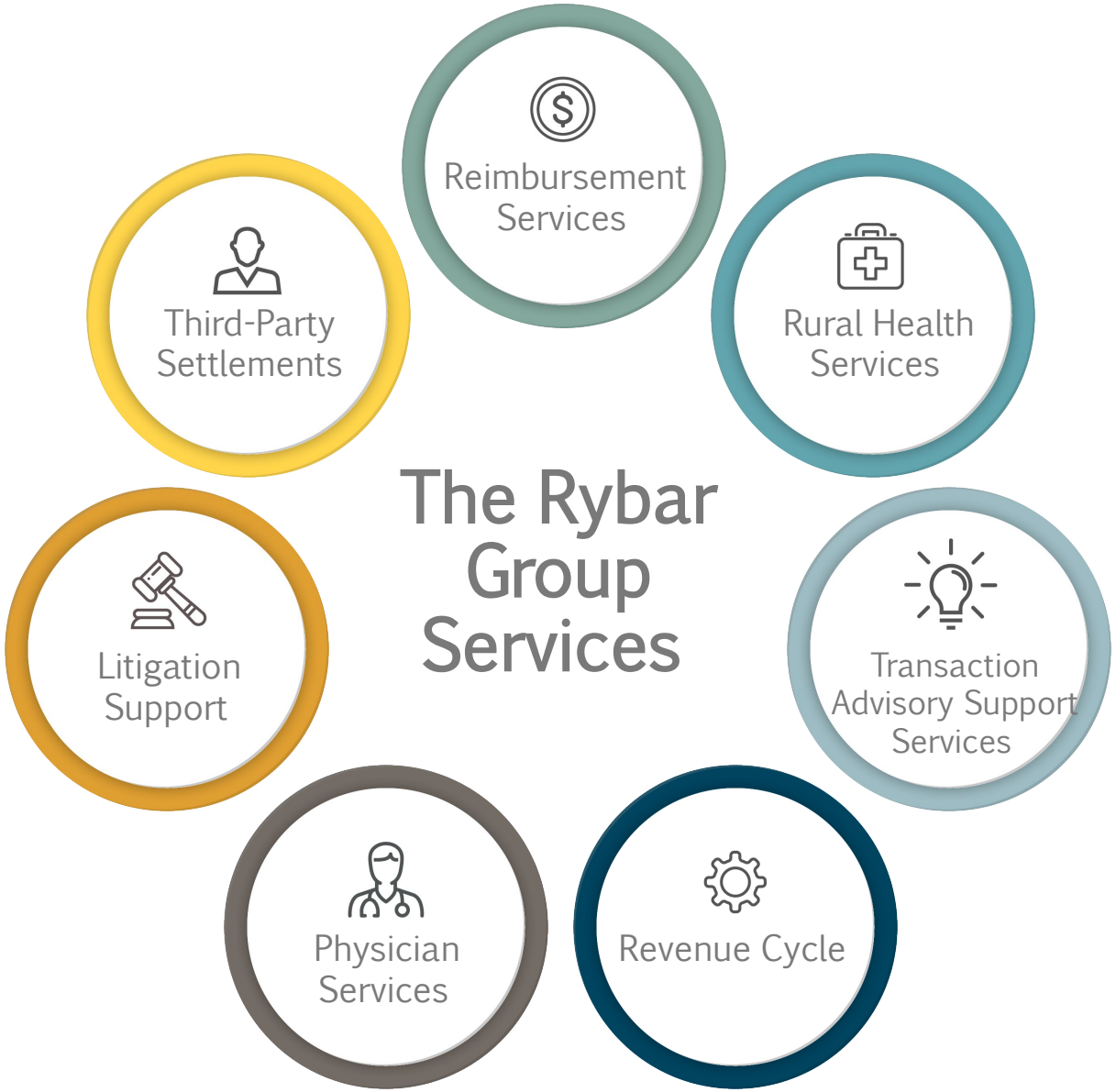
- Medicaid provides the second-largest source of GME funds
- States follow broad federal rules to receive federal matching funds
- States have flexibility to design and administering their own programs
- Payments can be made through fee-for-service, managed care, or both
- Direct and Indirect Programs

Directed Payments Programs

- Additional per-member-per-month (PMPM) made through MCOs
- PMPM based on Medicaid utilization
- Approved by CMS through 438.6(c) Pre-prints
- Actuarially sound
- Requires providers to submit quality metrics to State to substantiate additional payments
- Hospitals, physician groups
- States can also implement additional payments for FFS delivery system using Average Commercial Rate

Questions?

Dedicated to ensuring that your facility receives and retains the optimal reimbursement and appropriate supplemental Medicaid payments.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