

We Make Healthcare Reimbursement Easy



Medicaid 101: Program Basics and Reimbursement Opportunities

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With You Today

Brooke Yowell Medicaid Reimbursement Manager

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.



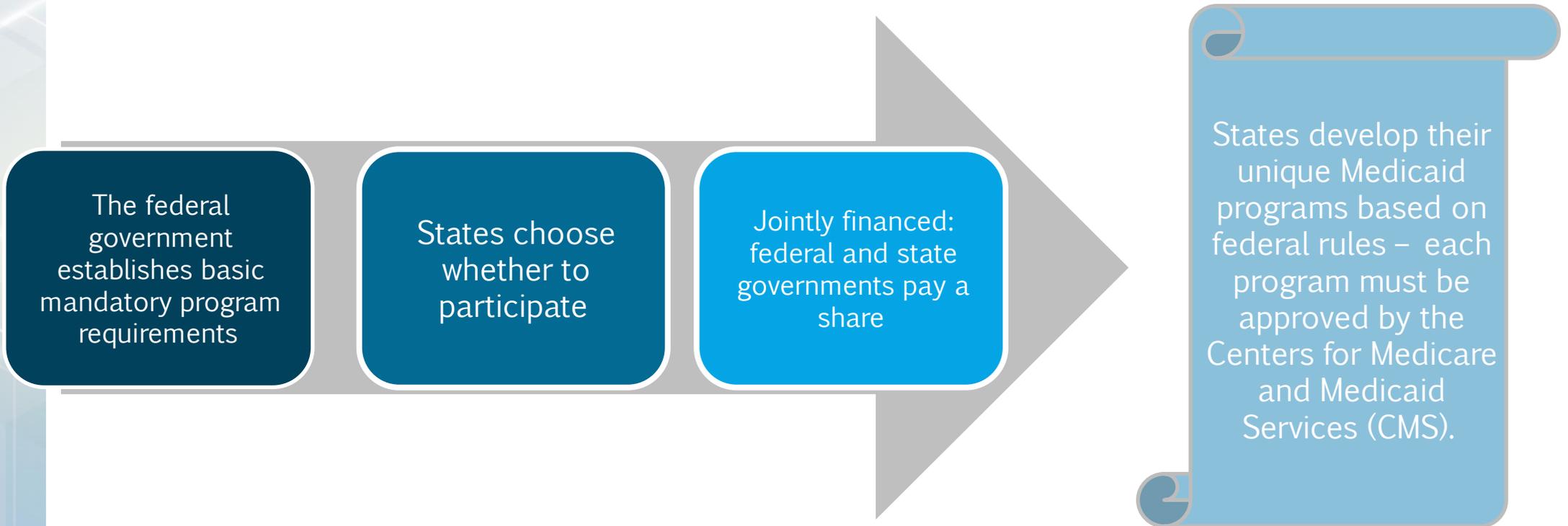
Today's Talking Points



- Overview of Medicaid
- Medicaid Reimbursement
- Fee-For-Service and Managed Care
- FMAP
- State Share Funding
- Medicaid Supplemental Payments
- Disproportionate Share Hospital (DSH) Program
- Uncompensated Care Pools
- Charity Care Updates
- Upper Payment Limits
- Graduate Medical Education
- Directed Payments

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.



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

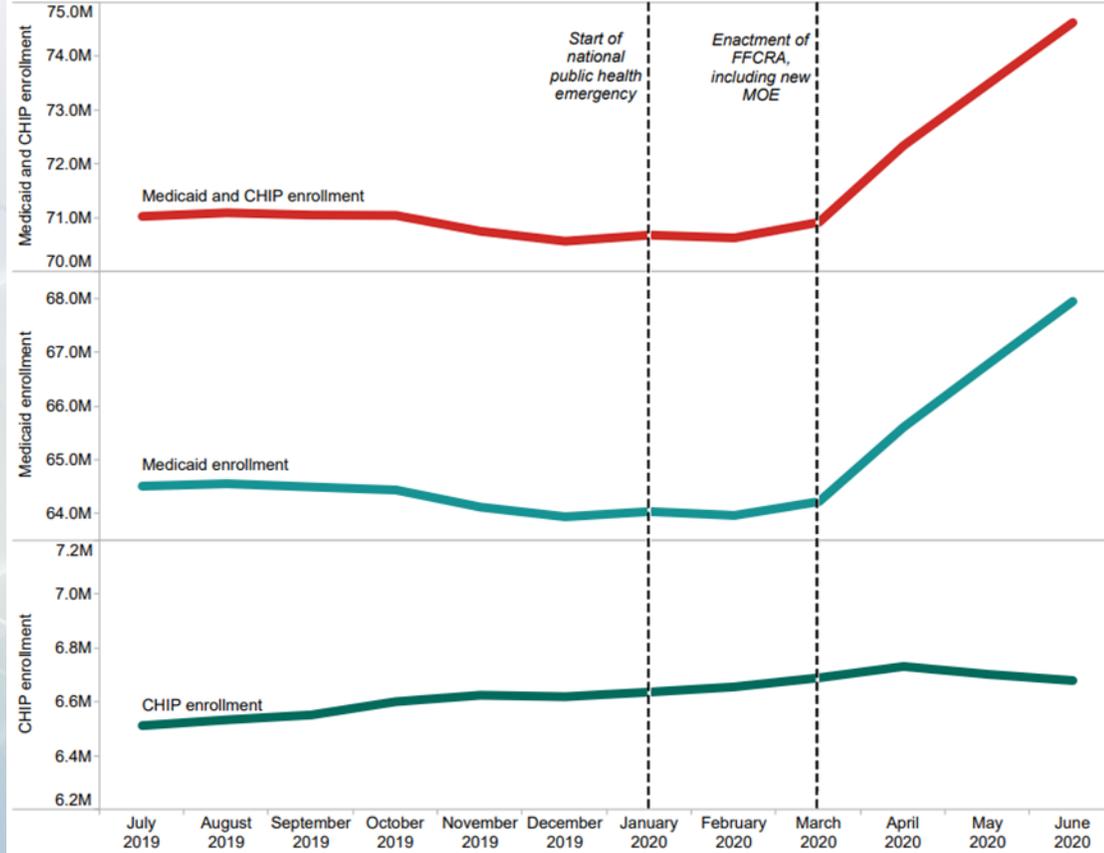
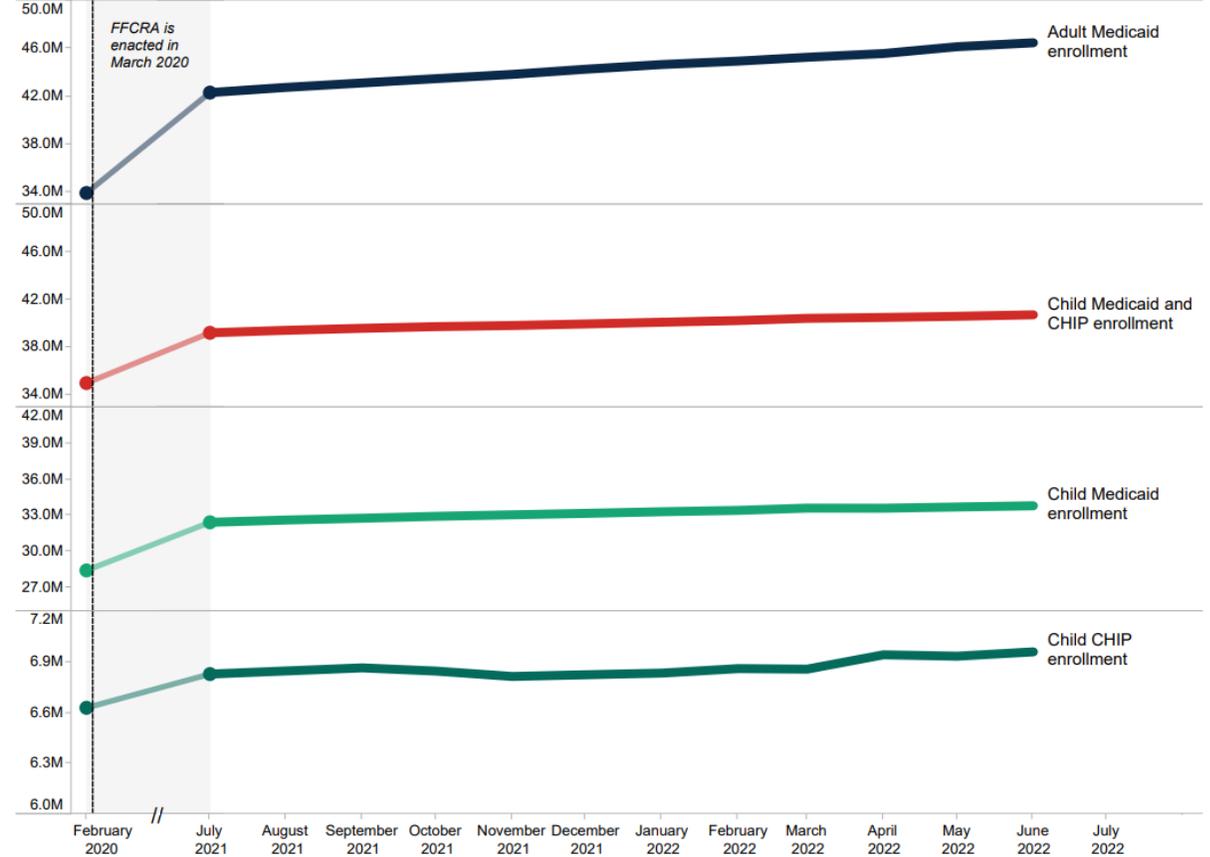


Figure 2. National adult and child enrollment in Medicaid and CHIP, February 2020 to June 2022, CMS Performance Indicator Data



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

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)



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
- Build Back Better – How does this effect states who have not expanded Medicaid?

Reimbursement

- Medicaid reimbursement varies by state
- Fee-for-service delivery system
 - Cost-based vs Prospective Payment System (PPS)
- Managed Care Delivery System
- 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



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.
- 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

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
- Upper Payment Limits
- Directed Payments Programs (Pass-through Payments)
- Graduate Medical Education
- Medicaid Enhanced Payments
- Emergency Medical Transportation 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.

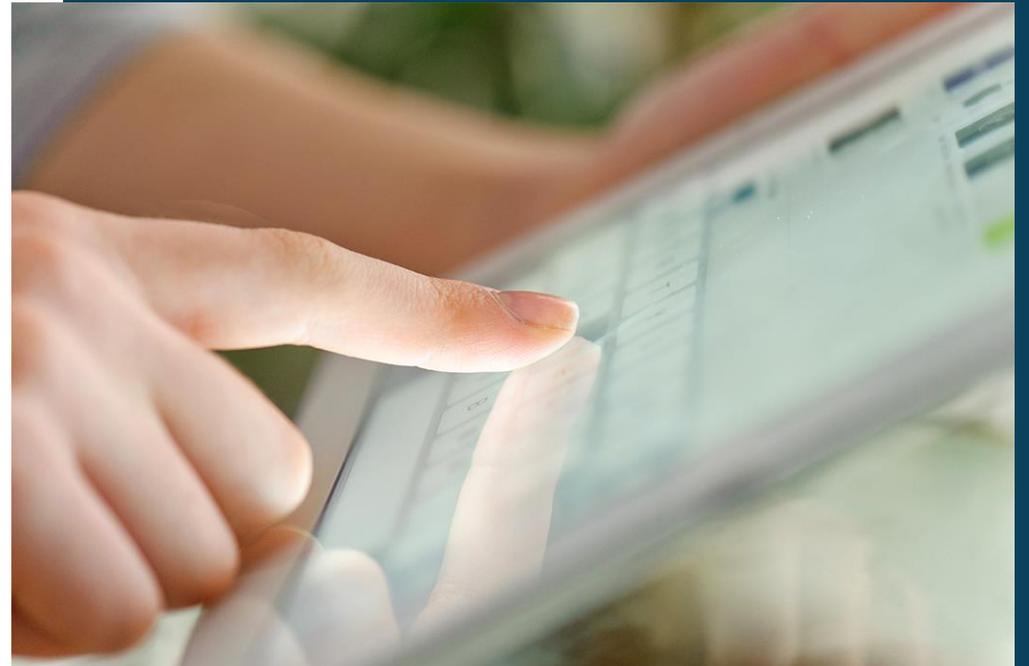
DSH Examination

- Myers & Stauffer's DSH Examination
- The State/Myers & Stauffer will send out examination letters to each provider required to submit examination surveys.
- Surveys due 30-45 days after letters are sent out.



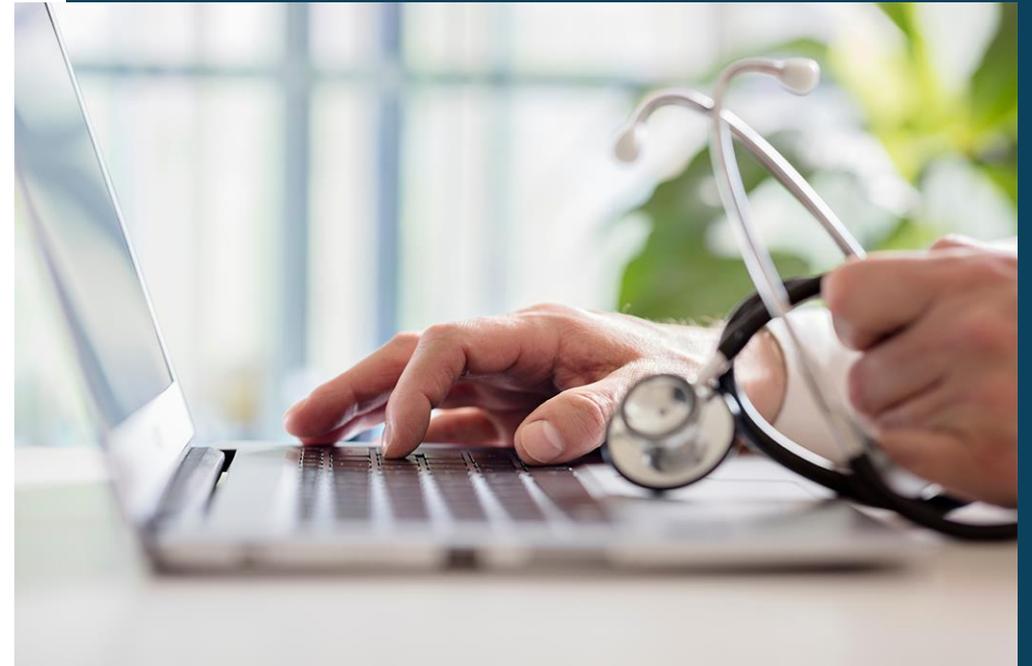
DSH Examination Surveys

- Hospitals will need to complete two surveys
- Completed using Medicare cost report and internal hospital data
- Survey part I
- Survey part II



Survey Part I

- Basic hospital information
- Cost report year
- OB Qualifying Questions
- Other Medicaid payments received
- Certification/signature page
- Checklist of required submission documents



Survey Part II

- Sections D-L
- MIUR/LIUR Calculation
- Myers & Stauffer will prepopulate the data for schedule G using your most recently filed Medicare Cost Report
 - Uses HCRIS data
 - Did you have an amended cost report?
 - Review data to ensure they are using the correct data
 - Data from Exhibits A-C will be used to complete portion of the survey
- Data from Exhibits A-C will be used to complete sections H-K

Survey Part II – Schedule H & I

Totals / Payments												
128	Total Charges (includes organ acquisition from Section J)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%
129	Total Charges per PS&R or Exhibit Detail	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
130	Unreconciled Charges (Explain Variance)	-	-	-	-	-	-	-	-	-	-	
131	Total Calculated Cost (includes organ acquisition from Section J)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	0.00%
132	Total Medicaid Paid Amount (excludes TPL, Co-Pay and Spend-Down)										\$ -	\$ -
133	Total Medicaid Managed Care Paid Amount (excludes TPL, Co-Pay and Spend-Down) (See Note E)										\$ -	\$ -
134	Private Insurance (including primary and third party liability)										\$ -	\$ -
135	Self-Pay (including Co-Pay and Spend-Down)										\$ -	\$ -
136	Total Allowed Amount from Medicaid PS&R or RA Detail (All Payments)	\$ -	\$ -	\$ -	\$ -						\$ -	\$ -
137	Medicaid Cost Settlement Payments (See Note B)										\$ -	\$ -
138	Other Medicaid Payments Reported on Cost Report Year (See Note C)										\$ -	\$ -
139	Medicare Traditional (non-HMO) Paid Amount (excludes coinsurance/deductibles)										\$ -	\$ -
140	Medicare Managed Care (HMO) Paid Amount (excludes coinsurance/deductibles)										\$ -	\$ -
141	Medicare Cross-Over Bad Debt Payments										\$ -	\$ -
142	Other Medicare Cross-Over Payments (See Note D)										\$ -	\$ -
143	Payment from Hospital Uninsured During Cost Report Year (Cash Basis)										\$ -	\$ -
144	Section 1011 Payment Related to Inpatient Hospital Services NOT Included in Exhibits B & B-1 (from Section E)										\$ -	\$ -
145	Calculated Payment Shortfall / (Longfall) (PRIOR TO SUPPLEMENTAL PAYMENTS AND DSH)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
146	Calculated Payments as a Percentage of Cost	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
147	Total Medicare Days from W/S S-3 of the Cost Report Excluding Swing-Bed (C/R, W/S S-3, Pt. I, Col. 6, Sum of Lns. 2, 3, 4, 14, 16, 17, 18 less lines 5 & 6)										4,514	
148	Percent of cross-over days to total Medicare days from the cost report										0%	

ERROR! No other eligibles reported! See certification statement on DSH Survey Part I.

- Note A - These amounts must agree to your inpatient and outpatient Medicaid paid claims summary. For Managed Care, Cross-Over data, and other eligibles, use the hospital's logs if PS&R summaries are not available (submit logs with survey).
- Note B - Medicaid cost settlement payments refer to payments made by Medicaid during a cost report settlement that are not reflected on the claims paid summary (RA summary or PS&R).
- Note C - Other Medicaid Payments such as Outliers and Non-Claim Specific payments. DSH payments should NOT be included. UPL payments made on a state fiscal year basis should be reported in Section C of the survey.
- Note D - Should include other Medicare cross-over payments not included in the paid claims data reported above. This includes payments paid based on the Medicare cost report settlement (e.g., Medicare Graduate Medical Education payments).
- Note E - Medicaid Managed Care payments should include all Medicaid Managed Care payments related to the services provided, including, but not limited to, incentive payments, bonus payments, capitation and sub-capitation payments.

DSH Exhibits

- The Exhibits will include patient-level detail
 - Some of this data will come from the state, and some will need to be pulled from internal hospital records
- Exhibit A – Uninsured
- Exhibit B – Cash Payments
- Exhibit C – Medicaid FFS, Medicaid MCO, Medicaid Other Eligible, Crossover, Out of State

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

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
- Typically reconciled to Medicare cost report (worksheet E-4)

Directed (Pass-Through) Payments

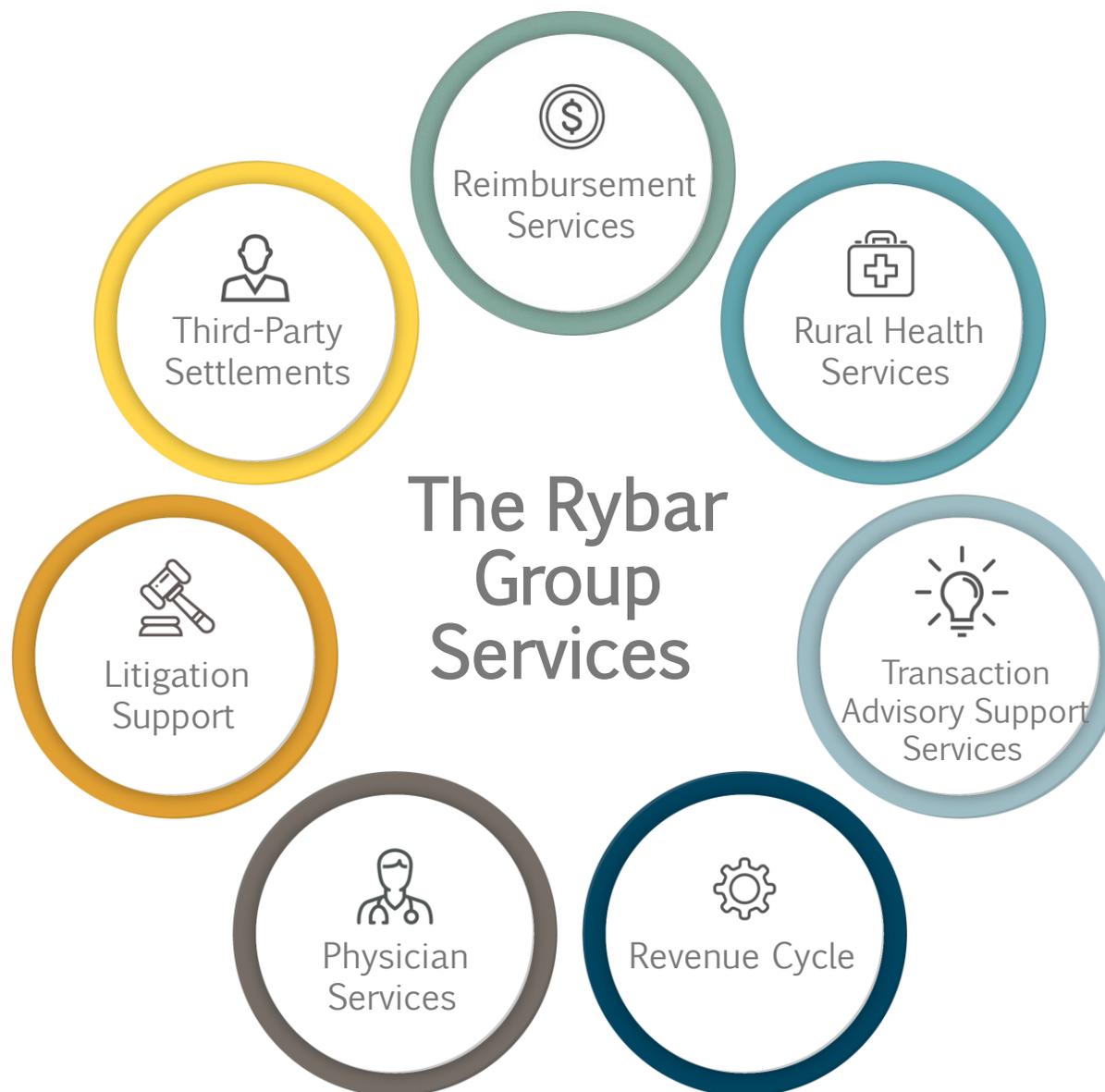
- Additional per-member-per-month (PMPM) made through MCOs
- PMPM based on Medicaid utilization
- Approved by CMS through 438.6(c) Pre-prints
- Actuarially sound
- Requires providers to submit quality metrics to State to substantiate additional payments
- Hospitals, physician groups
- States can also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

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Questions?

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





Contact Us

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