

Medicaid Handbook: Interface with Behavioral Health Services

Module 5

Structure and Reimbursement Methodologies

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Office of Policy, Planning, and Innovation, SAMHSA, 1 Choke Cherry Road, Rockville, MD 20857.

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Module 5: Structure and Reimbursement Methodologies

How a State's Medicaid Program Can Be Structured

A state can choose to operate its Medicaid program using a fee-for-service (FFS) framework, a managed care framework, or a combination of the two. FFS and managed care are service delivery structures, but they are also types of reimbursement arrangements. Thus, as described below, program architecture and reimbursement are intimately linked.

Fee for Service

Historically, states structured their Medicaid programs as FFS delivery systems. In this structure, a provider renders a service to a Medicaid consumer, submits a bill to the state Medicaid agency, and is paid a fee by the Medicaid agency for the provision of that service.

The FFS system is often regarded as rewarding quantity of services over quality, because its basic structure pays providers for each unit of service rendered, with a financial incentive to increase the number of units delivered. Before advocates and experts in health care delivery systems began to focus on the importance of care coordination and quality, FFS systems were the norm. Over the last few years, however, health care service delivery and payment system reformers have begun to move away from a system that operates strictly based on the number of tests and services provided.

Additionally, FFS systems are often criticized for an inability to adequately coordinate the care of high-risk consumers because consumers can go to any provider they choose. Conversely, Medicaid managed care and the other care coordination strategies discussed below are widely regarded as working to improve care management for Medicaid consumers. For these reasons, FFS is not currently the dominant delivery system for Medicaid services, although it remains a prevalent reimbursement methodology.

While serving fewer individuals in Medicaid systems, for many states FFS systems remain important for more complex or vulnerable populations—for whom care is often more expensive. This is precisely because of the advantages of a FFS arrangement; FFS reimbursement is the most accurate with regard to the type and amount of service rendered to an individual, and it provides no barrier or disincentive for the provider to render needed care.

Managed Care: Arrangements

Under managed care, a state contracts with an organization to provide services to Medicaid consumers through a defined network of providers.

There are three types of Medicaid managed care arrangements:

1. **Primary care case management (PCCM) programs.** PCCM programs build on the Medicaid FFS system but are considered a form of managed care. Under a PCCM program, the state contracts with primary care providers (PCPs) that agree to provide case management services to Medicaid enrollees assigned to them, including

coordination and monitoring of primary health care.¹ This approach has the benefit of the coordination provided by the PCP without the downside associated with managed care risk.

As in risk-based managed care whereby the state develops standards for managed care organizations (MCOs), states set specific requirements for PCPs participating in a PCCM. The requirements for the PCPs may include provision of specified primary care services, minimum hours of operation, specific credentials or training, and responsibility for referrals to specialists.

PCPs are usually paid a monthly fee to provide case management, and they are also paid on a FFS basis for the other health care services they provide. PCPs are usually physicians, physician group practices, or clinics (such as federally qualified health centers [FQHCs]), but a state may also recognize nurse practitioners, nurse midwives, and physician assistants as PCPs. The state Medicaid agency provides or contracts for the administration of the PCCM, including network development, credentialing, and quality monitoring. The state usually assumes full financial risk for the utilization of health care services.²

2. **Risk-based MCOs or health plans.** Under this structure, the state contracts with MCOs to provide a defined package of benefits to enrolled Medicaid consumers. The state pays the MCO a set per-member, per-month (PMPM) fee. This fee is known as *capitation* or a *capitated rate*. It means that the MCO receives the same amount of money for each of its enrollees, regardless of each consumer's service utilization and related cost to the MCO. In this arrangement, the MCO is said to be financially *at risk*.

The MCO is responsible for coordinating the care of its enrollees and must manage the cost of care and all administrative expenses within the capitated amount reimbursed by the state. The financial incentives put a premium on providing preventive or primary care to reduce the use of more expensive services, although some argue that capitated arrangements provide an incentive to deny needed care. Medicaid MCOs may be commercial health maintenance organizations (HMOs) that also serve people with employer-sponsored insurance, or they may be Medicaid-only plans with no commercially insured members.¹

State Medicaid authorities develop their own standards of participation for MCOs, which usually include specified protocols for enrollment and member support, requirements to ensure adequate access to care, benchmarks for quality and quality improvement, and data collection requirements.¹ Section 1932(c) of the Social Security Act requires states operating Medicaid managed care programs to contract with an external quality review organization to ensure compliance with Medicaid managed care standards and state contracts, thereby monitoring the quality of services provided to managed care enrollees.

In addition to programmatic, clinical, and other requirements developed by state Medicaid programs, most state insurance regulations also govern Medicaid MCOs.

This requires the state Medicaid authority and insurance regulators to communicate to prevent duplicative regulations and to react in the event that quality or financial problems with a health plan arise.

3. **Noncomprehensive prepaid health plans (PHPs).** States contract with PHPs on a risk basis to provide either comprehensive or noncomprehensive benefits to enrollees.¹ Federal regulations that govern Medicaid managed care refer to MCOs as a comprehensive type of PHP and identify two types of noncomprehensive PHPs: prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs).³

A PIHP provides, arranges for, or otherwise has responsibility for a defined set of services that include some type of inpatient hospital or institutional service, such as inpatient behavioral health care.²

A PAHP provides, arranges for, or otherwise has responsibility for some type of outpatient care only.²

Common types of noncomprehensive PHPs provide only behavioral health services or only dental services. In many instances, these are *carved out* of the benefit package provided by MCOs.

Today, 23 million people—about 40 percent of the Medicaid population—are enrolled in MCOs and another 13 million, or 22 percent are enrolled in PCCMs.⁴ As of October 2010, only three states (Alaska, New Hampshire, and Wyoming) reported that they did not have *any* Medicaid managed care.⁵

Choosing to Carve Behavioral Health In or Out

A state may choose to “carve out,” meaning that it contracts with a specialty MCO for management of its Medicaid behavioral health benefit. A state might choose this option for the expert knowledge the organization has in providing specialized services.

The creation of separate benefits for physical and behavioral health care reflects a desire to manage the behavioral health benefit within different limits and in different ways from medical/surgical benefits. Some would suggest that the *separateness* has become an impediment to the desired goals of greater access, incentivizing cost effective alternatives, and innovation. As states continue to review their decisions related to the use of managed care for those with specialty needs and the goal of improving integration they will, by necessity, be compelled to reconsider the structural use of carve outs.

Ohio is an example of a state with behavioral health services carved out of its managed care program. Ohio’s Medicaid program uses mandatory risk-based managed care structure as the foundation for physical health care. Publicly funded mental or substance use disorder (M/SUD) treatment services are provided through a *carve out* administered through the Ohio Department of Mental Health and Addiction Services. Although services are coordinated with the managed care plans, the plans are not *at risk* for behavioral health services.

In a research study conducted by the BEST Center, BEST used Ohio Medicaid claims data to identify adults with serious mental illness (SMI). Several findings shed light on the dynamic of a carved out behavioral health system, specifically with regard to adults with SMI—

- Approximately 29 percent of adults with SMI do not receive services in the carved out, specialty behavioral health system
- Adults with adjustment disorder or substance use disorders were mostly—approximately 56 percent—served in the carved out system
- The majority of adults with schizophrenia and bipolar disorder receive services from both systems—65 percent and 56 percent, respectively⁶

In any consideration of how to integrate physical and behavioral health services, the issue of carving in or carving out will arise. There is no one right way to address this issue, but there is a growing body of information about financial, structural, and clinical practice to improve integration. The goal is for individuals to experience care and communication with their providers in a seamless fashion. Although there are a number of ways to approach it, there should be alignment in the financing, structural relationships, and infrastructure.

Some carved out models have been customized to support clinical integration efforts, whereas some carved in models have had the effect of reducing overall levels of behavioral health spending and services. In all aspects related to integration and the associated structural considerations, details are critical.

Managed Care: Authorities

States can implement managed care under several types of federal authorities, all of which give them the flexibility to waive Medicaid principles outlined in §1902 of the Social Security Act—

- **Statewide**ness. Waiving statewide
- ness lets states implement a managed care delivery system in specific areas of the state (generally counties or parishes) rather than the whole state.
- **Comparability of Services**. Waiving comparability of services lets states provide different benefits to people enrolled in a managed care delivery system.
- **Freedom of Choice**. Waiving freedom of choice lets states require individuals to receive their Medicaid services from a managed care plan or primary care provider. Using this authority allows the managed care plan to specify requirements to be included in their panel of providers.⁷

When deciding the authority under which it should design its managed care program, a state should formulate goals and consider the policy options afforded by each authority that may best accomplish the identified objectives. For example, states should contemplate the following:

- **Geography**. Some of the authorities described below permit a state to limit statewide
- ness. Choosing an authority that allows for this option is necessary for a state that wants to target its managed care program to a certain region(s).
- **Population**. Some of the authorities below permit a state to offer its managed care program to all consumers or to select populations. Choosing an authority that allows

for this option is necessary for a state that wants to target its managed care program to a population based on age, eligibility category, disability, etc.

- **Voluntary or Mandatory Implementation.** Some of the authorities below permit a state to establish its managed care program as mandatory for populations that are not specifically precluded from mandatory enrollment; others allow a state to offer its managed care program as voluntary for those eligible individuals who choose to enroll.
- **Network of Service Providers.** Some of the authorities below permit a state to limit freedom of choice of provider. Choosing an authority that allows for this is necessary for a state that wants to let managed care plans restrict or tailor the network of providers with which it contracts. A state wishing to limit the provider network has significant flexibility in deciding the degree of limitation that it includes in its contract. For example, a state may very specifically describe network criteria—including provider types and minimum provider requirements—or it may give little specificity regarding the types and number of providers that a network must include.
- **Choice of Managed Care Plans.** Some of the authorities below permit a state to selectively contract with managed care plans, thereby limiting the consumer's choice of plans.

Section 1932(a) State Plan Option

States can establish a managed care delivery system by getting Centers for Medicare & Medicaid Services (CMS) approval to include it in the Medicaid State Plan. The state indicates on the preprinted State Plan pages the types of entities it will use and what groups of people will be enrolled. Section 1932(a) State Plan managed care and §1915(b) waiver managed care—described below—are the two most common types of managed care arrangements that states employ.

Section 1932(a) State Plan Medicaid managed care authority does the following—

- Allows the state to implement a voluntary or mandatory managed care program
- Allows the state to offer managed care statewide or limit the program by geography
- Allows the state to offer the program to all consumers or select populations
- Requires that managed care enrollment be voluntary for certain children with special needs, those dually eligible for Medicaid and Medicare, and Native Americans
- Allows the state to selectively contract with plans as long as there is a choice of two plans in rural areas⁸
- Allows the state to selectively contract with providers

CMS currently reports that 21 states are operating 28 managed care programs using §1932(a) State Plan authority.⁷

Example: Ohio

- Mandatory statewide managed care for certain populations
- State divided into regions
- Choice of at least two plans in all regions

Section 1915(a) Voluntary Contracting

States can implement a voluntary managed care program under §1915(a) of the Social Security Act simply by executing a contract with plans that the state has procured using a competitive bidding process and by getting CMS approval. This arrangement does not require a waiver or inclusion in the State Plan. This authority cannot be used to implement a mandatory managed care arrangement.

Section 1915(a) managed care authority does the following—

- Allows the state to offer managed care statewide or limit the program by geography
- Allows the state to offer a unique benefit package to specific populations
- Prohibits the state from selectively contracting with plans

CMS currently reports that 13 states (and Puerto Rico) use §1915(a) contracts to administer 24 voluntary managed care programs.⁷

Example: Minnesota (Special Needs Basic Care)

- Special Needs Basic Care is a voluntary managed care program for individuals aged 18 through 64 years, who are certified as disabled through the Social Security Administration or the state Medical review team or who have a developmental disability.
- Enrollees may have a care coordinator or navigator to help them obtain health care and support services.
- Plans coordinate with other payers, including Medicare.
- Beginning in 2012, people with disabilities who are younger than age 65 and who have FFS coverage will be asked to enroll in a special needs basic care health plan for their health care.
- Some populations may be excluded.
- Anyone can choose not to enroll and to stay in the FFS plan.⁹

Example: New York (Managed Long-Term Care Plans)

- Managed long-term care plans provide long-term care services (e.g., home health, adult day care, and nursing home care) and ancillary and ambulatory services (e.g., dentistry, optometry, eyeglasses, and medical equipment) and receive Medicaid payment only.
- Members continue to receive Medicaid and Medicare to obtain services from their PCPs and inpatient hospital services—the managed long-term care plan does not control or provide any Medicare services, and it does not control or provide most primary Medicaid care.
- Members must be eligible for nursing home admission.
- Although several plans in New York state enroll younger members, most managed long-term care plan enrollees must be at least 65 years old.¹⁰

Example: Wisconsin (Children Come First and Wraparound Milwaukee)

- Wisconsin has two multiagency, community-based programs for M/SUD services for children with serious emotional disturbance (SED).

- The goals of these programs are to keep children with SEDs out of institutions and to reallocate resources previously used for institutionalization to community-based services.
- To be eligible, a child or adolescent must be a Medicaid recipient, have SEDs, and be at imminent risk of institutional admission to a psychiatric hospital, child caring institution, or juvenile correction facility.¹¹

Section 1915(b) Waiver

States can use waiver authority under §1915(b) of the Social Security Act to create a mandatory managed care program. Section 1915(b) waiver managed care authority does the following:

- Allows the state to require enrollment of Medicare-Medicaid enrollees and other aged, blind, or disabled (ABD) populations through §1915(b)(1) authority
- Allows the state to offer managed care statewide or limit the program by geography
- Allows a state to selectively contract with providers under §1915(b)(4) authority
- Prohibits a state from impairing access to medically necessary services.⁷

The state can choose to use the §1915(b) managed care authority under one or more subsections of §1915(b).

- **§1915(b)(1).** The state requires enrollees to obtain medical care through a PCCM system or specialty physician services arrangements. This includes mandatory capitated programs.
- **§1915(b)(2).** A locality will act as a central broker (i.e., agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs, PIHPs, or PAHPs in order to provide enrollees with more information about the range of health care options that are available to them.
- **§1915(b)(3).** The state will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver.

Section 1915(b)(3) offers states the opportunity to provide additional services to waiver enrollees that are paid through savings achieved under the waiver. In order to offer additional services under §1915(b)(3), the §1915(b)(3) authority must be concurrent with the §1915(b)(1) or §1915(b)(4) authority. If a state uses the §1915(b)(3) authority, the managed care program must be cost effective and must demonstrate that it will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services.

- **§1915(b)(4).** The state requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards that are consistent with access, quality, and efficient and economic provision of covered care and services.

If it chooses to use §1915(b)(4) authority, the state must choose one of the following managed care programs: PIHP, PAHP, MCO, PCCM.¹²

CMS currently reports that there are 48 approved §1915(b) waivers operating in 28 different states.⁷

Example: California (Medi-Cal Specialty Mental Health Services)

- Coverage for specialty mental health services is provided through Mental Health Plans (MHPs) in California’s 58 counties. In most cases, the MHP is the county mental health department. MHPs render or authorize and pay for specialty mental health services.
- Medi-Cal recipients are enrolled automatically in the MHP serving their county. The MHP in the recipient’s assigned county is responsible for providing MHP-covered services for eligible recipients in that county.
- Medi-Cal beneficiaries who have a mental disorder or a treatment need that requires the services of a mental health specialist are entitled to services from the MHP.¹³

Section 1915(b)/(c) Waiver

Section 1915(b)/(c) waiver authority is used to implement a mandatory managed care program that includes home and community-based waiver services in a managed care arrangement. The §1915(b) authority is used to mandate enrollment in managed care and to limit freedom of choice and/or create selective contracts. The §1915(c) authority is used to target eligibility and provide home and community-based services (HCBS).

Section 1915(b)/(c) managed care authority does the following—

- Allows the state to selectively contract with providers
- Requires the state to apply for each waiver authority separately and concurrently
- Requires cost effectiveness for §1915(b) and cost neutrality for §1915(c)
- Allows the state to add non-State Plan HCBS in the capitation rate under the §1915(c) waiver authority or in the §1915(b) waiver as §1915(b)(3) services
- Allows the state to use §1915(b) authority to use a limited pool of providers

Example: North Carolina (Innovations waiver and Mental Health, Developmental Disabilities, and Substance Abuse Services Health Plan waiver)

- Local management entities (LMEs) operate as PIHPs to coordinate the provision of specialty services, including mental health, developmental disability, and substance use services to certain mandated populations.
- LMEs contract for services with provider agencies.
- The LMEs assume financial risk for a set of services and act as managed care entities; however, the state bears some of the financial risk because the state law limits the financial risk on counties.
- Historically, this capitated model operated as a pilot in five counties, but the state is expanding this model statewide.
- Consumers meeting eligibility requirements are mandatorily enrolled.¹⁴

Section 1115 Waiver

Under §1115 of the Social Security Act, states have broad waiver authority at the discretion of the Secretary of HHS to implement projects that test policy innovations that are likely to further the objectives of the Medicaid program. They can use this authority to structure managed care programs to suit the needs of their beneficiaries.

Example: Arizona (Arizona Health Care Cost Containment System)

- The Arizona Health Care Cost Containment System is inclusive of the Arizona Acute Care Program (AAP) and the Arizona Long-Term Care System (ALTC).
- Both of these programs contract with providers and MCOs to deliver services to Medicaid beneficiaries on a managed care basis.
- Behavioral health services are delivered separately through AAP and ALTC, and are provided by regional behavioral health authorities (RBHAs).
- The state also received federal Medicare-Medicaid enrollee program-planning grant dollars to implement a health home initiative. The initiative will make the RBHA in Maricopa County fully responsible for coordinated and integrated behavioral health care and physical health care for Medicaid-eligible adults with SMI.¹⁵

Example: Florida (Florida Medicaid Reform)

- Florida requires most Medicaid-eligible individuals in several counties to enroll in a managed care plan—either a capitated health plan or the FFS Provider Service Network plan.
- The state allows consumers to choose the plan that best suits their needs.
- It allows plans to offer customized benefit packages, but each plan must cover all mandatory services as outlined in federal law.
- The Florida Demonstration program also allows the establishment of an Enhanced Benefits Account (EBA). This program provides direct incentives to Florida Demonstration enrollees who participate in state-defined activities that promote healthy behaviors. Beneficiaries accumulate funds in their EBA and use them for approved, noncovered health-related needs such as over-the-counter medications. Individuals who leave the Medicaid program can retain use of any funds remaining in their EBA (for approved health-related uses) for up to 3 years, as long as their incomes remain at or below 200 percent of the federal poverty guidelines.
- Participation is mandatory for §1931 eligible persons and related groups and the ABD group, with some exceptions.¹⁶

In short, a state should evaluate the following policy interests in addition to considerations related to the authority under which it chooses to implement its managed care program—

- Degree of risk each party will tolerate
- Type and degree of care coordination desired
- Core benefits and additional or optional services to be included
- State and federal procurement requirements
- State insurance requirements
- Contractual issues

Reimbursement Methodologies

How Do States Set Reimbursement Rates for Services?

Before 1990, federal law required states to pay hospital, nursing home, and several other provider categories their *reasonable costs* or rates that were *reasonably cost-related*. Reimbursement for all other providers was to have been in compliance with the *Equal Access*

Provision described below. During this period, at least with respect to hospitals and nursing homes, CMS actively reviewed and approved changes to state Medicaid payment methodologies.¹⁷

In 1990, Congress enacted the *Boren Amendment*, which required rates for hospitals and nursing homes to be “reasonable and adequate.” It also required states to assure the federal government that their rates conformed with federal law. While the Boren Amendment was in effect, HHS construed its role to be extraordinarily minimal and, in essence, to simply ensure that states made certain advance findings before changing their Medicaid reimbursement rates. As a result, reimbursement rates for these classes of providers were predominantly the product of negotiation between the states and providers. When states attempted to change their rates to levels that provider groups considered inadequate, providers would challenge the methodology by bringing actions in federal and state courts or by using the Boren amendment standard to negotiate an acceptable alternative.¹⁷

As part of the Balanced Budget Act of 1997, Congress repealed the Boren Amendment, leaving the Equal Access Provision to govern the adequacy of reimbursement for all providers.

Today, states have significant latitude in deciding how to structure reimbursement methodologies for the Medicaid services they provide, as long as they are in compliance with the *Equal Access Provision* of §1902(a)(30)(A) of the Social Security Act. CMS regional offices (ROs), overseen by the central office (CO), are charged with reviewing and approving proposed payment methodologies in light of this federal statute and its associated regulations.

The Equal Access Provision of §1902(a)(30)(A) of the Act requires that payment standards:

- Guard against unnecessary utilization;
- Are consistent with efficiency, economy, and quality of care; and
- Are sufficient to enlist enough providers so that care and services are available to the same extent that care and services are available to others in the community.¹⁸

The Equal Access Provision ensures that state reimbursement methodologies provide Medicaid consumers with adequate access to health care services.

Because there is limited guidance in federal law or regulation pertaining to payment standards, federal case law largely fills in the gaps. The courts are split as to what §1902(a)(30)(A) actually requires—a process by which states ensure access to care (i.e., focus on process or procedure) or that services are accessible (i.e., focus on result). Examples are provided below.

- In *Methodist Hospitals v. Sullivan*, the Seventh Circuit Court of Appeals held that §1902(a)(30)(A) does not require states to conduct access studies before modifying their rates. Rather, the question for states to consider is whether the rate “elicited enough medical care.” This ruling squarely focused on access over procedural requirements.
- The Third Circuit reached a similar conclusion in *Rite Aid v. Houstoun*, holding that the Equal Access Provision dictates a result (adequate access), not a process. It further noted that §1902(a)(30)(A) does not specify a particular process for a state Medicaid agency to follow in establishing rates.

- The Ninth Circuit reached a different result in *Orthopaedic Hospital v. Belshe*, holding that §1902(a)(30)(A) requires that state payment rates “bear a reasonable relationship” to the cost of providing services, and that states cannot set rates without doing a cost study.¹⁹

The variability in interpretation, coupled with review standards applied differently by each CMS RO, often leads to unpredictability and does little to standardize the understanding of reimbursement methodologies.

Fee-for-Service Rates

As described above, in an FFS structure, a provider renders a service to a Medicaid consumer, submits a bill to the state Medicaid agency, and is paid a fee by the Medicaid agency for the provision of that service. States may develop FFS rates based on—

- The costs of providing the service
- A review of what commercial payers pay in the private market
- A percentage of what Medicare pays for equivalent services

Payment rates are often tied to inflationary factors like the Medicare Economic Index. States must describe reimbursement methodologies in their Medicaid State Plans.²⁰

Currently, FFS is not the predominant structure by which Medicaid programs are operated, although it is still a dominant reimbursement methodology. For example, managed care plans may negotiate their own reimbursement methods with network providers for services, but many utilize similar or, in some cases, identical FFS rates as the state’s Medicaid rates.

Medicaid Managed Care Rates and Capitation

Just as states have significant flexibility in determining FFS rate structures, the process by which they develop managed care rates may vary in a number of ways, including the type and time frames of data they use as the basis for setting rates and the approach they use to negotiate rates with health plans. States make capitation payments prospectively to Medicaid managed care plans to provide or arrange for services for their Medicaid enrollees.²¹ Managed care plan capitation rates are *risk-based*. This means that the managed care plan receives the same payment from the state for each of its enrollees every month, regardless of whether (and the extent to which) each enrollee actually receives services.

Because Congress was concerned that this system might create an incentive to deny access to care, they implemented several safeguards. One is the requirement that state capitation rates be *actuarially sound*.²² According to the Balanced Budget Act of 1997, actuarially sound rates are payments that are adequate to cover medical costs, administration, taxes, and fees.²³ In 2002, CMS issued regulations defining actuarially sound rates as those that are:

- Developed in accordance with generally accepted actuarial principles and practices;
- Appropriate for the populations to be covered and the services to be furnished; and
- Certified as meeting applicable regulatory requirements by qualified actuaries.²⁴

The regulations also require states to submit their rate-setting methodologies to CMS. Finally, they specify the documentation that states must submit to CMS ROs to demonstrate compliance with the requirements, including a description of their rate-setting methodology and the data used to set rates.²³ In 2003, CMS finalized a detailed checklist that its RO staff could use in their reviews of state rate settings. States and their actuaries also use the checklist when setting their rates. The items included in the CMS checklist illustrate the detailed type of information that the state must consider in setting managed care rates. For example—

- **Overview of Rate-Setting Methodology.** The state is required to provide documentation regarding the general rate-setting methodology, contract procurement, and the actuarial certification, including all of the following—
 - The rates and the time period for the rates
 - Description of risk-sharing mechanisms
 - A projection of expenditures
 - An explanation of rate setting
- **Base-Year Utilization and Cost Data.** The state is required to provide documentation and an assurance that all payment rates are:
 - Based only upon services covered under the state Medicaid Plan or costs related to providing these services, such as health plan administration; and
 - Provided under the contract to individuals eligible for Medicaid.
- **Adjustments to Base-Year Data.** The state is required to provide documentation of any adjustments to the base-year data, including the policy assumptions, size, and effect of the adjustments. Adjustments may include changes to the following—
 - Services covered
 - Administration
 - Medical service cost and trend inflation
 - Utilization
- **Rate Category Groupings.** The state is required to create rate cells that are specific to the enrolled population. Categories the state should normally consider in the establishment of rates include age, sex, locality or region, and eligibility. States may omit or combine categories.
- **Other.** The state is required to document their methodology in a number of other areas. For example:
 - Document that they have examined base year data for distortions—such as special populations with catastrophic costs—and adjusted rates in a cost-neutral manner
 - Document the use of reinsurance and other risk-sharing mechanisms
 - Explain any incentive arrangements in the contract.²⁵

The CHIP Reauthorization Act of 2009 (CHIPRA) required the General Accounting Office (GAO) to examine the extent to which state rates are actuarially sound. GAO's assessment concluded that CMS had been inconsistent in reviewing state rate settings for compliance with the actuarial soundness requirements. GAO specifically cited variation in CMS RO practices as a factor contributing to this inconsistency in oversight. For example, ROs varied in the extent to which they tracked state compliance with the actuarial soundness requirements, their interpretations of how extensive a review of a state's rate setting was needed, and their determinations regarding sufficient evidence for meeting the actuarial soundness requirements.

As a result of the study, CMS implemented practices to address some of the variation that contributed to inconsistent oversight.²⁵

Encounter Data

When states initially began to implement managed care programs, the reimbursement relied almost entirely on historical FFS data. As managed care expanded, there became less FFS data on which to rely. Most states use encounter claims data, which includes information related to the services provided by the Medicaid managed care program. Encounter claims data are the primary records of services for Medicaid managed care-enrolled consumers. Collecting data from encounter claims provides a basis for accurate managed care rate development and requires that fewer assumptions be made in the development of actuarially certified rates.²⁶ However, although encounter claims provide information about the types and volume of services, they do not necessarily provide any information about the cost of the services. To address this, some states utilize *pseudo billing* or *shadow billing* algorithms to provide a reflection of the estimated cost of providing services. As the managed care plan expands and matures, there is less FFS data and an increasing reliance on encounter data or other comparable commercial experience upon which to draw. CMS does not require that Medicaid managed care plans submit encounter information. The differences in information collected and reported for managed care services compared to FFS data present some challenges to getting a complete picture of cost and utilization at both the state and federal level.

Prospective Payment Rates

In most states, Medicaid reimbursement for inpatient and outpatient hospital services is not a retrospective, cost-based system; instead, it is a prospective payment system. These systems generally involve calculating per-case reimbursements, which are determined prospectively based on the patient's condition. Adjustments are made for certain categories of facilities or certain types of patients.²⁷ Under a prospective payment system, a provider receives a fixed payment to cover an episode of care during a period of time. The payment formulas are complex and have many adjustments to address everything from outliers or teaching-related costs to uncompensated care. The goal is to set the prospective payment based on what it costs an efficient provider to serve the patient.²⁸

Inpatient Hospital Prospective Payment System: Diagnosis-Related Groups

For inpatient hospital services, rates are often based on diagnosis-related groups (DRGs). DRGs classify patients according to diagnosis, complications, type of treatment, age, and other relevant criteria. Under the prospective payment system, hospitals are paid a set fee for the hospital or facility cost of treating patients in a single DRG, regardless of the actual cost of care for the individual.²⁹

Hospitals also may be paid an additional payment for covered inpatient hospital services that exceed certain thresholds established per DRG by the state. These *outlier payments* are intended to provide additional reimbursement for the provision of care that exceeds the anticipated regular cost or length of stay.

Outpatient Hospital Prospective Payment System

The outpatient prospective payment system is based on a fee schedule or cost-to-charge ratio. It sets payments for individual services using a set of relative weights, a conversion factor, and adjustments for geographic differences in input prices.³⁰

Bundled Payments

In the last few years—and embodied in the Affordable Care Act—the federal and state governments have been focused on increasing quality of care in conjunction with pursuing payment reform. The general idea is that the historical FFS system does not reward quality of care; instead, it focuses on more payment for more services.

One payment reform strategy is implementation of bundled payments. Bundled payments link payments for multiple services during an episode of care. For example, instead of a surgical procedure generating multiple claims from multiple providers, the whole team is reimbursed with a *bundled* payment. This method provides incentives to coordinate and deliver health care services more efficiently while improving quality of care.³¹ There is a continuum of payment bundling approaches; some even consider DRGs to be a limited form of bundling.

Currently, Medicaid and Medicare make separate payments to providers for a single illness or course of treatment, which results in little coordination across providers and health care settings. Payment is based on *how much* a provider does, rather than *how well* the provider treats the patient. Research has shown that bundled payments can align incentives for providers to partner closely across all specialties and settings to improve the consumer's experience during a hospital stay and following discharge.³¹

In an effort to test payment innovations, CMS is working with providers to develop models of bundled payments through the Bundled Payments initiative. In these models, CMS and providers will set a target payment amount for a defined episode of care. Applicants will propose the target price, which will be set by applying a discount to total costs for a similar episode of care as determined from historical data. Participants will be paid for their services under an FFS system, but at a negotiated discount. At the end of the episode, the total payments will be compared with the target price. Participating providers may share the gains resulting from the more efficient, redesigned payment model.³¹

Case Rates

A case rate is a reimbursement methodology in which a flat fee covers a defined group of procedures and services.³²

- An **evidence-informed case rate (ECR)** is a single, risk-adjusted payment to providers to care for patients who are diagnosed with a specific acute or chronic condition. The case rates are based on the resources required to provide health care in accordance with nationally accepted, evidence-based clinical guidelines.³³
- A **condition-specific case rate (CCR)** is an approach to bundling for outpatient care of chronically ill patients. A group of providers is paid a global fee to care for a patient with a chronic condition. The case rate covers the services needed during a defined period, such as a year. To the extent feasible, the case rate is all-inclusive,

covering all of the primary and preventive care, care management, patient education, and minor acute care services associated with the patient's chronic condition. Major acute care services, such as inpatient admissions, are paid separately.³³

Global Payments

A global payment is a patient-specific, prospective payment that is intended to cover the costs of care for all covered services delivered over a defined period (e.g., one year). Global payments are set based on an actuarial analysis, and they should be risk adjusted to recognize the variation in costs between patients with different health care conditions. Unlike ECRs and CCRs, global payments can be used for patients with no specific chronic or acute condition.³³

Individualized Budgets and Self-Directed Services

As discussed in Module 9, self-direction of Medicaid services is a model of service delivery that is an alternative to managed care or the traditional FFS system. Self-directed services can be provided under several Medicaid authorities, including §1915(c), §1915(i), §1915(j) and §1915(k) of the Social Security Act. Although each authority has slightly different requirements and guidelines, there are consistent principles.

From a reimbursement perspective, a unique feature of self-directed services is the use of individualized budgets. A budget is created based on an individualized plan of care in accordance with the needs and preferences of each individual. The plan is *costed out* using a method for calculating the dollar value that is specified by the state, and the budget is under the control and direction of the individual. Self-direction can include the hiring or employment of support staff. There is much evidence to demonstrate that when individuals direct their own services, their care can be provided more economically and with higher levels of satisfaction.³⁴

Reimbursement Methodology for Federally Qualified Health Centers

As discussed in Module 4, FQHCs serve a disproportionate number of uninsured and Medicaid-covered consumers. In recognition of health centers' status as important safety-net providers for these populations, the federal government provides grant funding to many health centers to support their efforts to treat the uninsured. The *Medicare, Medicaid, and State Children's Health Program (CHIP) Benefits Improvement and Protection Act of 2000 (BIPA)* established an all-inclusive (regardless of the medical prevention and/or treatment services rendered) Medicaid per-visit payment rate for health centers, using a prospective payment system methodology. The BIPA was created so that FQHCs receive adequate funding for the Medicaid-covered consumers they serve and so they are not forced to subsidize Medicaid losses with the grant funding they receive from the federal government for treatment of the uninsured.

This single all-inclusive rate guarantees health centers a minimum payment for services provided to Medicaid beneficiaries. The all-inclusive payment is specific to each health center and is calculated using an initial-year, per-visit rate based on the health center's reasonable cost per visit. The payment is capped at a maximum upper payment limit. It is adjusted annually for inflation and increases if there is growth in the center's scope of service.³⁵

Although the BIPA established the prospective payment system methodology for FQHCs, it does not require states to use it. States are allowed to select an alternative payment methodology—including reasonable cost reimbursement—as long as the methodology the state employs reimburses health centers at least what they would receive under the prospective payment system methodology, and as long as it is agreed to by the state and each health center.

With Medicaid managed care programs, health centers receive a *wrap-around* payment that is equal to the difference between the prospective payment system rate and the amount they receive under their contract with Medicaid managed care plans.³⁵ The intent of this supplemental payment is to ensure that the health center receives no less payment when it contracts with a managed care plan than it would receive if it was contracting directly with the state and being paid the full prospective payment system rate.

This reimbursement system is in return for the significant federal oversight with which the health centers comply and for their commitment to comprehensively serving uninsured consumers, including enabling services to assure access. This dynamic—described in §330 of the Federal PHS Act—is unique to health centers.

Some state Medicaid programs prohibit billing for a behavioral health visit and a physical health visit at the FQHC on the same day. There is no general Medicaid prohibition against this procedure, although some states follow the Medicare policy. Medicare reimburses a second all-inclusive rate for a FQHC visit with a clinical psychologist or clinical social worker on the same day as a medical visit. Medicare reimbursement is also permitted when a patient suffers another illness unrelated to the first medical visit.³⁶

Other Financing Mechanisms

Although the requirements of §1902(a)(30)(A) of the Social Security Act are one consideration that states contemplate when setting rates, they employ additional policies to ensure sufficiency of payment and access to services. These mechanisms, described more fully below, are frequently the subject of skepticism and congressional studies tasked with evaluating their value and appropriateness.

Disproportionate Share Hospital Payments

In the early 1980s, federal legislation established a requirement that states consider special payment needs of hospitals that serve a large portion of Medicaid and uninsured patients.³⁷ The rationale for the Disproportionate Share Hospital (DSH) program is that hospitals providing high volumes of care to low-income patients often lose money as a result of low Medicaid reimbursement and high levels of uncompensated care. Moreover, unlike other hospitals, they have fewer privately insured individuals onto which the costs of uncompensated care can be shifted. *High-DSH* hospitals tend to be public hospitals, children's hospitals, or certain other private nonprofit hospitals. They share a commitment to providing access to high-quality, cost-effective health care to all individuals in their communities, regardless of ability to pay.

Under the DSH program, the federal government makes supplemental Medicaid payments to eligible hospitals. States generally determine the amount of payments and methodology for

distribution. Aggregate DSH payments are capped by §1902(a)(13)(A)(iv) of the Social Security Act, and any individual hospital's DSH payments are capped at the difference between its costs of serving Medicaid and uninsured patients and its Medicaid compensation.³⁸

Under the Affordable Care Act, DSH payments to hospitals will be reduced over time. This scenario is discussed in greater detail in Module 7.

Upper Payment Limit

Although states have great flexibility in setting Medicaid rates, federal law prohibits them from paying certain types of facilities more than what Medicare would pay for the same services. For example—

- **For inpatient hospital or institutional services**, providers are divided into three primary groups: inpatient hospitals, nursing facilities, and intermediate care facilities for the developmentally disabled (ICFs-DD). Within these three provider groups, a secondary distinction is made for state owned or operated, non-state government owned or operated, and privately owned or operated facilities. Aggregate payments to each primary group of providers cannot exceed a reasonable estimate of what Medicare would have paid for those services.³⁹
- **For outpatient hospital and clinic services**, a single upper payment limit (UPL) is applied to aggregate payments for all providers combined; no distinctions are made between primary groups of providers or groups of facilities based on ownership (operation) status.³⁹

This ceiling is called the UPL. Because the rates that states pay providers are generally *lower* than Medicare rates, states can receive additional federal funding for the amount under the UPL by making supplemental payments to providers that are beyond regular Medicaid payments. Payments made to providers to fill in the gap between actual payments and the UPL are often generated by provider taxes and/or intergovernmental transfer (IGT) of funds from county or municipal governments (often the owners of local public hospitals) to state governments in order to generate the state's match. Provider taxes and IGTs are discussed further below.

The extra federal funding associated with the gap between Medicaid payments and the UPL can be retained by the state as net savings. These funds are used to finance other programs, paid to hospitals and/or other providers, or divided between the state and the provider community in any other fashion based on the state's UPL program design.³⁹

Medicaid managed care constrains states' gap financing. Services provided to Medicaid consumers enrolled in managed care are not included in the calculation of the gap financing payment to be made to the state. This means that states often must weigh the savings resulting from implementing or expanding managed care and the gap financing payments it receives from the federal government.⁴⁰

Provider Taxes

Under federal rules, the Medicaid state share (i.e., the portion of the Medicaid payment made by a state government) must be non-federal *public funds*. These may come from three sources—

- Direct appropriations to the state Medicaid agency (from the state legislature)
- IGTs
- Certified public expenditures (CPEs)⁴¹

Provider taxes fall into the first category because they produce revenue that flows into a state's treasury and are then directly appropriated to the state Medicaid agency. States can use provider taxes as part of the state Medicaid share in order to draw down FFP. As of May 2011, 47 states had at least one provider tax—

- 38 states had nursing home taxes
- 34 states had hospital taxes
- 34 states had taxes on ICFs-DD
- 11 states imposed taxes on MCOs⁴²

Provider taxes are any mandatory payment, including licensing fees or assessments, for which at least 85 percent of the burden falls on health care providers. The tax can apply to health care items or services or to the provision of (or payment for) such services.⁴³ Assessments or fees imposed on health insurance premiums paid by individuals or employers are not provider taxes.⁴⁴ There are 19 classes of health care services on which provider taxes may be imposed.⁴⁵ They are—

1. Inpatient hospital services
2. Outpatient hospital services
3. Nursing facility services
4. ICF-DD services^A
5. Physician services
6. Home health care services
7. Outpatient prescription drugs
8. Services of MCOs (including HMOs and preferred provider organizations [PPOs])
9. Ambulatory surgical center services (includes facility services only and not surgical procedures)
10. Dental services
11. Podiatric services
12. Chiropractic services
13. Optometric/optician services
14. Psychological services
15. Therapist services (includes physical therapy, speech therapy, occupational therapy, respiratory therapy, audiological services, and rehabilitative specialist services)
16. Nursing services (includes all nursing services, including those of nurse midwives, nurse practitioners, and private duty nurses)
17. Laboratory and x-ray services (includes services provided in a licensed, free-standing laboratory or x-ray facility)
18. Emergency ambulance services

^A This includes similar services furnished by community-based residences for the developmentally disabled, under a waiver under §1915(c) of the Act, in a state in which (as of December 24, 1992) at least 85 percent of such facilities were classified as ICFs-DD prior to the grant of the waiver.

19. Other health care items or services not listed above on which the state has enacted a licensing or certification fee, subject to certain additional requirements.

States may not use revenue from a provider tax as a state share unless the tax meets three basic requirements. Provider taxes must—

- **Be broad based.** To be broad based, a provider tax must be imposed on all the health care items or services furnished by all the non-federal, non-public providers in the class in the state. This principle also applies to taxes imposed on managed care plans. For example, a tax cannot be levied against just *Medicaid* managed care plans; it must be levied against *all* managed care plans.
- **Be uniformly imposed.** In general, a provider tax is uniformly imposed if it is the same amount or rate for each provider in the class.
- **Not hold providers harmless.** A provider tax is considered to hold a provider harmless if the providers paying the tax receive, directly or indirectly, a non-Medicaid payment from the state or any offset or waiver that guarantees to hold the provider harmless for all or a portion of the tax.⁴⁶

A general business tax that is not limited to health care providers—for example, a tax based on commercial activity—is not a provider tax, so the above analysis does not apply.

Intergovernmental Transfers

IGTs are funds transferred from other state or local public entities to the administrative control of the state Medicaid agency in order to draw down federal matching dollars. The funds used in IGTs must be *public* funds. IGTs are a permissible funding mechanism under §1903(w)(6)(A) of the Social Security Act, although §1902(a)(2) of the Act mandates that state governments pay for at least 40 percent of the non-federal share of Medicaid.

A survey conducted by the Kaiser Commission on Medicaid and the Uninsured in April 2001 indicated that there were 20 states with some form of local financial matching requirement. For example, New York requires counties to contribute 50 percent of the state share for Medicaid acute care services.⁴⁷ Note that just because a state has a county-based Medicaid delivery system does not necessarily mean that it uses IGTs.

IGTs are a legal and helpful financing tool for states, but they may become problematic when used in conjunction with other Medicaid special financing mechanisms such as UPLs or DSH payment arrangements. IGTs are sometimes criticized for:

- Making federal matching funds available for purposes other than purchasing covered health care services for Medicaid-eligible individuals
- Inflating Medicaid spending rates without a commensurate increase in spending for services for Medicaid enrollees
- Creating incentives for states to reduce their own funding for the facilities they operate and replacing their funds with federal dollars.⁴⁷

Certified Public Expenditures

CPEs are funds certified by a contributing public agency, such as a county government, or provider that is owned by a state, county, or city, such as a county hospital. They represent expenditures for which federal matching payment is allowable. A CPE must be an expenditure by another unit of government on behalf of the single state Medicaid agency. A CPE equals 100 percent of a Medicaid expenditure, and the federal share is paid in accordance with the appropriate federal medical assistance percentage (FMAP). In a state with a 60 percent FMAP for services, the CPE would be equal to \$100 in order to draw down \$60 in FFP.⁴⁸

A nonprovider public agency that pays for a covered Medicaid service that is furnished by a provider can certify its actual expenditure, in an amount equal to the State Plan rate (or the approved provisions of a waiver, if applicable) for the service. In this case, the CPE would represent the expenditure by the governmental unit to the service provider.⁴⁸

If the unit of government is the health care provider, then it may generate a CPE from its own costs if the State Plan (or the approved provisions of a waiver, if applicable) contains an actual cost-reimbursement methodology. If this is the case, the provider may certify the costs that it actually incurred that would be paid under the State Plan.⁴⁸

With both IGTs and CPEs it is important to note that, although a sub-state entity may contribute matching funds, Medicaid eligibility cannot be limited to the availability of funds within the local jurisdiction unless operating under a waiver of statewideness. So, although the responsibility for match can be shared with local jurisdictions, the Medicaid eligibility remains statewide.

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Appendix A: Authors and Reviewers

Authors

Vorys Health Care Advisors

Maureen M. Corcoran, M.S.N, M.B.A

Daphne Kackloudis Saneholtz, J.D.

Truven Health Analytics

John Easterday, Ph.D.

Rosanna Coffey, Ph.D.

Linda Lee, Ph.D.

Anika Hines, Ph.D.

Katharine Levit

Susan Raetzman, M.S.P.H.

Reviewers

Substance Abuse and Mental Health Services Administration

Kevin Malone

Juli Harkins

Rita Vandivort-Warren, M.S.W.

Allison Colker

Centers for Medicare & Medicaid Services

John O'Brien, M.A.

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SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities

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