Medicaid Managed Care
Proposed Concept Paper

Addressing Hospital Supplemental Payments in the Transition to Managed Care

North Carolina Department of
Health and Human Services

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Contents

I. Introduction

North Carolina currently reimburses hospitals for care delivered to Medicaid enrollees through a combination of base payments for services rendered and supplemental payments. Base payments account for $1.6B or roughly 40% of hospital reimbursements each year, while supplemental payments account for $2.5B or 60% of total hospital payments.

After the State transitions to Medicaid managed care, it will no longer be permitted to make most types of supplemental payments. To ensure that hospitals receive comparable reimbursement after the transition to managed care, the Department of Health and Human Services has worked closely with stakeholders to develop the following proposal for transitioning most supplemental payments to base payment rates.

II. Current Payment Structure

North Carolina currently makes base payments and supplemental payments to hospitals for services provided under the fee-for-service program.[1]

- **Inpatient Base Payments.** To calculate inpatient base reimbursement, North Carolina uses a Diagnosis Related Group (DRG) methodology.
    - Most hospitals have a base payment of $2,704 that is multiplied by the applicable DRG weight.
    - Hospitals also receive outlier payments to offset a portion of costs above a specified threshold.
    - Teaching hospitals have a graduate medical education (GME) component added to their base rate to offset a portion of Medicaid GME costs.
    - Critical access hospitals receive an interim payment based on the DRG methodology and receive a year-end cost settlement to get them to 100% of their inpatient and outpatient Medicaid costs.
- **Outpatient Base Payments.** Today, hospitals receive an initial reimbursement based off 70% of the hospital's costs, based on a ratio of cost to charges.
- There are two state teaching hospitals, UNC-Chapel Hill and Vidant Medical Center, that are also settled to their inpatient and outpatient costs.
- **Supplemental Payments.** North Carolina also makes several categories of supplemental payments to hospitals.[2] The three major categories are:
    - **Disproportionate Share Hospital (DSH) payments.** North Carolina makes several categories of DSH payments to various provider types. Public hospitals and critical access hospitals receive "basic DSH" payments, and public and private hospitals receive "HMO DSH" payments. UNC and institutions for mental disease each also receive DSH payments, and public hospitals receive "teaching DSH" payments.[3]

[1] This document provides an overview of the generally applicable payment methodologies. Some specific hospitals, including Vidant Medical Center and hospitals in the UNC Health System, are paid using different methodologies.

[2] Supplemental payments apply to inpatient and outpatient services, except that teaching DSH payments apply only to inpatient care.

[3] Most DSH payments are financed through intergovernmental transfers and certified public expenditures (CPEs). Distributions are made to public and private hospitals based on hospital class and degree of Medicaid and uninsured care delivered.

- **Deficit payments.** Public hospitals receive deficit payments to cover the difference between Medicaid DRG payments and Medicaid costs. Public hospitals finance the non-federal share of these payments through intergovernmental transfers**.** Private hospitals receive a deficit payment and an equity payment to cover the difference between the Medicaid DRG payments and Medicaid costs. Private hospitals fund the equity payment through a provider assessment. For hospitals with graduate medical education programs, the deficit payments cover any GME costs not covered by the base rate add-on described earlier.
- **Upper Payment Limit (UPL) payments.** Finally, hospitals receive a UPL payment to cover the difference between Medicaid costs and what Medicare would have paid. Both private and public hospitals fund the non-federal share of these payments through a provider assessment.

Hospital payments made for behavioral health claims covered by LME/MCOs are negotiated in contracts between those entities and are generally not prescribed by the Department. These claims are not reflected in the supplemental payment methodology described below.[4]

State appropriations fund the non-federal share of base payments, but the sources of the non-federal share for supplemental payments are predominantly provider assessments, intergovernmental transfers and certified public expenditures.

III. Proposed Payment Methodology: Guiding Principles

The Department has developed a proposed approach to hospital reimbursement in managed care based on the following guiding principles:

- Ensure reimbursement adequately compensates hospitals for provision of Medicaid and uninsured care.
- Ensure hospitals continue to equitably share the responsibility for provision of Medicaid and uninsured care.
- Link compensation directly to services rendered to enrollees.
- Promote value in the health care system.
- Achieve cost neutrality to the State.

The Department intends to work closely with the North Carolina General Assembly to secure any legislative authority needed to implement the approach proposed in section IV.

IV. Proposed Payment Methodology: Inpatient Payments[5]

Under the proposed model for inpatient payments, developed collaboratively with stakeholders, each hospital would have a unique DRG base rate that would apply in both fee-for-service Medicaid and Medicaid managed care, unless the hospital and plan agree to another reimbursement arrangement, for the first two to three years after managed care implementation.

[4] Rates for state facilities are set by the State and are not subject to negotiation.

[5] The payment methodology for UNC hospitals may differ.

The hospital-specific DRG base rates would be calculated to ensure that all hospitals in a class of providers—state-owned public, non-state owned public or private—receive the same portion of total Medicaid and uninsured costs covered. Specifically, the hospital-specific rates would be calculated as follows:

1. For each of the three required CMS classes of hospitals (public, state and non-public), calculate the aggregate amount of total Medicaid and uninsured costs for all hospitals in the class, including direct and indirect GME costs.[6]
2. Sum the total inpatient Medicaid payments currently made across all hospitals in each class based on the latest available supplemental payment plans.[7] Total payments include all hospital base, UPL, deficit and GME payments, but exclude DSH.[8]
3. Determine the ratio of aggregate inpatient payment to aggregate inpatient Medicaid and uninsured cost for each class of hospital ("ratio").
4. Multiply each hospital's total Medicaid and uninsured costs by its respective ratio to determine each hospital's total aggregate value of inpatient Medicaid payments.
5. Subtract each hospital's GME costs (if applicable) from its total aggregate value of inpatient Medicaid payments.
6. Divide each hospital's aggregate value of inpatient Medicaid payments, less GME costs, by its case-mix index adjusted discharges to establish the hospital-specific base payment per discharge.

PHPs would pay the hospital-specific DRG base rate per discharge as published by the Department, unless the PHP and hospital mutually agree to some different amount or methodology.[9] The Department would define an annual inflation factor at which the payment per discharge would increase in years following the initial calculated rate.

DSH and GME payments would continue to be paid directly by the Department and would remain outside of PHP capitation payments, as permitted under federal rules.

Under this model, hospitals would have the same percentage of Medicaid and uninsured costs covered as other hospitals in their class. Relative to the current system, this methodology provides more equitable compensation for hospitals that deliver a disproportionate amount of care to uninsured patients. Because this model accounts for care delivered to uninsured patients, there will be little disruption to the distribution of dollars among hospitals if the North Carolina General Assembly enacts Carolina Cares or similar legislation.

V. Proposed Payment Methodology: Outpatient Payments[10]

Under the proposed model for outpatient payments, each hospital would be paid a defined percentage of charges that approximates 100% of outpatient costs. This methodology would apply both in fee-for-service Medicaid and in Medicaid managed care for the first two to three years after managed care implementation.

[6] GME costs are calculated using Medicare cost finding principles.

[7] Refers to the annual MRI/GAP supplemental payment plan developed by the Department.

[8] Approach to outlier payment methodology currently under development.

[9] PHPs would be required to offer the Medicaid FFS rate to any hospital that meets objective quality standards and is interested in joining the PHP's network, due to the State's any willing provider provision.

[10] The payment methodology for UNC hospitals may differ.

Specifically, hospitals would be reimbursed for outpatient care based on a fixed percentage of charges, using the following methodology:

- Prior to the first year of implementation, the Department determines each hospital's Medicaid cost-to-charge ratio based on the most recent supplemental payments plan.[11]
- The Department publishes each hospital's unique Medicaid cost-to-charge ratio prior to implementation of the new methodology.
- Hospitals submit charges for outpatient claims to PHPs.
- PHPs multiply the submitted charges by the hospital-specific cost-to-charge ratio published by the Department to determine the payment amount,[12] unless the PHP and hospital mutually agree to some different amount or methodology.[13]
- The Department defines a maximum annual inflation factor at which hospitals can increase charges.

Under this model, hospitals would be reimbursed for the full costs of providing outpatient care and should see little disruption in payment for outpatient services. After the first two to three years of managed care implementation, hospitals and PHPs would be permitted to develop other mutually acceptable payment arrangements, including fee schedules or ambulatory payment classifications.

VI. Applying the New Payment Methodology

The new payment methodology would apply for non-behavioral health discharges and encounters[14] as described below.

- Fee-for-Service.
    - Fee-for-service rates, which apply to Medicaid and NC Health Choice programs, would incorporate this methodology concurrent with managed care rollout, or sooner as feasible.[15]
    - This would increase Medicaid payments to hospitals for cost-sharing for individuals with primary coverage from Medicare or commercial insurance—referred to as "crossover claims."
    - This would also increase fee-for-service payments to hospitals under the NC Health Choice program.
    - As discussed in section VII, the non-federal share of these enhanced fee-for-service and crossover claims will be paid through a small increase in the provider assessment.

[11] Supplemental payments plan cost-to-charge ratios derived from information reported on CMS Form 2552-10.

[12] As PHPs would be required to pay each hospital 100% of its cost-to-charge ratio, the terms "cost-to-charge" and "payment-to-charge" ratio may be used interchangeably.

[13] PHPs would be required to offer the Medicaid fee-for-service rate to any hospital that meets objective quality standards and is interested in joining the PHP's network, due to the State's any willing provider provision.

[14] As noted above, hospitals currently negotiate behavioral health reimbursement with LME/MCOs and would continue to negotiate behavioral health reimbursement with PHPs.

[15] The Department is assessing the feasibility of making this change in advance of PHP implementation as this change will require a State Plan Amendment approval from CMS and a change to NCTracks.

- Managed Care.
    - For the first two or three years of managed care, PHPs would be required to pay the fee-for-service rate for inpatient and outpatient reimbursement. For inpatient, this includes 1) the hospital-specific base rate that applies in fee-for-service, 2) the DRG base weights used in fee-for-service, and 3) the outlier methodology used in fee-for-service, unless the PHP and hospital mutually agree to some different amount or methodology.
    - Capitation rates would account for hospital payments at these levels.[16]

VII. Changes to Provider Assessments

Hospitals would continue to provide the same aggregate level of funding for the non-federal share, except that total contributions would increase slightly to reflect the increase in crossover claims and other fee-for-service payments.

To establish the new provider assessment rate, the Department would review historical aggregate contribution amounts, from hospital provider assessments and intergovernmental transfers, as a percentage of Medicaid costs. The new provider assessment rate would be set at a historical average to ensure adequate funding for all payments,[17] plus an upward adjustment to reflect crossover claims and any other payment changes. The State retention percentage would be adjusted to ensure there is no net budget impact to the State. The Department would adjust the assessment rate as necessary to account for changes in hospital payment levels.

[16]As discussed in the Department's "North Carolina's Proposed Program Design for Managed Care" (August 2017), the minimum medical loss ratio (MLR) would be set to account for the treatment of supplemental payments. As supplemental payments currently made to certain providers would be included in the capitation payments to PHPs, the minimum MLR would be higher than if the Department were to make those payments directly. The Department would require a rebate (i.e., payback to the Department) if PHPs report an MLR below the minimum MLR.

[17] Average would likely be based on most recent two to three years.